Mentally Ill Individuals in Jails and Prisons

ABSTRACT

Both targeted programs and wholesale changes are sorely needed in how individuals with mental illness are processed in the criminal justice system. Mental illness is not as directly related to criminal involvement or violence as is often assumed. Mentally ill individuals are nonetheless disproportionately present in jails and prisons. Efforts to reduce their numbers must take account of the heterogeneity of mental conditions and their changing nature. Understanding of the complex ways in which mental illness and involvement in crime and violence are related is a precondition for formulating realistic policies. The disproportionate presence of mentally ill individuals in jails and prisons will not be substantially ameliorated by new programs alone; these have limited reach and effect. Doing better in five respects is key: expand the reach of standard and innovative mental health services, divert mentally ill individuals early in the criminal justice process, enrich training of criminal justice personnel, use data more effectively, and promote interdisciplinary aftercare programs for people with mental illness when they are released from jails and prisons.

The disproportionate number of mentally ill individuals in jails and prisons raises broad ethical concerns and programming challenges. Incidents in which individuals with mental illness commit a crime blur the line of culpability and raise doubts about the likely effectiveness or fairness of criminal justice processing. At the same time, efforts to deal with these incidents must accommodate the realities of the nexus be-
tween mental illness and criminal behavior. Unfortunately, criminal justice system responses seem to be based more on vague notions, myths, and misunderstanding than on sound policy analysis.

If being mentally ill means “experiencing symptoms or receiving mental health treatment,” estimates are that about 56 percent of state prison inmates and 64 percent of jail inmates are mentally ill (James and Glaze 2006). If the focus is narrowed to serious mental illnesses, such as psychotic symptoms, mania, and severe depression, between 10 and 20 percent of jail inmates and 25 percent of prison inmates are seriously mentally ill (Daniel 2007; Steadman et al. 2009). The prevalence rate of serious mental disorders among jail inmates is somewhere between three and six times that in the general population; the level of disparity in prevalence rates doubles when considering just female detainees (Fazel and Danesh 2002; Steadman et al. 2009). If substance use disorders are added to the clinical picture, the rates are higher. Over half of both jail and state prison inmates have a substance use disorder. As many as three-fourths of both jail and state prison inmates with mental health problems have also been diagnosed as having a substance use disorder (James and Glaze 2006).

This is a broad, entrenched problem and cannot easily be dismissed as artifactual or fleeting. The mentally ill are overrepresented in these settings, even when analyses are adjusted to correct for differences in background characteristics between the general population and the incarcerated population (Teplin 1990; Teplin, Abram, and McClelland 1996). The scale of this problem increases when measured consistently. The average prevalence rate for serious mental health disorders in prisons reported by states has risen steadily in recent years, going from 17 percent in 2004 to 28 percent in 2011 (Hill 2004, 2008; Corrections Compendium 2011). There is some dispute about the stability and precision of the magnitude of estimates, but there is no doubt that disproportionate numbers of individuals with mental illness are in jails and prisons (Fazel and Danesh 2002; Prins 2014).

This is a substantial public policy problem. Consider jails. About 11.4 million people passed through the approximately 3,000 county lockups and jails in the United States in 2014. About 745,000 people are locked up in jails on any given day (Minton and Zeng 2015; Subramanian et al. 2015). If 15 percent have a serious mental health disorder, American jails have about 1.7 million annual contacts with seriously mentally ill individuals and have daily responsibility for about 112,000. Assuming a conservative 20 percent rate of mental disorder among the
approximately 1.6 million inmates in state and federal prisons, their man-
gagiers have daily responsibility for about 320,000 seriously ill people. As
John Wetzel, secretary of the Pennsylvania Department of Correc-
tions, notes, “It’s not great public policy for the secretary of correc-
tions to be responsible for mental-health care to a greater degree than
anyone else in the commonwealth” (quoted in Melamed 2014).

In this essay, we examine what is known about mentally ill offenders
in the criminal justice system, interactions between mental illness and
criminal activity, evidence about effective criminal justice policies, and
the implications of this information for thinking about and improving
practice and policy. We acknowledge that there are clear problems with
current procedures for processing and intervening with mentally ill in-
dividuals in the criminal justice system. There are philosophical and prac-
tical reasons for concern. However, simply identifying “mentally ill” of-
fenders, diverting some from the criminal justice system, and providing
better mental health services for those who remain are decidedly simplistic
solutions. Coordinated changes in programming, increased collaboration
across the mental health and criminal justice systems, and systemic reforms
in criminal justice case processing are all needed. Each is necessary. None
is sufficient.

This essay has three major sections and a conclusion. In Section I, we
examine the evidence about the disproportionate number of mentally ill
individuals in the criminal justice system. The estimates are striking. We
also examine theories that explain the origins of the overrepresentation.
None is totally convincing by itself. A combination of factors are in op-
eration.

Second, we examine what is known about relations between mental
illness and involvement in crime and violence. This is essential if policy
proposals are to be grounded on evidence rather than supposition. The
presence of a mental illness is rarely directly related to involvement in
crime but often should be a major consideration in formulating a success-
ful intervention strategy to reduce such involvement. Providing more,
standard mental health services is unlikely to have marked effects on re-
ducing violence or crime.

Third, we offer five proposals. These call for intervening with programs
of demonstrated effectiveness at strategic points and changing methods of
case processing. The proposals focus on upgrading standard mental health
services and developing innovative services for reasons of humane treatment,
developing structured decision making and guidelines for diverting mentally
ill individuals at the earliest stages, providing more extensive training to
Reinventing Systems for Mentally Ill Offenders

Stereotypes.—The vast majority of cases involving mentally ill individuals in the criminal justice system do not mirror those seen in the media. Most mentally ill people in the criminal justice system did not get there as a result of psychiatric deterioration precipitating crime or violence.

Diversity.—Mentally ill individuals are at higher risk for involvement in violence or crime, but the categorization of “the mentally ill” as a group masks important differences among individuals and changes over time within individuals.

Proposal 1.—Service Availability: Greatly increase the availability of mental health services in jails and prisons to avert crises related to psychiatric deterioration among prisoners with severe, identifiable mental health disorders. This is not done to reduce crime; it is the humane thing to do and will avert dangerous incidents and horrific conditions.

Proposal 2.—Diversion: Divert seriously mentally ill individuals charged with less serious crimes out of the criminal justice system at the earliest possible stages of official processing, preferably before or in lieu of jail entry.

Proposal 3.—Training: Expand training on mental health issues for personnel throughout the criminal justice system. Ensure that all personnel in criminal justice settings have at least rudimentary knowledge of what mental illness looks like and how to react to people who are afflicted with it.

Proposal 4.—Data: Identify and characterize individuals with mental health problems at each stage of criminal justice processing. Collect consistent and actionable data and take them seriously. Refine the data and put them to use by getting them to personnel who need them for decision making.

Proposal 5.—Aftercare: Form collaborations to improve service provision for mentally ill individuals returning to the community. Criminal justice and mental health professionals have to get adequate care and medications in place before release from jail or prison. Stop handing inmates off from one agency to another. Instead, form service teams that integrate information and resources.
criminal justice professionals about mental health issues, improving collection and use of data, and promoting interdisciplinary and focused aftercare programs.

Individuals with mental illness are much like the rest of us, including those who work in the criminal justice system. The solution to reducing their involvement in the justice system does not depend on curing their illnesses. It lies in helping them formulate plans for managing their illnesses in the community without having to deal with unnecessary additional difficulties and complications from the justice system.

I. The Problem

Diverse theories attempt to explain how current problems of mentally ill individuals in the criminal justice system arose and are perpetuated (Hills, Siegfried, and Ickowitz 2004). The simplest and most recurrent is that closing state psychiatric hospitals shifted mentally ill people to jails and prisons (“criminalization” of the mentally ill; Abramson 1972; Harcourt 2006). Although rhetorically appealing, this is far too simplistic. Numerous studies show that there was not a major transfer of individuals from state hospitals to jails or prisons (most deinstitutionalized mental patients returned to the community and largely stayed there) and that the formerly hospitalized people and the mentally ill individuals in jails and prisons are neither demographically nor clinically similar (Trestman et al. 2007; Pinta 2009). A small proportion of recent growth in incarceration rates (less than 20 percent) may be attributable to an increased number of mentally ill individuals who might formerly have been treated in hospitals (Raphael and Stoll 2013), but there is no credible evidence of a wholesale shift from one type of institutional care to another.

The deinstitutionalization movement provided opportunities for more autonomous living for a large group of intellectually and mentally disabled individuals (Kim, Larson, and Larkin 1999). At the same time, mental hospital closures resulted in painful examples of mentally ill individuals who ended up in jail or prison because of lack of adequate community care. The best evidence, however, does not suggest that deinstitutionalization was the only or a predominant explanation for current problems of mental illness in jails and prisons. It is more likely that mentally ill people have long been disproportionately present in jails and prisons, but there are now more than before. The relations between mental health care and the criminal justice system are far more
complex than a simple deinstitutionalization explanation can encompass.

Other reasonable explanations have been offered, but there is not convincing evidence of the validity or estimated effects of any of them (Fisher, Silver, and Wolff 2006). One is that mentally ill individuals are repeatedly arrested and charged for public nuisance offenses or homelessness related to an untreated disorder, thus building extensive criminal histories and a higher likelihood of being given jail time for future minor offenses (Borum 2000; Draine et al. 2002; the Sentencing Project 2002). This proposition is only partly supported by criminal record information; individuals with mental health problems in jail are about equally as likely to have committed a violent or property offense as a drug or public-order offense (Peterson et al. 2010). Inmates with mental health problems in state prisons are largely there for violent offenses (49 percent) rather than property or drug (about 19 percent each) or public-order offenses (12 percent; James and Glaze 2006).

Another hypothesis is that individuals with serious mental illness are arrested and processed unfairly by the courts, receiving harsher sentences than others convicted of similar charges. This may appear plausible because people with serious mental health disorders often have co-occurring substance use problems that may result in arrests for low-level drug offenses or they may associate with individuals especially likely to engage in other criminal offenses. There is only limited empirical support for this contention (Teplin 1983; Engen and Silver 2001), and it may or may not be linked to the high prevalence of co-occurring substance use disorders.

Finally, it has been suggested that lack of access to effective community mental health treatment exacerbates symptoms and complications that can result in an arrest. Support for this is sparse (Frank and Glied 2006; Peterson et al. 2010). It is likely that selective enforcement, concentration of mentally ill individuals in high-crime settings, and inadequate community mental health treatment all collectively contribute to the problem.

Once mentally ill people are arrested, the dynamics of criminal justice processing contribute to their high prevalence rates in jails and prisons. People with serious mental illness, compared with others charged with similar offenses, stay longer in jail (Ditton 1999). They are less likely to be placed on probation or other forms of community-based supervision (Council of State Governments Justice Center 2012). Mentally ill
prison inmates are more likely to be involved in assaults while there and more likely to be assault victims (Blitz, Wolff, and Shi 2008). Perhaps not surprisingly, mentally ill inmates are less likely to be granted parole at an early date and are more likely to serve out their maximum sentences (James and Glaze 2006; Schnell and Leipold 2006; Sarteschi 2013). They are also more likely once released to violate parole conditions and be returned to prison as a result (Wood 2011). These patterns may or may not result from insufficient mental health service provision in prison and in the community, but they clearly partly explain why high numbers of individuals with mental illness are incarcerated.

All of these regularities converge to create critical problems for corrections professionals who, despite being ill-equipped for the job, have the daily challenges of housing and effectively managing many people with significant mental health problems. These are not problems that can be ignored: “The courts have made it abundantly clear that correctional facilities are legally and constitutionally required to provide adequate mental health services for the inmates in their custody” (Hills, Siegfried, and Ickowitz 2004, p. 1). These problems must be addressed far better than we now do if we want to claim to have anything close to a fair and effective criminal justice system.

Addressing these problems will require more than simply improving the quality and quantity of mental health services in jails and prisons. Reduction in unwarranted overrepresentation of mentally ill individuals will also require innovative strategies to reform case processing. Just as a broad set of initiatives spanning the criminal justice system is needed to address the problems of mass incarceration (National Research Council 2014), an equally broad set of approaches is needed to address the imprisonment of too many mentally ill individuals. New and better methods are needed for keeping them from entering the front door of the criminal justice system, for letting more of them out the back door, and for reducing the number who are returned for technical violations.

Successful reduction of the proportion of mentally ill individuals in jails and prisons would serve a humane purpose and improve the climates inside jails and prisons. Mentally ill individuals are at higher than normal risk of being victimized (James and Glaze 2006; Blitz, Wolff, and Shi 2008), and these environments can contribute greatly to psychiatric deterioration (the Sentencing Project 2002; Angelotti and Wycoff 2010). Solitary confinement is particularly harmful (Grassian 2006). Mentally ill inmates are more likely to be involved in fights and to have misconduct
reports, which both disrupts the institutions and hurts their chances of release. A jail or prison is just not the right place for a person who is having a severe mental health incident or who has limited ability to relate to people or to negotiate dangerous social situations. Leaving mentally ill individuals in jails and prisons hurts them and undermines efforts to maintain safe and ordered institutional environments.

A commitment to increased humanity, however, will not be sufficient to motivate the changes needed. The vast majority of mentally ill individuals in jails and prisons did not get there because of malicious, unwarranted police action. They got there by committing illegal acts. Changes in case processing and in mental health services have to make involvement in the criminal justice system less harmful to mentally ill individuals and at the same time reduce their chances of future involvement with the justice system. A vein of utilitarianism must flow through proposals for special consideration for mentally disordered criminals. Their success will depend on whether they make sense in light of the goals of the criminal justice system and the realities of the relations between mental illness and crime. For that reason, we next consider how mental illness is related to violence and crime and how current research findings can help frame and assess policy choices.

II. Mental Illness, Violence, and Crime
Mentally ill people are sometimes portrayed in the media as victims of the criminal justice system and sometimes as villains who deserve whatever they get. In 2014 in Milwaukee, 31-year-old Dontre Hamilton, who had schizophrenia, was shot 14 times during a struggle after being rousted from sleeping in a park. In Houston at about the same time, 24-year-old Terry Goodwin, incarcerated on a marijuana charge and reportedly in need of mental health care, was alleged to have been locked into a filthy-ridden solitary confinement cell for nearly 2 months after attempting to assault a guard. There are also horrific stories of mentally ill individuals who commit heinous crimes. The Virginia Tech shooting, the movie theater shootings in Colorado and Louisiana, and the Newtown, Connecticut, massacre of school children are familiar examples.

These jarring high-profile cases receive wide media coverage, but we have to avoid thinking of mental illness and crime or violence in sensationalized, Home Box Office terms. These cases are unrepresentative and misleading. They shed little light on the relations between mental disorders
and violence or on how many thousands of mentally ill people are processed and affected by the criminal justice system. These cases are most instructive for illustrating how much can go wrong when public agencies abrogate their responsibilities to troubling, mentally ill people and when severe mental illnesses go unrecognized, untreated, or poorly treated.

A. Summary Point 1

STEREOTYPES.—The vast majority of cases involving mentally ill individuals in the criminal justice system do not look like those seen in the media. Most mentally ill people in the criminal justice system did not get there as a result of psychiatric deterioration precipitating crime or violence.

The most typical incidents at the nexus of the mental health and criminal justice systems are less stark than those described above. They rarely involve a clear, reprehensible victimization or villainy that poses issues in clear moral terms. They more commonly involve incidents in which a family member once again confronts a child or brother who is out of control and about to do harm, a partner who is drinking heavily and deteriorating psychiatrically, or a victim who has been harmed by an obviously confused or cognitively limited perpetrator who has clearly broken the law.

The relations between mental illness and crime or violence are murky because they are sometimes highly related, but not cleanly or directly. An individual who believed the cable repair man was an agent of the devil and must be attacked to thwart his evil actions offers a clear example of crime of violence related to mental illness. Less clear is an individual with a manic disorder who cannot stop talking nonsensically, thereby provoking a drunken fight over politics at a family get-together. Or a socially awkward young man with an autistic spectrum disorder and depression handcuffs another client at a day program, escorts her to a secluded room, and keeps her there as part of a sexually exciting “game.” These all exemplify situations in which the illegal act is a by-product of the mental health disorder, but they involve different models of the connection and of the actor’s culpability.

Mental illness and criminal behavior, including violence, are linked, but not simply in the facile story line in which someone “loses it,” “snaps,” or “has a breakdown.” When the offense is violent, it typically
involves a family member or a close acquaintance and is embedded in a history of tumultuous encounters (Newhill, Mulvey, and Lidz 1995; Steadman et al. 1998). Less than 20 percent of crimes involving people with mental illnesses are directly preceded by exacerbated symptoms (Peterson et al. 2014). In most cases, the relation between mental disorders and criminal behavior is indirect.

The largest proportion of criminal cases involving mental illness involve people of limited means who are living stressed and sparse lives and are difficult to engage and treat with conventional clinical approaches. Rarely does a mental illness provide either an adequate excuse or even a dispositive explanation for a crime or act of violence (Monahan and Steadman 2012; Skeem et al. 2015). Mental disorder is one factor that may sometimes be relevant, but it is seldom the only factor, or even a causal factor. Looking for a direct connection is a rational strategy to take when confronted with the aftermath of serious crimes or the harshness of the criminal justice system. High-profile cases in hindsight can make it appear that the connection is obvious and direct. The reality of the lives of hundreds of thousands of mentally ill individuals in jails and prisons rarely corresponds to this model.

B. Policy Implications of Summary Point 1

The simplistic but erroneous model of mental illness driving violence or crime leads to a simplistic policy solution: provide more mental health services. This might be politically popular, but it is ineffectual. Because the causal links between mental health problems and offending are often overestimated, it is easy to overestimate the likely effects of treating mental health problems (Peterson et al. 2014; Skeem et al. 2015). In addition, we overestimate the reach of traditional services. The reality is that many individuals with mental health and violence problems are not involved with mental health services. Individuals who commit serious violence, for example, homicide, and have serious mental health problems usually are not in treatment prior to the commission of the crime (Martone et al. 2013). Increasing funding for services not generally used by troubled, crime-prone individuals, and that if used are unlikely to be effective, is not a reasonable solution to violence or crime.

The most efficient approach would be to provide mental health services to individuals whose criminal involvement it would affect. This
might be achievable if we could accurately identify individuals for whom a decline in mental health functioning is linked to involvement in crime or violence. This implies methods for judging how influentially and how a mental disorder is related to crime or violence. Increased knowledge about this is critical (Monahan and Steadman 2012).

Reliance on mental health clinicians, particularly psychiatrists, to make these judgments unaided is unlikely to be the answer. Confirmation bias is alive and well in mental health practice, with professionals making inflated assessments of the magnitude of the link between psychiatric deterioration and medication compliance in high-risk patients and the occurrence of violence (Mulvey and Lidz 1998; Skeem et al. 2005). Development of semistructured assessment methods would be useful for identifying cases for intensive intervention and supervision, but no such methods are now available. Classification of mentally ill offenders in relation to the nexus between their disorder and their criminal involvement would be a valuable basis for policy making, but such a system does not exist. It is unlikely that clear links will be found between disorders and crime or violence for more than a small proportion of mentally ill individuals involved with the justice system.

There are grounds for some optimism that we could treat and monitor many of these individuals if we could identify them. There has been some progress on development of services to engage high-risk individuals over an extended period, which means that periods of heightened risk could prompt focused service. Some models of this sort (e.g., forensic assertive community treatment teams) have proven feasible and useful and are well worth developing and including in an array of services for justice-involved mentally ill individuals (Lamberti, Weisman, and Faden 2004; Morrissey 2013). In short, we have some usable knowledge about delivery of services to mentally ill, criminally prone people, but we need to become better at identifying them.

These types of services, however, would not be a panacea for dealing with the vast majority of mentally ill people in the criminal justice system. The group for whom such services might be prescribed and effective is relatively small, reductions in recidivism are significant but not overwhelming, and there is no indication from evaluations that symptom reduction is related to lower recidivism rates (Case et al. 2009; Steadman et. al. 2014). These services do, however, have a role to play in integrated systems of care.
C. Summary Point 2

DIVERSITY.—Individuals with mental illness are at higher risk for involvement in violence or crime, but the categorization of “the mentally ill” as a group masks important differences among individuals and changes over time within individuals.

In thinking about policy options, consideration needs to be given to the overlap between mental disorder and violence or crime at a broad population level. Epidemiological studies have repeatedly demonstrated an association (Tiihonen et al. 1997; Walsh, Buchanan, and Fahy 2002; Stuart 2003; Elbogen and Johnson 2009). While many find this uncomfortable because it inflames an already unrealistically high level of stigma of the mentally ill (Corrigan and Watson 2002; Pescosolido 2013), the finding that people who report mental health symptoms at levels above diagnostic thresholds also report committing doing more violence toward others is well documented. Several studies indicate a stronger association between having a mental disorder and being a victim of violence or crime (Teplin et al. 2005; Desmarais et al. 2014). Individuals with mental illness are at statistically significant increased risk of being involved in violence as a perpetrator or as a victim.

The limitations of this research need stressing. First, existing studies do not clearly indicate what types of mental health problems are consistently related to crime and violence. Particular disorders show different associations in these studies. Serious mental health disorders, such as schizophrenia and depression, generally show associations several times weaker than those for more behaviorally based diagnoses such as substance abuse or antisocial personality disorders (Swanson et al. 1990; Steadman et al. 1998; Elbogen and Johnson 2009; Oakely, Hynes, and Clark 2009). The strength of the associations between mental disorder and violence is neither strong nor totally consistent. Meta-analyses find that the association varies considerably across studies and appears to be related to study design features (Fazel et al. 2009; Fazel and Yu 2011). Some comprehensive, soundly controlled field studies using self-report methods indicate no higher likelihood of violence in individuals with serious mental disorders compared with their neighbors; increased involvement is associated only with co-occurrence of a substance use disorder (Lidz, Mulvey, and Gardner 1993; Monahan et al. 2001).
Second, these studies are not tests of the predictive power of mental health disorders as a risk factor for an individual engaging in violence or crime. Some research demonstrates that mental illness is more prevalent in a group of violent or criminal individuals than would be expected (e.g., Teplin 1990; James and Glaze 2006). Other studies compare samples of individuals with and without a mental illness (usually a sample of mentally ill individuals discharged from a hospital or program compared with those in a given community) and show that they differ significantly in their levels of violence or crime (e.g., Krakowski and Czobor 1994; Swanson et al. 1996; Fazel and Danesh 2002). These types of studies are valuable but do not provide clean empirical estimates of the likelihood that a mentally ill individual will be involved in violence or crime in a given period after diagnosis, or how much a mental disorder increases the likelihood of these activities (Elbogen and Johnson 2009). Obtaining these estimates would require studies that follow large samples of mentally ill and non-mentally ill individuals over extended periods; such a study has not been done for a variety of methodological and financial reasons.

The presence of a serious mental disorder is, however, probably not a particularly powerful predictor of future violence or crime. Other characteristics, including age, socioeconomic status, and alcohol or illicit drug use problems, are much more statistically predictive of involvement in violence or crime for people with or without mental illness (Bonta, Law, and Hanson 1998). The power of mental illness as a predictor diminishes greatly when these characteristics are taken into account (Elbogen and Johnson 2009; Skeem et al. 2014; Prins et al. 2015). Because an overwhelming percentage of people with mental health disorders are not violent or criminal and the occurrence of serious mental disorders is relatively low, only about 4 percent of criminal violence in the United States can reasonably be attributed to mentally ill individuals (Swanson 1994). The case for mental illness being a strong causal factor for crime or violence at individual or population levels is weak (cf. Kraemer et al. 1997).

This is not terribly surprising if criminal involvement and mental illness are understood as outcomes associated with growing up in high-risk environments. The field of developmental psychopathology has long recognized that behavioral problems cluster (Jessor, Donovan, and Costa 1991) and that individual risk factors seldom predict a singular
outcome. There is considerable variability. Large numbers of individuals do not develop serious mental health problems despite exposure to significant risk factors (e.g., mentally ill parents), and many individuals develop mental health problems despite having little exposure to risk factors (Rutter 1987; Cicchetti and Rogosch 1999). The concepts of equifinality and multifinality are important to keep in mind (e.g., see Cicchetti and Rogosch 1996). That is, different types of risk and protective factors can lead to the same outcome (equifinality), and any given risk or protective factor can lead to a multitude of different outcomes (multifinality).

People growing up exposed to high levels of multiple risks are more likely to develop mental health problems, criminal behavior, or both. This produces an association between those outcomes but does not indicate a causal link. It is therefore not surprising that adults and juveniles in the justice system with marked mental health problems are also likely to be high on indicators of criminogenic risk (Schubert, Mulvey, and Glasheen 2011; Skeem et al. 2014). Addressing one set of risks, however, does not mean that the other set of risks will be reduced. Programming directed at reducing both criminogenic and mental health–related risks seems to be required (Peterson et al. 2010).

To make things even more complicated, people fluctuate in their levels of mental health disturbance. A mentally ill individual can behave very differently depending on the stage or state of his or her disorder. For example, a person in the early onset stage of a psychotic disorder may exhibit a different symptom profile than later on (Schultz, North, and Shields 2007). Mental health disorders can “flare up”; manifested symptoms ebb and flow, affecting how an individual relates with others or functions in society (Odgers et al. 2009).

Mental health problems are best conceptualized along a fluctuating continuum of severity rather than as absolute invariant sets of symptoms (Adam 2013). Mental disorders do not simply unfold to an inevitable end state; the unfolding results from the person’s susceptibility to the disorder (how severe the loading for it) and the social context in which it is embedded. As with pulmonary disorders or other chronic conditions, people have different levels of susceptibility. They follow different paths of manifestation that are partly or largely related to the immediate environment. Mental disorders progress, deteriorate, stabilize, or get better with time and circumstance, just like other chronic diseases.
D. Policy Implications of Summary Point 2

These findings have broad implications that force us to recognize that there are not totally distinct groups of mentally ill individuals and criminals in the criminal justice system. The two conditions often overlap, a little or a lot depending on the type of disorder, the type of criminal activity, and the characteristics of the sample (e.g., history, current social context). This is generally understood intellectually but is often ignored in planning efforts concerning the disproportionate number of mentally ill individuals in the criminal justice system.

Thinking about the “mentally ill” as a group provides little theoretical or practical leverage. Mental health problems are not central components of the lives of many mentally ill people. Thinking of them as a readily identifiable group to whom “different” dynamics of living apply misses the opportunity to design practices and policies based on similarities and variability among them. As with any physical disorder, such as heart conditions, mental illness must be continually managed to avoid decompensation; having a chronic condition does not entail constant throes of impaired functioning. Mental health problems are best thought of as factors affecting what criminologists call “routine activities” or “local life circumstances” (Fisher, Silver, and Wolff 2006). Mental illness is an influential force in shaping the social context of an individual. Intervening may be useful for preventing relapse and averting crime. However, policies categorizing the “mentally ill” as a whole are too broad to be effective.

The majority of cases are more fruitfully conceptualized as involving individuals on whom mental disorders have diffuse effects that make violence or criminal involvement more likely through an indirect effect on their social world. In these cases, interventions are probably more effective if they adopt a “recovery” rather than a “cure” model (Pope et al. 2016). Recovery models recognize that people with mental health problems are dealing with a long-term disability and striving to manage their disease or symptoms effectively and construct self-directed lives (Institute of Medicine 2001; New Freedom Commission on Mental Health 2003; Farkas 2007). Positive change is related to increased hope and a sense of greater control over one’s life.

Adoption of this model for the vast majority of cases still involves mental health treatment for relevant disorders but reframes the importance of the disorder and the focus of the intervention. It requires think-
ing of the mental health disorder as a factor that affects the individual’s adjustment to an institutional setting or community rather than as a risk factor to be controlled to reduce reoffending. In the terminology of the risk-need-responsivity model for targeting interventions to reduce recidivism in the criminal justice system, mental health problems should be thought of as “responsivity” rather than “risk” factors (Andrews, Bonta, and Hoge 1990). After all, the most influential factors related to recidivism in non–mentally ill individuals are the same as for mentally ill individuals. Mental illness has to be considered in relation to the use of appropriate criminal risk reduction interventions. The question to be addressed is how to adjust for or integrate mental disorders into planning for services aimed at reducing rearrests.

III. Policy Proposals
This section offers policy proposals for addressing the disproportionate numbers of mentally people in jails and prisons. They are based on a number of premises:

- mental illness is a chronic condition that fluctuates in its presentation and severity and requires ongoing treatment;
- mental illness is a direct causal factor in criminal involvement in a small proportion of cases in the criminal justice system;
- individuals with mental illnesses, just like people without them, can be serious criminals characterized by many criminogenic risk factors who present substantial threats to public safety;
- except for acutely, seriously mentally ill individuals, identifying the mentally ill as a group has little usefulness for formulation of broad policies;
- time spent in jails and prisons almost never has a positive effect on mental illness, only rarely reduces future offending, and can reduce the chances of successful recovery.

The flow of less serious, mentally ill individuals into the criminal justice system needs to be reduced. New services need to be introduced that can benefit mentally ill individuals at different case processing stages by promoting recovery. Such efforts must be implemented systematically, and collaboratively, by personnel in both the criminal justice and mental health systems.
The sequential intercept model (Munetz and Griffin 2006) provides a useful framework for analyzing points in criminal justice processing at which mentally ill individuals might be diverted and, when appropriate, be directed toward mental health care. The “intercepts” are shown in figure 1. These are points in criminal justice processing at which diversion might take place through collaboration and targeted programming. The model proposes five intercepts from the point of arrest through re-entry into the community from jail or prison. Our proposals are discussed in relation to the five intercepts.

This framework is useful in efforts to promote changes at local levels (Griffin et al. 2014). Local “system mapping workshops” engage criminal justice and mental health professionals to identify strengths, gaps, and priorities for action. The effects of these workshops on functioning of local systems have yet to be demonstrated convincingly, but the approach provides a valuable starting point.

**PROPOSAL 1.**—Service Availability: Greatly increase the availability of mental health services in jails and prisons to avert crises related to psychiatric deterioration among prisoners with severe, identifiable mental health disorders. This is not done to reduce crime; it is the humane thing to do and will avert dangerous incidents and horrific conditions.

Individuals who commit serious crimes or pose a danger to society will be sent to jail or prison regardless of their mental health status. Once there, the stress of life behind bars, interruptions in treatment, or both may exacerbate mental health conditions and create hazards for other inmates. Yet the level of mental health care and programming in these settings is barbarically low. One analysis of the California prison system, for example, indicated that there were only 11,000 slots for substance use treatment for the 112,200 prisoners with substance use treatment needs (and this is without regard for the quality of the treatment provided; Petersilia and Weisberg 2010). Improved access to better treatment of mental health disorders in jails and prisons is desperately needed. Current levels of accessible care fall far short of adequate. Investments must be made in basic service provision.

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FIG. 1 — Sequential intercepts for change: criminal justice–mental health partnerships. Source: Adapted from Munetz and Griffin (2006).
The improvement of these services, however, should not be pursued in the belief that it will substantially reduce the frequency with which mentally ill, criminal individuals reappear in the criminal justice system. It won’t hurt, but it probably won’t help much either. It needs to be done simply because it is the right thing to do. Subjecting people with chronic disorders to conditions that promote suffering is cruel, not just, retribution.

Many correctional administrators have tried to increase availability of appropriate mental health services in their facilities for humanitarian reasons or in response to *Estelle v. Gamble*, 429 U.S. 97 (1976), which affirmed prisoners’ rights to mental health care. Guidelines have been developed to improve the identification of inmates with mental health problems, to provide and monitor systematic provision of medication and services, to set up procedures for proper use of restraint and seclusion, and to promote successful transition to community care (Hills, Siegfried, and Ickowitz 2004; Petersilia 2004; Osher et al. 2012). These efforts face considerable challenges, given the magnitude of the problem in relation to scant resources, the intractability of many prison environments, and the inherent difficulties of delivering effective mental health services within an environment in which security is a constant concern (Steadman and Veysey 1997; Farabee et al. 1999; Daniel 2007; Effective Health Care Program 2012). Limited access to services and dreadful conditions in many prisons make it clear there is much work to be done (Fellner 2006; Adams and Ferrandino 2008; Metzner and Fellner 2010). There are, however, several steps that can be taken to move in the right direction.

First, prisons must establish well-equipped special housing units. Prisons cannot escape the costs and needs for specialized settings for individuals experiencing psychiatric deterioration. Lawsuits for injuries from incidents relating to negligent identification and treatment of inmates’ psychiatric deterioration will continue to be successful and expensive. As a result, prison officials should be motivated to establish units that provide adequate security and safety and psychiatric attention to individuals experiencing the onset of severe symptoms. These units, which will need to resemble those in forensic hospitals, are being expanded in several state systems. This is likely to continue. Providing these specialized settings to individuals is the most reasonable alternative to holding these individuals in solitary confinement.
A complementary approach is to develop alternative services for mentally ill inmates to keep them from deteriorating. This can be done by adapting existing community treatment models to the realities and constraints of prison settings. Given the very limited behavioral health resources available to jails and prisons, this may be the most viable way to expand available services. Alternative services must be pursued in addition to expanding more traditional services.

Peer support is one innovative approach that has gained recent popularity and deserves serious consideration. The provision of peer support has been recognized as a potentially valuable mental health service for several decades in the community, becoming a fixed feature of mental health service networks; the number of these agencies is now twice the number of professionally run mental health organizations (Lucksted et al. 2009). Peer support is defined as “social emotional support, frequently coupled with instrumental support, which is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change” (Gartner and Riessman [1982] in Solomon [2004, p. 393]). The activities of trained peer support professionals in the community are directed toward identified goals in an individualized treatment plan, thus helping patients regain control over their lives (Sabin and Daniels [2003], cited in Grant et al. [2010]).

Several aspects of peer support make it an attractive alternative treatment model for jails and prisons. First, peer support aligns with the “recovery model.” The recovery approach is a reasonable frame for addressing chronic mental disorders for those spending long times in controlled settings. Second, many of the techniques and approaches used mirror those used in cognitive behavioral treatment that have been shown to be highly effective as components of prison-based rehabilitation programs aimed at reshaping criminal attitudes and problem solving (Allen, MacKenzie, and Hickman 2001; Wilson, Bouffard, and MacKenzie 2005). Third, peer support relies on the premise that positive change occurs from a social learning process, positing that individuals adopt positive (or negative) behaviors by modeling what works for others and that positive change comes from developing more self-efficacy, a sense that things can be different in their lives and that they can be active agents in making those changes. Finally, in the prison setting, peer support models can benefit both the peer support specialist (through positive skill building and focus) and the recipient (through the support provided)
at relatively low cost. Despite widespread acceptance and potential validity, though, no one knows whether this type of service will have positive effects on mentally ill inmates.

PROPOSAL 2.—Diversion: Divert seriously mentally ill individuals charged with less serious crimes out of the criminal justice system at the earliest possible stages of official processing, preferably before or in lieu of jail entry.

The simplest and most cost-effective way to keep mentally ill individuals out of the deep end of the criminal justice system is to divert them at the front end. It is often observed that once someone is entangled in the justice system, it is hard to disentangle them, and considerable resources are invested in the process. Methods have been developed for moving mentally ill individuals to other services or community placements at intercepts 1 and 2 in figure 1. These approaches must be improved.

Much activity in recent decades has focused on increasing the capacity of police officers to recognize and divert mentally ill individuals. Specialized police response programs have been established in many places (Steadman et al. 2000; Hails and Borum 2003). These come in three forms: police-based response (specially trained police officers respond), police-based mental health response (mental health professionals work in the police department to provide consultation to officers in the field), and mental health–based specialized response (mobile mental health crisis teams operate independently but often in cooperation with police). In all three, the primary goal is to recognize incidents involving a mental health crisis, defuse the situation, avoid a confrontation, and promote contact with mental health services.

The Crisis Intervention Team (CIT) is the most widely known and used police-based program, currently estimated to be operating in 2,600 communities in 45 states (http://cit.memphis.edu/). CIT was developed in Memphis following the 1988 police shooting of 27-year-old Joseph Dewayne Robinson, who was in a mental health crisis, was threatening suicide, and was cutting himself with a knife. CIT is an attempt to improve how municipalities manage mental health emergencies by increasing use of criminal justice–mental health partnerships. Part of the effort is crisis intervention training for police officers, a 40-hour program that includes modules on mental health disorders, de-escalation tactics, and mental health treatment options available in
the community. The approach is attractive to police departments because it generally fits their accepted worldview (it was created by cops) and expands officers’ skills that can reduce injury in a broad range of situations, not just those involving mentally ill individuals. Mental health care providers see it as a positive opportunity to work with a segment of the community (law enforcement) that they have long avoided. The involvement of patients opens up communication lines that are often frayed.

Many jurisdictions have replicated the Memphis program with varying levels of fidelity. Officer training has received more emphasis under CIT auspices than have partnerships with mental health agencies (Canada, Angell, and Watson 2010; McGuire and Bond 2011; Cross et al. 2014; Munetz et al. 2014). There is empirical evidence of positive effects of training on officer knowledge and attitudes, but little work has been done on the dynamics of cooperation and referral between police officers and mental health agency representatives (a key measure of success identified by the program’s originators). Multiple studies indicate that CIT improves officers’ attitudes about interactions with persons with mental illness and officers’ confidence in their ability to respond appropriately (Compton et al. 2008; Ritter et al. 2010; Watson et al. 2010). Some recent research indicates that trained officers arrest mentally ill individuals less often (Compton et al. 2014a) but may be just as likely to use force in an incident (Compton et al. 2014b). Testimonials are many, but scientific evidence on outcomes is sparse.

It is difficult to gauge whether police training and specialized responses have substantial effects on rates of arrest or diversion of mentally ill individuals from jail. Police behavior is generally shifted by broad organizational mandates (e.g., required arrests in domestic assault cases) or changes in everyday outcome measures (e.g., efficiency measures such as response time). The lack of specified, justice system–related outcomes expected from the initiation of CIT and other specialized response approaches makes it questionable whether they will have large intended effects. The benefits may be substantial in terms of officer competencies and attitudes; whether these efforts stem arrests and jailing of mentally ill people is an open question.

This training may have a sustained effect only when it is paired with organizational changes in how police departments and mental health agencies cooperate to provide readily available options for police referrals in mental health crises involving suspects with less serious charges.
The desired goal is for mentally ill individuals to be connected with appropriate mental health services rather than be processed in the criminal justice system. However, simply not arresting someone is different from moving that person into an alternative system. One challenge is that community mental health providers sometimes resist working with justice-involved individuals, citing increased liability or the intractability of this group of patients (Massaro 2004). For alternative referral systems to work, this reality must be addressed with vigor equal to that expended on police training. Police and mental health agencies must confront these realities openly and collaboratively, by setting clear guidelines and behavioral expectations for both law enforcement and mental health personnel. This will require that cooperation agreements between police and service providers be in place.

There are some promising successes. Portland, Oregon, built an organizational framework for assuring appropriate referrals (Subramanian et al. 2015). Specialized teams of officers respond to calls involving suspected mental health disturbances. A mobile crisis unit pairs an officer with a mental health professional. Officers work with a service coordination team that offers treatment instead of jail for individuals with mental health or substance use problems who have had repeated contacts with the police. Rudimentary analyses of cost savings have been done (Cloud and Davis 2013; Waller et al. 2013), but systematic evaluations are lacking. Elaboration and assessment of organizational reforms are needed to capitalize on widespread implementation of training.

Efforts can be made to identify and divert mentally ill individuals with less serious charges (usually misdemeanors) at later points in criminal justice processing. This becomes increasingly difficult, however, as criminal justice processing becomes increasingly “official” and numerous legal actors are associated with diversion. Some locales have placed people trained in mental health issues at booking desks in police stations or at arraignment hearings. They work out referrals or resolutions for treatment in lieu of prosecution (see http://www.pacenterofexcellence.pitt.edu). There is anecdotal evidence about the success of these efforts, particularly in smaller communities where the screening person can quickly contact alternative service providers.

Mental health courts provide the best-known example of a systematic effort to introduce a legally grounded alternative to standard processing and jailing of individuals with mental health problems. The first one was established in 1997. As of 2013, there were over 335 in 43 states (http://
These courts are designed to address underlying causes of offending rather than simply to determine guilt and punishment. The rationale is that appropriate treatment will reduce criminal justice contact and that close, supportive court supervision will increase treatment involvement. Judges use a variety of methods, including cajoling and threatening sanctions, to promote engagement in treatment until the “arrestee is consistently engaged in treatment, is less symptomatic, and avoids criminal justice contact” (Swartz 2014, p. 1077).

Evidence of the effectiveness of mental health courts (MHC) is inconclusive (Honegger 2015). It is accurate to say that “the popularity of MHCs in recent years has outgrown empirical evidence on their effectiveness” (Kim, Becker-Cohen, and Serakos 2015, p. 28). Some recent evidence shows that participants had significantly lower 1-year recidivism and a longer time to rearrest than did similar individuals who did not participate in MHC, even after controlling for possible confounding variables (Ray 2014; Hiday, Wales, and Ray 2015). Rossman et al. (2012), using propensity score matching, found significantly lower recidivism rates in MHC participants. Meta-analyses of MHC evaluations, however, note that evaluations are consistently weak, with only two randomized clinical trials in the literature (Kim, Becker-Cohen, and Serakos 2015). There is no clear evidence that MHCs reduce clinical symptoms among participants or that reduced recidivism from MHC involvement is related to symptom reduction (Griffin and DeMatteo 2009; Steadman et al. 2014). Processes and experiences in MHCs appear to vary, and that variability matters. Several investigators have found that perceptions of procedural justice and coercion interacted with MHC court outcomes (Pratt et al. 2013; Canada and Hiday 2014; Munetz et al. 2014; Redlich and Han 2014) and with participants’ attitudes toward their own recovery (Kopelovich et al. 2013). This approach is considerably more complicated than simply coming before a judge and having a connection made with treatment professionals.

Part of the attractiveness of MHCs rests on their alignment with the realities of relations between mental illness and criminal involvement. The MHC provides ongoing assessment and supervision, allowing for tracking and responding to fluctuations in an individual’s symptoms and functioning. It recognizes the need to address the fluctuating state of mental disorders. If working well, it takes an individual’s criminogenic needs into account as factors to be addressed and monitored (Campbell
et al. 2015). Finally, it addresses a range of elements related to the individual’s adjustment in the community (such as job performance), recognizing that the presence of a mental health disorder is just one aspect of how well someone might function every day. In short, MHCs promote a recovery model melded with the power of the court to sanction criminal behavior.

MHCs, however, have the capacity to reach only a small proportion of individuals with serious mental illness who are involved in the criminal justice system. Eligibility criteria are usually negotiated between treatment providers and the district attorney; political considerations are often highly influential. District attorneys and victims usually retain a veto over court entry in individual cases. As a result, persons charged with serious violent or sexual offenses are usually excluded, since a high-profile incident involving an MHC client is in no one’s interest. In addition, involvement with the court generally requires that a person agree to abide by and complete the conditions laid down; these are sometimes more demanding or take longer than simply serving the sentence. As a result, not all offenders opt in.

These approaches, even if successful, will have limited impact, reaching a select and relatively small number of mentally ill offenders. Given the large number of mentally ill individuals entering the court system, the limited resources available for these programs, and the need to limit eligibility to people charged with less serious offenses, these interventions are unlikely to reduce greatly the flow of mentally ill individuals into the criminal justice system.

MHCs are a valuable option to promote diversion of some mentally ill offenders, but policies to reduce charges or defer prosecutions for lower-level offenses may be more promising. Wholesale diversions may move a large number of mentally ill people away from criminal prosecution, in much the way in which wholesale prosecution moved them in. Despite efforts expended on developing targeted diversion strategies, initiatives aimed at reducing prosecution of lesser drug offenses or diverting cases toward alternative dispute resolution may have larger effects.

Initiation of systemwide programs, however, rests heavily on the willingness of district attorneys to champion them. The better connected district attorneys are to the community and its service providers and the more they can obtain political cover from a structured screening process, the more comfortable they may be with such efforts. Wholesale reforms of system penetration involving district attorneys may be worth
more than increased implementation of any of the specialized models yet
developed.

Proposal 3.—Training: Expand training on mental health issues for per-
sonnel throughout the criminal justice system. Ensure that all per-
sonnel in criminal justice settings have at least rudimentary knowl-
edge of what mental illness looks like and how to react to people
who are afflicted with it.

The general public is woefully misinformed about mental illness. Misperceptions abound. A common view is that mentally ill individuals
are dangerous, violent, and unpredictable (Arbore-Florez and Sartorius
2008). This view varies somewhat with age, gender, and level of education
(Rabkin 1974; Segal 1978; Ojanen 1992; Morrison, DeMan, and Drum-
heller 1993; Chou and Mak 1998). The pool from which criminal justice
personnel are drawn is likely composed of similarly misinformed individ-
uals. Police officers, prosecutors, defense attorneys, court personnel, jail
and prison staff, probation and parole officers, and others in the criminal
justice process are too often ignorant of the myths and realities of mental
illness and the implications of mental health problems.

This can be addressed in a straightforward way. There should be
broad-based efforts to increase knowledge about mental illness, with
such training being standard in orientation of new personnel. The logic
is simple: appropriate use of discretion requires that criminal justice per-
sonnel understand the problems they face and know how best to react.

Police departments have taken great strides. A widely accepted training
approach, Mental Health First Aid (MHFA), has emerged as an extensively
distributed supplement to CIT training. MHFA was developed in Aus-
tralia and brought to the United States in 2008. It is a general, 8-hour
course that covers risk factors and warning signs for mental health and ad-
diction problems and how to help someone with these problems. This ap-
proach is particularly attractive to small police departments or agencies
that cannot devote large amounts of resources to training. There is some
evidence that it alters attitudes about mental health disorders and social
distance with mentally ill individuals (Hadlaczky et al. 2014).

MHFA would be appropriate training for any criminal justice person-
nel. After booking and before trial, expanded training could help person-
nel recognize the possibility of a mental health problem, thus prompting
assessment for the appropriateness of diversion (Steadman et al. 1999). Basic training for jail and prison personnel would help them understand and interpret behaviors of inmates with mental health problems. An inmate with a serious disorder who does not respond to a command to go into a cell, for instance, may not be flaunting authority, but may be influenced by distracting thoughts or inner voices. The Pennsylvania Department of Corrections (with the Pennsylvania Commission on Crime and Delinquency) recently completed MHFA training for over 15,000 employees. Going forward, the training will be part of basic training for all new employees (http://www.prnewswire.com/news-releases/pennsylvania-department-of-corrections-meets-aggressive-goal-for-mental-health-training-300103479.html).

Training for probation and parole officers would also be useful. Seventy percent of offenders with mental illness are under parole or probation supervision at some point (Bonczar and Glaze 2009). They are more likely to violate conditions than are nondisordered people (Dauphinot 1996). Some of this difference may be attributable to the propensity of probation and parole officers to exaggerate the role of mental illness in their assessments of risk (Eno Louden and Skeem 2013). Accurate information could reduce this tendency.

PROPOSAL 4.—Data: Identify and characterize individuals with mental health problems at each stage of criminal justice processing. Collect consistent and actionable data and take them seriously. Refine the data and put them to use by getting them to personnel who need them for decision making.

Estimates of the prevalence of particular mental health disorders in jail and prison populations vary widely. This is mainly the result of differences in sampling strategies and definitions of disorders. A similar situation exists in practice. Police departments rarely have a systematic or uniform method for identifying calls involving a mentally ill individual. This determination is usually made by the dispatcher assigning the call (on the basis of the initial request for help) or by the officer writing the incident report. Exact definitions do not exist. Courts generally identify cases as presenting mental health problems only when an attorney or judge requests an evaluation. Jails and prisons use a variety of methods to screen for the mental health status or suicide risk of inmates (includ-
ing some structured instruments), but most locales neither use a validated instrument nor screen consistently.

A critical step is being able to identify who has a serious mental health disorder at each point in criminal justice processing. Yet we do not do this consistently or uniformly, crippling both sound policy development and service refinement (Mulvey and Schubert 2014). Doing so, however, would provide accurate assessments of the flow of these individuals and identification of problems and progress in intervening with identified cases. No competently run business would make strategic decisions based on suppositions rather than data, but this is what is done at the nexus of the criminal justice and mental health systems.

While clearly aspirational, some achievable steps could be taken. One might be the addition of a “premises flag” to police databases, a system used in Chester County, Pennsylvania. The alert program provides families with a uniform method for alerting first responders about individuals with special needs who reside at a particular address. Families or individuals proactively submit a form containing information about the individual. This assists first responders by giving them advanced knowledge, both medical and behavioral, that helps them be better prepared before they enter a residence or interact with the individual. Such information could be included in police databases and linked to a particular address so the information routinely appears when an incident occurs at that address. Officers could expand the information and include additional addresses as encounters occur. It is not realistic to think that police officers will become accurate screeners for specific types of mental illness in the field, but an alert system could provide forewarning to such situations.

The first point at which more detailed, systematic data collection could be available is at initial arrest or detention (intercept 2 in fig. 1). Booking centers, pretrial services, and detention facilities are all appropriate points at which structured screening procedures could be implemented and valid data could be collected for use at subsequent stages of processing. Several field-tested jail screening instruments are available (Steadman et al. 2005; Ford et al. 2007; National Institute of Justice 2007). These have been used effectively in numerous sites nationwide to find individuals with mental health needs before trial (to identify appropriate candidates for specialty courts) and at jail entry. In some locales, this information is then sent to a specialized team that contacts the jail inmate to see if appropriate services might be offered or if his
or her mental illness may be a factor in obtaining effective representation. Making these practices standard makes sense.

This will not be as easy or straightforward as it should be. There are two common challenges. First, small jails often have limited or no resources to collect this type of information. There may be few staff on duty at any given time and no system for recording centralized information on a computer. Second, screening for the presence of problems is too often where the process ends, leaving people minimally invested in making the data accurate or complete. The use of screening information to trigger more in-depth assessments or particular services is usually done inconsistently, and organization of those data into a centralized database is rare. Screening is possible and is becoming more accepted, but it is a long way from being fully implemented in most locales.

States could encourage wider screening and more uniform local assessments. Statewide adoption of a uniform screening instrument and the development of a software platform for implementing that screen would be first steps. Tying funding opportunities to the provision of information about mental health jail counts would also help. More assertively, states could require counties to report in standard formats using accepted methods, much like the procedures in child welfare. Subsequent state publication of county-level data regarding the processing of identified mentally ill offenders would promote interest, and possibly dread, in many locales.

Prisons have similar problems with consistent screening and assessment, but these activities may be more feasible and desirable to do. Prisons benefit from having initial assessment information to determine unit assignments. In addition, individuals are in prisons for longer stays and the window for careful screening and assessment is wider. Thus, many state correctional systems do extensive assessments of individuals upon admission. Refinement of these methods to characterize treatment needs and more extensive data analyses might be the only major improvements needed in many systems.

The identification of individuals with mental health problems is a key step in addressing the problem that too many mentally ill people are incarcerated. It is difficult to get accurate and comparable information within or across criminal justice processing points, across time at any one point, or across processing points in different locales. Defining this problem so poorly leads to well-intentioned, but often uncoordinated and poorly targeted, efforts at reform. Substantial improvements in iden-
tification and treatment rest on having more fine-grained and consistent information.

Consistent data also allow for identification of cases requiring more resource investment. Particularly expensive or intense services, such as forensic assertive community treatment, should focus on individuals who have a serious mental health disorder and who are highly likely to recidivate (Lamberti, Weismann, and Faden 2004). Identification of individuals who use a large number of services, who do not comply with services, or who cannot maintain a stable lifestyle under certain living conditions is possible only with extensive, organized data over time. The chronic quality of mental illness means that an individual’s patterns over time are most telling about what services or sanctions make the most sense. Efficient allocation of resources and the proper matching of interventions with individuals can be accomplished only with comprehensive records of mental health interventions and criminal justice contacts that can be accessed by both processing and treating personnel.

**Proposal 5.—Aftercare:** Form collaborations to improve service provision for mentally ill individuals returning to the community. Criminal justice and mental health professionals have to get adequate care and medications in place before release from jail or prison. Stop handing inmates off from one agency to another. Instead, form service teams that integrate information and resources.

Individuals with serious mental illness are particularly vulnerable to disruptions in life circumstances during the transition back to the community. Inmates with mental health disorders require a more complex set of supports and a broader range of services than does the typical inmate at reentry. Yet few states provide discharge services or follow-up care upon release from correctional settings (Theurer and Lovell 2008). Recently released inmates oftentimes have difficulty accessing community mental health care (Lamb, Weinberger, and Gross 1999). Perhaps as a result, mentally ill releasees are at twice the risk of failing in community supervision compared with non–mentally ill individuals and are more likely to fail because of technical violations (Porporino and Motiuk 1995; Baillargeon et al. 2009). These individuals are likely to be rearrested or hospitalized. Feder (1991) reported that 64 percent of offenders with behavioral health problems were rearrested within 18 months of release and 48 percent were hospitalized. A recent report by the New York
City Mayor’s Office bluntly notes, “The evidence is clear that connecting people with supports decreases the risk of re-offending and re-arrest and improves their lives and the lives of those around them” (City of New York 2014, p. 14). Mental health care providers in jails and prisons and criminal justice personnel have an obligation to formulate and participate in a recovery plan for mentally ill individuals leaving a facility (intercept 4 in fig. 1).

Putting together an effective recovery plan requires cooperation from agencies outside of the control of any jail or prison; oftentimes this is a bureaucratic nightmare. Community mental health care providers, family members, local law enforcement officials, and local support agencies (e.g., employment services) need to address the issues facing an individual trying to stabilize in the community after a jail or prison stay. The soundest strategy is to begin the planning process well before release. Some argue this needs to begin on the initial date of confinement, with reintegration teams constructed well in advance to make sure that any plan is carried out (La Vigne et al. 2008).

There are programs that can serve as models. These almost uniformly call for multidisciplinary and collaborative teams, including parole or probation professionals and local service providers. The more successful teams develop and follow an individualized reentry plan, guiding the returning prisoner through reentry (Solomon et al. 2006; Visher, Baer, and Naser 2006; Draine and Herman 2007; Mallik-Kane and Visher 2008). Most importantly, encouraging results indicate that such efforts can promote positive outcomes (Kim, Becker-Cohen, and Serakos 2015), with a Washington State team showing a 2-year recidivism rate approximately half that of a matched comparison group (Theurer and Lovell 2008). Maximal effects can be obtained from focusing resources on individuals with the highest need. This could be achieved by enrolling cases classified as high risk for recidivism on a structured assessment instrument and having a severe mental health disorder that would limit the person’s ability to enroll in and take advantage of community services.

Other promising approaches are “assisted outpatient treatment” and “forensic assertive community treatment” (Lamberti, Weisman, and Faden 2004). These use outpatient treatment laws to allow courts to order an individual to comply with treatment while living in the community. These orders compel the mental health system to provide appropriate treatment. Assisted outpatient treatment orders include more intensive case management or assertive community treatment team
services that closely monitor an individual’s involvement with required services (http://mentalillnesspolicy.org/aot/assisted-outpatient-treatment-guide.html).

Swanson et al. (2013) found that assisted outpatient treatment successfully reduced the number and length of psychiatric hospitalizations and decreased criminal justice involvement. Assisted outpatient treatment also increased the use of outpatient and medication services. These improvements were observed even after the court order for treatment had expired. Another California program, operating from more of an assertive community treatment model, has also shown positive results. This program was assessed using a randomized clinical trial approach, showing a significant difference between the groups in the proportion returning to jail on a new charge within a year (Burke and Keaton 2004).

The use of coercion to secure treatment for justice-involved individuals with serious mental illness is both promising and controversial. The idea of “coerced treatment” during a period of court supervision seems a reasonable demand in light of alternative court actions like imprisonment and may be viewed as a promising opportunity to improve service use by individuals with serious mental illness (Monahan and Steadman 2012). The idea of coerced treatment, however, has drawbacks. Some argue that the infringement on civil liberties and the undermining of a patient’s right to refuse treatment, and the erosion of the therapeutic relationship, are not worth the benefits (Mulvey, Geller, and Roth 1987).

One possible, and potentially important, benefit of assisted outpatient treatment is its coercive effect on providers. Mental health providers sometimes resist working with justice-involved individuals (Massaro 2004). The assisted outpatient treatment model helps overcome this obstacle by involuntarily committing the mental health system to provide its services to these clients, since the court order applies to both the patient and the provider (D. J. Jaffe; cited in Belluck 2013). Thus, this approach represents an opportunity to pressure providers and individuals, ensuring that mental health providers meet their duties decreed by the court. In the best outcome from this approach, a period of coerced treatment may be a conduit to continued involvement in care past the expiration of the court order (Swanson et al. 2013).

Specialized probation and parole officers represent another form of innovative assistance during reintegration, relying less on coercing the justice-involved individuals and more on providing criminal justice personnel with enhanced training and skills. Well-trained and supervised
parole and probation officers who handle specialized caseloads of mentally ill offenders could work with multidisciplinary local treatment teams. Having these specialized officers use strategies for forming well-structured collaborative teams could produce an effective method for promoting successful reintegration.

Many professionals have entrenched notions about why approaches that involve collaboration between the mental health and criminal justice systems often do not work (“boundary spanning”; Steadman 1992). One common barrier is that regulatory bans on information sharing of medical records prevent such efforts, that is, that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not allow it. This belief has become an immutable fact among many justice and mental health care professionals, even though the restrictions on information sharing are rarely as stringent or restrictive as they believe (Petrila, Fader-Towe, and Hill 2015). Efforts to mount these potentially effective programs should not be thwarted by misinterpretations of HIPAA; these are often simply excuses for organizational inertia. Locales can increase the likelihood of mounting effective reentry teams by clarifying and documenting the parameters of information sharing prior to service initiation (usually through memoranda of understanding).

There are also genuine obstacles to community integration planning and reentry. Perhaps the largest is the lack of adequate housing for mentally ill offenders. In a series of county planning sessions conducted recently throughout the state of Pennsylvania to promote diversion and reintegration of mentally ill offenders, housing problems were the most consistently identified difficulty for efforts to promote successful reentry (see http://www.pacenterofexcellence.pitt.edu). Unfortunately, there do not appear to be many readily identifiable solutions. Including housing officials or innovative housing program providers on the reentry team, however, is one step that could pay large dividends.

Ensuring continuity of care is also a major challenge, with or without specialized services. Not every mentally ill individual in jail or prison gets locked in an isolation cell and ignored. For many individuals, the treatment regimen they experience produces relatively stable functioning. Maintaining these improvements is achieved when appropriate community-based services, particularly medication, are provided expeditiously and closely monitored. In a patently counterproductive move, a number of states terminate an individual’s eligibility for Medicaid during incarceration, thus requiring reenrollment when returning to the
community. In addition, institutions often provide only a limited amount of prescribed psychotropic medication upon release, oftentimes not enough to cover the period required to complete the medical coverage reenrollment process or to be reassessed by a psychiatrist for a new prescription.

Changes in regulations regarding medical coverage for mental health services are needed to make the transition to the community smoother. It is essential that states establish methods for making inmates eligible for services the day they leave the institution or very shortly thereafter (and before they run out of medications provided upon release). In some locales, this means suspending, rather than terminating, Medicaid coverage during jail or prison incarceration. In others, it may mean bringing the eligibility qualification process into the prison or jail or streamlining the reactivation of service eligibility upon release. Whatever it takes is worth the effort. Creating an unnecessary barrier to reintegration makes no sense. The passage of the Health Care Affordability Act should alleviate some of these barriers (Regenstein and Rosenbaum 2014), but careful planning at the policy and casework levels to provide seamless coverage is essential.

Finally, reintegration teams could draw on some of the lessons learned in prior efforts to establish “wraparound” services for adolescents or intensive community services to mentally ill individuals coming out of hospitals (e.g., Walker, Koroloff, and Schutte 2003; Hodges et al. 2007). First, the number of cases must be limited and clearly defined. Providing this type of service with adequate intensity requires coordination and flexibility by service providers and justice officials. Enrolling too many inmates in a program guarantees that each will receive inadequate attention and individualization. Prioritizing cases by need and likely risk of recidivism is a prerequisite to avoid “mission creep” with inevitably limited resources. Second, the team must have access to funds outside normal channels, and the individual’s team must have the power to approve the use of these funds. Teams are not effective if they have to coordinate multiple funding mechanisms on different time frames with different approval processes; more time is spent coordinating paperwork than planning, delivering, and monitoring services. A single funding source is easier to accomplish in locales in which the corrections department is merged administratively with probation and parole services. Finally, the team must have a clinically sound consensus on the issues to be addressed and the approaches to be taken. Consistent clinical supervision and an explicit, ac-
cepted formulation of how an individual’s mental health problems fit into his or her community readjustment is essential.

IV. Conclusion
There is a sizable and formidable problem with mentally ill individuals in jails and prisons. There are too many in these settings. Getting them out will require a variety of approaches across several steps of criminal justice processing. There is no magical technology or single policy fix for this problem.

It will be necessary to consider the contours of the relationships among mental illness, violence, and crime before mounting programs and changing policies. The ideas that people with mental illness are distinct from others in the criminal justice system, always consistent in the presentation of their illness, and affected by a clear causal link between increased symptoms and violence or crime and mental health treatment (in terms of reduced offending) are all false. This makes the design and implementation of programs and policies tricky. It means that programs have to be specific about who are identified as “mentally ill” and how they are supported to prevent the recurrence of their chronic disorder and offending behavior. We need to recognize the realities of mental disorder, not media or political hype, and to be more effective in our efforts to identify, divert, treat, and reintegrate these offenders.

There are no overwhelmingly successful approaches that can realistically be expected to have large effects. There are things that need to be done or are worth trying. Many are discussed here. It is essential to take a collaborative approach in partnership and, within the criminal justice system, to take a comprehensive approach that spans all stages of criminal processing. However, even if things are done with a reasonable level of success, an unconscionably large number of mentally ill individuals may remain in jails and prisons.

It is almost inconceivable to think of a criminal justice system in which some “mentally ill” people are not confined. Having an illness does not necessarily limit a person’s capacity to judge right from wrong or to refrain from committing illegal acts. A person can be mentally ill and act knowingly and with disregard for community standards. An illness is not a dispensation from the social contract.

Current and likely future prevalence estimates of mental illness among people in the criminal justice system, however, make us wonder...
when that number is much too high. This is rooted in our discomfort with the injustice of persons being punished, often inhumanely, for a situation they did not bring on themselves. We should not punish someone harshly for being sick. We might be able to live with a little gray in judgment about these issues, but the consistently high rates of individuals with mental illness in the criminal justice system make us wonder whether this judgment has not swung substantially out of balance.

Given the currently overburdened mental health care system and unprecedented levels of incarceration, it makes sense to question whether far too many people are locked up who would be better off treated. Common sense tells us we must be locking up a large number of people for whom our only other recourse seems to be benign neglect. Just because someone commits a crime does not mean that imprisonment should be the inevitable consequence. If anyone should be deemed eligible for discretionary treatment, seriously mentally ill individuals are prime candidates.

Substantially reducing the number of mentally ill individuals in jails and prisons will rest on efforts to address this problem at a systemic level. Well-designed and well-implemented programs to divert or treat mentally ill offenders can have an effect. More are clearly needed. But broader systemic reforms also must be initiated. These are needed to move mentally ill people out of the justice system just as disproportionately as current practices move them into the correctional system and keep them there. Paradoxically, the way to address the problem may lie in recognizing that the mentally ill are not that different from anyone else. They just deserve a chance at more refined justice.

REFERENCES


Teplin, Linda A., Gary M. McClelland, Karen M. Abram, and Dana A. Weiner. 2005. “Crime Victimization in Adults with Severe Mental Illness: Comparison...


