

Criminal Justice Responses to the Mentally Ill

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Mentally ill criminal offenders often attract substantial attention from a broad cross section of society, particularly in the media. One of the most famous cases in history involving a mentally ill offender is the 1981 assassination attempt on President Ronald Reagan by John Hinckley Jr. Hinckley, who was diagnosed with schizophrenia, was found not guilty by reason of insanity in 1982 and since that time remains under institutional care at St. Elizabeth's Hospital in Washington, DC. It does not take an assassination attempt on a U.S. President, however, for the media to devote significant attention to the crimes committed by mentally ill offenders, or those presumed to be. Consider the following recent cases:

- Just before Christmas of 2012, 20-year-old Adam Lanza committed the most deadly school shooting spree in U.S. history. Armed with three of his mother's guns, he killed 20 children and 6 adults inside an elementary school in Newtown, Connecticut, before turning a gun on himself. Details about his mental status remain fuzzy, but news reports suggested that Lanza committed these acts after learning his mother was preparing to commit him to a psychiatric facility. But, much of what was reported in the news was either hearsay or conjecture. As of this writing, the fact is that it is not yet known whether Lanza had a history of psychiatric illness or if he had been exhibiting signs of a psychotic breakdown. Yet, reports of Lanza's purported mental status filled speculative media accounts of his heinous crime.
- In the summer of 2012, James Holmes killed 12 people and wounded 58 others inside an Aurora, Colorado, movie theater during a screening of *The Dark Knight Rises*. As of this writing, his case is pending, but his defense attorneys represented to the court that Holmes was mentally ill at the time of the shooting massacre and, therefore, they intend to litigate an insanity defense. In fact, before Holmes dropped out of a PhD program in neuroscience at the University of Colorado's Anschutz campus, he sought mental health assistance from professionals associated

with the university's mental health services. Details of Holmes's mental status have not yet been made public, but any mental illnesses revealed are likely to play a central role in his defense. Moreover, there will surely be significant questions about the civil liability of the university employed mental health professionals for their actions (or inactions) after meeting with Holmes and assessing his potential *dangerousness*.

- In 2011, Jared Loughner opened fire on a crowd of people in a Tucson, Arizona, shopping center parking lot. The shooting killed six people, including a federal judge, and injured 13 others, including U.S. Representative Gabrielle Giffords, whose treatment was followed intently by the media up until her resignation from her congressional seat in 2012. Loughner had been diagnosed with schizophrenia. He spent more than a year and a half in a secure *mental hospital* where mental health professionals worked to restore his competency to stand trial. In August 2012, a federal judge found that his competency was restored through treatment and then accepted Loughner's guilty plea. He was subsequently sentenced to life in prison without the possibility of parole.
- In April 2007, Seung Hoi Cho, who had been treated over a period of time for a variety of psychiatric symptoms, embarked on a shooting spree at Virginia Tech University, killing 32 people and injuring dozens more. At various times in his life, Cho had been diagnosed with major depression, social anxiety disorder, selective mutism, and an otherwise unspecified mood disorder.
- In 2001, Andrea Yates killed her five children by drowning them in the bathtub. Although diagnosed with postpartum depression and postpartum psychosis, Yates was initially convicted of five counts of murder. Her convictions were set aside by an appellate court when it was revealed that a mental health expert falsified evidence in the case. On retrial, she was found guilty by reason of insanity and committed to the North Texas State Hospital, where she remained until 2007, before being transferred to a minimum security hospital.

The interplay between the media and criminal justice may be greater today than ever before—between the 24-hour news cycle's unquenchable thirst for reporting sensational crimes and Hollywood's seemingly endless depiction of crime stories in television and film (Surette, 2011). But, other factors beyond the media contribute to the pervasive narratives of offenders with mental illnesses, such as the prevalence of mentally ill offenders committing crimes, the lack of access to mental health services that might prevent mentally ill people from committing crimes, and the poor outcomes that result from the way that those offenders are treated.

The Back Story: Historical Foundations

Since the founding of the United States, people with *serious mental illnesses (SMIs)* were often confined in jails rather than hospitals. That slowly began to change in the 1820s and 1830s with early reform efforts in Massachusetts. Between 1840 and 1880, the first wave of major treatment reforms for the mentally ill had taken firm root. Advances in the behavioral sciences in the early twentieth century spurred a second wave of reforms that produced little fruit. Advances in psychiatry in the 1950s and 1960s ushered in a third wave of reform efforts that produced profound effects, most notably the advent of psychotropic medication that allowed the mentally ill to lead lives outside the walls of institutions. But, the unintended consequences of those reforms led to the current situation, namely with hundreds of thousands of incarcerated inmates who have SMIs that not only affect their behavior, but also impact the lives of correctional officials, the other inmates, and the courts (see Fradella, 2003).

First-Wave Reform Efforts: From Jails and Prisons to Asylums

In the early part of the 1800s, a Massachusetts minister, Rev. Louis Dwight, began a crusade to improve the shockingly inhumane living conditions of mentally ill offenders when he delivered Bibles to prisoners. His efforts led the state legislature first to appoint a commission to investigate his claims, and then to enact a law making it illegal to confine the mentally ill in jails rather than in hospitals (Grob, 1966, as cited in Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010). A few years later, Massachusetts constructed the State Lunatic Asylum at Worcester to house up to 120 patients.

In the early 1840s, Dorothea Dix began to build on Reverend Dwight's early efforts. As a nurse, she witnessed the atrocious living conditions of inmates with SMIs, such as the caging and whipping of people experiencing psychotic symptoms in futile efforts to control their behavior (Viney & Zorich, 1982). Dix eventually visited in excess of 300 jails and 18 state prisons, documenting the cruel treatment of the incarcerated mentally ill (Dix, 1975, as cited in Torrey et al., 2010). As a function of her era predating the dawn of modern psychology and psychiatry, her views were radical for the time, although through her presentation of detailed case studies, Dix successfully convinced policy makers that more humane conditions for the mentally ill could lead to their improved functioning. By the time she died in 1887, she had visited every state east of the Mississippi River and 13 European countries (Viney & Zorich, 1982). Dix's efforts on both sides of the Atlantic are credited with facilitating the construction of 32 psychiatric hospitals and 15 schools for the "feeble minded" across the eastern United States, and her work had great impact on reform efforts in Europe (Viney & Zorich, 1982). According to Torrey and colleagues (2010), her reform efforts were so successful that by 1880, the U.S. Census "identified 40,942 'insane persons' in 'hospitals and *asylums* for the insane'[,] but only "397 'insane persons' in jails and prisons, constituting less than 1% (0.7%) of the jail and prison population" at that time (p. 14). Largely as a result of her accomplishments, the *Encyclopedia of Human Behavior* describes Dorothea Dix as "the most effective advocate of humanitarian reform in American mental institutions during the nineteenth century" (Goldenson, 1970, p. 341).

The first wave of reforms was based primarily on moral arguments about the ethical treatment of people with SMIs. These reform efforts brought long-lasting changes. The movement's emphasis on caring for the mentally ill fostered acceptance of a medical-psychological model of mental illness rather than theories of demonic possession that had prevailed until that time (Grob, 1966; Morrissey & Goldman, 1986). This, in turn, led to the establishment of asylums that were supposed to offer compassionate treatment of the mentally ill.

The spread of asylums was effective in moving those with SMIs out of jails and prisons and into treatment facilities. Indeed, until the 1960s, most studies found similar prevalence rates (i.e., less than 2%) of the mentally ill in jails and prisons as reported in the 1880 Census (e.g., Bromberg & Thompson, 1937). Rather, those with SMIs "were treated as patients, not as criminals, and were sent to mental hospitals [even though] the hospitals had little treatment to offer them at that time" (Torrey et al., 2010, p. 14). But, the goal of providing compassionate treatment to people with SMIs was never fully realized.

Asylums actually predate the first-wave reform movement. The first public asylum, Eastern State Hospital, was created in 1773 in Williamsburg, Virginia (*New York Times*, 1900). But most early asylums established in the United States were created by Protestants whose religious convictions led them to believe that it was their religious duty to care for "the less fortunate members of society" (Morrissey & Goldman, 1986, p. 14). Many of these asylums established a patient-care model based on the principles espoused by the Quakers at the time, who believed that people with SMIs should be treated "in a comfortable, clean, family atmosphere, in the tranquil surroundings of a country house" (Parry-Jones, 1988, p. 408). Indeed, the term "asylum" stems from the notion of a place of refuge—"a quiet haven in which the

shattered bark might find a means of reparation or of safety (p. 408). This philosophy guided most of the private asylums throughout the 1800s. Public asylums were generally created with this same patient-care model in mind. But, lack of public funding and sufficient staffing led public asylums to become sprawling, overcrowded places where people with SMIs lived in “bleak, impoverished wards” that served merely as custodial institutions rather than treatment facilities (Parry-Jones, 1988, p. 408; see also Morrissey & Goldman, 1986). Moreover, as the U.S. population increased, so did the demand for custody arrangements for those with SMIs. As a result, the wealthy largely turned to private, pastoral facilities while the poor filled public asylums that became human warehouses, which served as “a general-purpose solution to the welfare burdens of a society undergoing rapid industrialization and stratification along social class and ethnic lines” (Morrissey & Goldman, 1986, p. 17). In other words, treatment became a concern secondary to low-cost custody and community protection (Rothman, 1970).

Second-Wave Reform Efforts: The Rise of Psychiatry and Psychology

Around the turn of the 20th century, a scientific approach to mental illness began to take a firm hold. Scientific advances in neurology, psychiatry, psychology, and social work were spawned as a result of the work of researchers such as Adolf Meyer and William James. Their work focused on therapeutic treatments of mental disorders, “especially by early intervention in acute cases” (Morrissey & Goldman, 1986, p. 18; see also Deutsch, 1944).

The second-wave reform efforts led to the creation of “psychopathic hospitals” for the acute treatment of people with SMIs, most of which were affiliated with research universities (Morrissey & Goldman, 1986). Other mental health facilities, mostly clinics, were also created as a result of the increasing medicalization of mental illness care. But, these facilities, just as the psychopathic hospitals, were designed to provide acute care; patients with SMIs who needed long-term care were eventually sent to state asylums where they received little, if any, real care.

Some scholars argued that the various forms of mental institutions that operated between the late 1800s and the mid-1900s were driven primarily by humanitarian concerns to care for those with mental illness (e.g., Grob, 1994; Ziff, 2004). Others, however, argued that asylums and mental hospitals primarily served a social control function to reinforce individual conformity with prevailing societal expectations—especially in poor, immigrant populations (e.g., Foucault, 1965; Rothman, 1970; Scull, 1991). Whatever the motivations, it is clear that public mental hospitals proliferated in the first half of the twentieth century and their patient population ballooned from 150,000 in 1903 to 512,000 in 1950—“a rate of growth nearly twice as large as the rate of increase in the U.S. population as a whole” (Morrissey & Goldman, 1986, p. 19). Moreover, in spite of scientific advances in the behavioral sciences, most state facilities remained primarily custodial in nature, providing long-term custody not only to those with SMIs, but also to the poor and disabled who could not care for themselves.

Third-Wave Reform Efforts: The Community Mental Health Movement

The third wave of reform is referred to as the Community Mental Health (CMH) movement. CMH efforts emerged in the aftermath of the Second World War as a function of several significant factors. First, new psychosocial techniques developed during the war to provide acute care for those in military service proved to be successful on the front lines (Morrissey & Goldman, 1986; Spiegel & Grinker, 1945). Psychiatrists who returned to practice after serving in the military brought these techniques back with

them and taught others in state mental hospitals how to use them. Second, increased understanding of the importance of aftercare led mental hospitals to open outpatient clinics to serve those who were discharged after inpatient treatment while, at the same time, regular hospitals opened acute psychiatric care units (Morrissey & Goldman, 1986; Linn, 1961). Third, the federal government enacted a series of laws that not only established the National Institute of Mental Health, but also created far-reaching policies to foster mental health in the United States (Morrissey & Goldman, 1986; Foley & Sharfstein, 1983). Fourth, charges of neglect, abuse, and dehumanizing conditions in many state-run mental hospitals—such as those described in landmark sociological studies like Ervin Goffman's *Asylums* (1961), and those depicted in the movie *One Flew Over the Cuckoo's Nest* (Douglas, Zaentz, & Forman, 1975)—led civil libertarians and other activists to advocate for sweeping treatment reforms for those with SMIs. And perhaps most importantly, new psychotropic medications were introduced in the 1950s and 1960s (Talbot, 1982). These antipsychotic drugs—including Haldol, Mellaril, Moban, Navane, Perphenazine, Prolixin, Stelazine, and Thorazine—altered brain chemistry by regulating neurotransmitters. In doing so, these drugs enhance clarity of thought in those affected by psychosis, control for emotions, and prevent interference with rational thought processes. These developments led to the widespread release of the mentally ill through *deinstitutionalization* policies, which sought to reintroduce these patients to the community for supportive services.

The CMH movement spurred civil liberties activists to seek tightening of the methods which were used to involuntarily civilly commit the mentally ill. Prior to the 1950s, most states had only loose protections to prevent a person from being involuntarily hospitalized for psychiatric treatment. “Some jurisdictions statutorily authorized civil commitment for those persons defined as being a ‘social menace’ or ‘a fit and proper candidate for institutionalization’” (Fradella, 2008, p. 1972). But the advent of antipsychotic medicines, combined with the social movements of the 1960s—the CMH movement included—generated action by both legislatures and the courts to recognize that people with mental illnesses possessed a range of liberty interests protected by the U.S. Constitution, including “community-situated treatment, due process procedural protections, the right to treatment, medical and constitutional minimal standards in treatment, and the right to refuse treatment” (Arrigio, 1992/1993, pp. 139–140).

The landmark decision in *Lessard v. Schmidt* (1972) was decided at a time before many of the modern due process protections associated with civil commitment were enacted. Indeed, *Lessard* was largely responsible for transforming the legal landscape concerning due process in civil commitments (Mossman, Schwartz, & Elam, 2012). The case centered on a woman who was involuntarily hospitalized following an *ex parte* hearing about which she never received notice. She won her class action suit enjoining the state of Wisconsin from enforcing its involuntary commitment statute. One of the provisions the court ordered as part of its remedy in *Lessard* was to require evidence of risk as demonstrated by an actual threat or an *overt act*—some observable behavior from which dangerousness could be inferred. Several states subsequently adopted the overt act requirement as part of their own due process reforms, while other states did not (Mossman et al., 2012).

In the wake of *Lessard*, most states tightened their civil commitment laws so that mental illness alone, even if serious, did not suffice as the singular reason for commitment. Significantly, someone could only be involuntarily committed for treatment if a court found, by clear and convincing evidence, that the person represented a danger to themselves or to others (see *Addington v. Texas*, 1979). Although this *dangerousness* standard is universally concerned with imminent physical harm to oneself or to others, in about 30 states, it also includes dangerousness to oneself because of grave disability. This is described as a condition where someone is unable to provide for their basic needs, such as food, clothing, shelter, health,

or safety, but often only with the caveat that a failure to assist the person would result in a substantial deterioration of their previous ability to function on their own (Fradella, 2008).

The federal government also played an important role in facilitating deinstitutionalization. The CMH movement was successful in getting Congress to include incentives for moving patients out of psychiatric hospitals and into **community-based treatment** programs. Most notably, Medicaid and Medicare legislation passed in 1965 “purposefully excluded payments to ‘institutions for the treatment of mental diseases’ because the programs were not designed to supplant state control and financing of psychiatric facilities” (Harcourt, 2011, p. 67). This gave states an incentive to move psychiatric patients out of their hospitals and into communities where they became eligible for “Supplemental Security Income . . . Medicaid, food stamps, and other federal benefits” (p. 67).

Deinstitutionalization caused the resident population of state mental hospitals to decline by more than 75% between 1955 and 1980, while during this time frame more than 700 CMH centers were created (Morrissey & Goldman, 1986; Morrissey, 1982). As a result, state mental hospitals were closed across the country. But, on their release from mental hospitals, those people with SMIs rather than receiving community-based care were largely ignored because adequate funding was not provided to communities to support the needs of these patients (Bassuk & Gerson, 1978).

Deinstitutionalized patients encountered the hostility and rejection of the general public and the reluctance of community mental health and welfare agencies to assume responsibility for their care. Tens of thousands ended up in rooming houses, foster homes, nursing homes, run-down hotels, and on the streets. (Morrissey & Goldman, 1986, pp. 21–22)

The population in state mental hospitals peaked at more than 558,200 patients in 1955; that number stands in sharp contrast to the fewer than 70,000 patients with SMIs who were housed in public psychiatric hospitals in the mid-1990s (The Sentencing Project, 2002). By 2006, there were only 228 state psychiatric hospitals operating 49,000 beds, nearly a third of which were occupied by forensic patients—those “committed by the criminal courts because their competency to stand trial has been questioned, they have been found incompetent and have not regained competency, or they were adjudicated as not guilty by reason of insanity” (Fisher, Geller, & Pandiani, 2009, p. 679).

The overly optimistic CMH movement left tens of thousands of former patients “homeless or living in substandard housing, often without treatment, supervision, or social support” (Goldman & Morrissey, 1985, p. 729). Sadly, this state of affairs largely continues today; many communities currently have no services in place to assist those with SMIs. Largely as a function of these deficiencies, the mentally ill are often arrested for so-called “nuisance crimes,” which leads to prolonged contacts with the criminal justice system among people who are often unable to conform their behaviors to the rules of society due to their severe and chronic psychiatric issues.

On the other end of the spectrum, lack of access to quality mental health services has dire consequences, as it appears to have had for the Aurora movie theater victims in the James Holmes case. In the wake of Adam Lanza’s school massacre in Newtown, Connecticut, President Obama stated, “We are going to need to work on making access to mental health care at least as easy as access to getting a gun.” This is a tall order since between 2009 and 2012, states cut more than \$4.35 billion in public mental health spending, or about 12% of the total budget; as a result, more than 3,200 psychiatric hospital beds, or 6 of the total, have disappeared and another 1,249 beds are in danger of being lost (Glober, Miller, & Sadowski, 2012).

The Current State of the Policy

In contrast to the height of mental hospitalizations in 1955 when there was one public psychiatric bed for every 300 people in the United States, only one such bed currently exists in both public and private facilities for every 3,000 people. In other words, without including private facilities or beds in psychiatric units of general hospitals, people with SMIs were 10 times more likely to find space available in public psychiatric hospitals in 1955 than could be found at the start of the 21st century at general hospitals, public psychiatric hospitals, and private psychiatric facilities *combined* (Torrey et al., 2010). Conversely, there are more than three times as many people with SMIs incarcerated in correctional institutions today than there are in psychiatric hospitals; thus, “America’s jails and prisons have become our new mental hospitals” (Torrey et al., 2010, p. 3).

Estimates of Mentally Ill Inmates

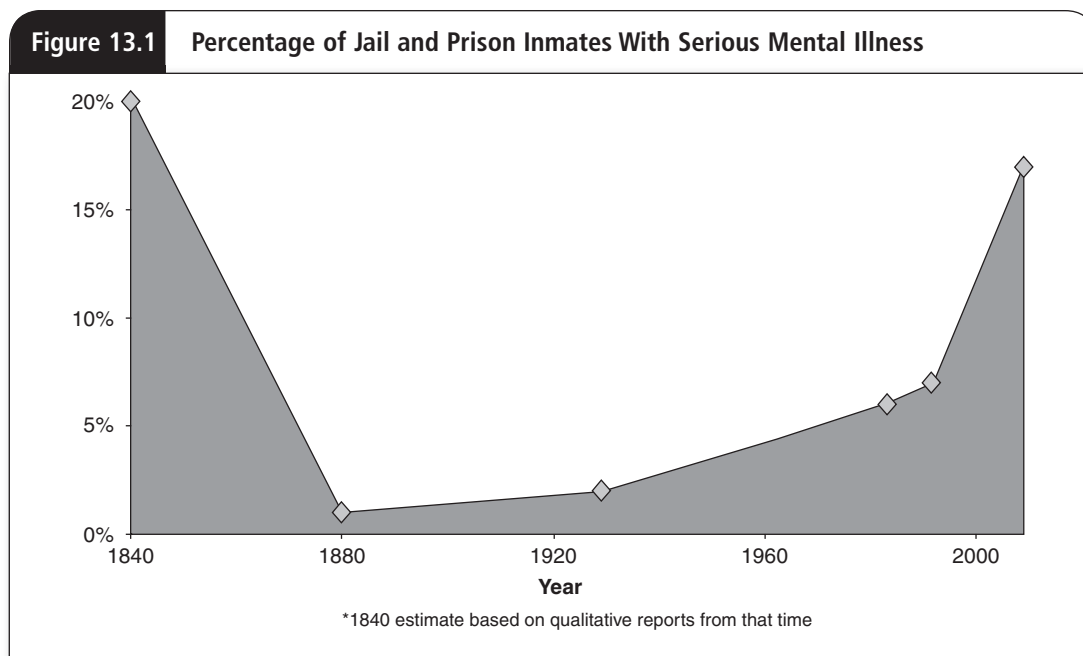
Currently available data indicate that approximately 7.1 million adults were under the supervision of state or federal correctional authorities in the United States at the end of 2010 (Glaze, 2011)—the most recent year providing official statistics. Of these people, roughly 2.26 million were incarcerated in prisons and jails (Glaze, 2011, p. 2). A sizable portion of this population suffer from SMIs.

One study concluded that up to 17.5% of inmates in state prisons had schizophrenia, bipolar disorder, or major depression (Veysey & Bichler-Robertson, 2002). Another study found that 16.6% of inmates in five jails met the diagnostic criteria for SMIs that included schizophrenia, schizophrenia spectrum disorder, schizoaffective disorder, bipolar disorder, brief psychotic disorder, delusional disorder, and psychotic disorder not otherwise specified (Steadman, Osher, Robbins, Case, & Samuels, 2009). And a 2006 survey conducted by the U.S. Department of Justice concluded upwards of 24% of inmates in certain metropolitan jails evidenced symptomology of a psychotic disorder (James & Glaze, 2006).

Studies show that the number of persons with SMIs in the prison system has risen from 7% in 1982 to 10–19% of jail populations, 18–27% of state prison populations, and 16–21% of federal prison populations. To put these prevalence estimates into perspective, the current rate of SMIs in jails and prisons is two to four times higher than rates of SMIs found among the general public. (Litschge & Vaughn, 2009, p. 542 [internal citations omitted]; see also Skeem, Manchak, & Peterson, 2010)

Based on these studies and official reports from many states, Torrey and colleagues (2010) concluded that we “have thus effectively returned to conditions that last existed in the United States in the 1840s” when Dorothea Dix first began her campaign against imprisoning the mentally ill in jails (see Figure 13.1). This conclusion is supported by the fact that the largest psychiatric facility in the United States is New York City’s Rikers Island, which is estimated to hold 3,000 mentally ill offenders at any given time (Stephey, 2007).

In addition to the high rates of those with SMIs placed in correctional institutions designed to punish offenders rather than provide treatment, it is important to note that substance abuse is high among those with SMIs. It is estimated that between 50 and 75% of all mentally ill offenders in jails have co-occurring substance abuse problems (Skeem et al., 2010). In part, this may be due



Source: Torrey et al. (2010)

to those with SMIs self-medicating with alcohol and/or illicit drugs to help relieve the unpleasant or painful symptoms of their disorders (e.g., Dixon, 1999; Khantzian, 1997; Modestin, Nussbaumer, Angst, Scheidegger, & Hell, 1997; Robinson, Sareen, Cox, & Bolton, 2009; Strakowski & DelBello, 2000).

Explanations for the High Prevalence of Inmates with SMIs

There are several possible explanations as to why there are so many people with SMIs in correctional facilities. First, much research demonstrates that police frequently arrest the mentally ill with whom they come into contact (Borum, Swanson, Swartz, & Hiday, 1997; Steadman, Coccozza, & Melick, 1978; Torrey et al., 1992). To some, the most obvious explanation for this is that the police do not understand the behaviors exhibited by people with SMIs and, therefore, make arrests based on misconceptions (e.g., Hylton, 1995). In landmark studies conducted in the 1980s, Teplin (1984, 1990) found that police were more likely to arrest people displaying psychiatric symptoms than those engaging in similar nuisance behaviors, but who do not outwardly show any signs of mental illness. But, other research questioned these findings. For example, after controlling for variables linked to police decision making, such as non-compliance and the relationship between the victim and offender, Engel and Silver (2001) found that police were actually less likely to arrest offenders with mental illnesses. The differences in results may be

a function of methodology. Teplin used clinical definitions while Engel and Silver relied on officer's perceptions of mental illness.

Second, in many U.S. jurisdictions—especially those where police departments subscribe to Broken Windows policing, formal criminal justice enforcement emerged as a significant—if not the preferred—response to disorderly people (Kelling & Coles, 1996). People with SMIs, especially those who are homeless, loud, or otherwise disorderly, often face formal arrests in these locales.

Third, it is clear that police often arrest the mentally ill to help them obtain services. Teplin and Pruett (1992) reported that police often make so-called “*mercy bookings*” to ensure that arrestees had a place to sleep, especially in extreme weather conditions, and were fed two or three meals each day. Torrey and colleagues (1992) similarly found that police arrested people with SMIs to keep them in a relatively safe environment until treatment space became available at mental health facilities.

Fourth, research suggests that many people with SMIs are arrested and criminally incarcerated due to a lack of availability of any mental health alternatives—even though such an alternative would have been preferable (Dupont & Cochran, 2000; Lurigio, Snowden, & Watson, 2006). Indeed, well-trained officers often recognize when people they encounter need mental health services, but nonetheless make arrests either because community resources are completely unavailable, or are so inadequate that frustration leads officers to doubt the feasibility of any public health options (Engel & Silver, 2001; Hails & Borum, 2003; Thompson, Reuland, & Souweine, 2003).

Finally, the high prevalence rates of inmates with SMIs call into question the fairness of the criminal justice system's treatment of mentally ill. Mentally ill offenders who commit minor crimes are the “frequent flyers” of local and county jail systems (Torrey et al., 2010). Largely due to frequency of arrests and the lack of coordination between the criminal justice and mental health systems, these offenders typically receive little or no aftercare treatment after their release from jail, which, in turn, can lead them to decompensation and rearrest (see Solomon, Osborne, LoBuglio, Mellow, & Mukamal, 2008).

People with SMIs who commit serious offenses often fare no better in light of hostility to criminal defenses of excuse, such as diminished capacity or insanity. Traditionally, the doctrine of competency to stand trial and the insanity defense were both designed to prevent those with SMIs from being subjected to criminal prosecution and punishment (Schug & Fradella, 2014). But, the standard for adjudicative competency is quite low, and detainees often languish for months awaiting trial while issues related to determining competency are hashed out by mental health experts, attorneys, and the courts (Schug & Fradella, 2014). And in the wake of John Hinckley's insanity acquittal for the attempted assassination of President Ronald Reagan, the federal government and more than two-thirds of U.S. states either significantly restricted the insanity defense or outright abolished it (Fradella, 2007). Similarly, legislatures, judges, and jurors have all proven to be hostile toward insanity and diminished capacity defenses, collectively contributing to the “sharp increase in the number of mentally ill people in prisons” since the mid-1980s (p. 120). Fradella argued that the U.S. Supreme Court's decision in *Clark v. Arizona* (2006) illustrated this hostility to defenses of excuse based on mental illness, and signaled a continued narrowing of the law in a manner that leads to the incarceration of those with SMIs. These prisoners cost more to incarcerate (Torrey et al., 2010), cause significant management problems for correctional officials and the courts (Fradella, 2003), and frequently decompensate to the point that roughly half of them attempt to commit suicide (Goss, Peterson, Smith, Kalb, & Brodey, 2002).

Case Study: Clark v. Arizona

In Flagstaff, Arizona in the early morning hours of June 21, 2000, 17-year-old Eric Clark was driving his pickup truck around a residential neighborhood with the radio blaring loud music. Police Officer Jeffrey Moritz pulled over Clark's truck in response to complaints. Less than a minute after approaching Clark and telling him to "stay where he was," Clark shot the officer and ran away. Before he died, the officer contacted the police dispatcher for help. Clark was apprehended later that day with gunpowder residue on his hands. The gun used to kill the officer was subsequently found close to where Clark had been arrested.

At Clark's trial, friends, family, classmates, and school officials all testified about his "increasingly bizarre behavior over the year before the shooting."

For example, witnesses testified that paranoid delusions led Clark to rig a fishing line with beads and wind chimes at home to alert him to intrusion by invaders, and to keep a bird in his automobile to warn of airborne poison. There was lay and expert testimony that Clark thought Flagstaff was populated with "aliens" (some impersonating government agents), the "aliens" were trying to kill him, and bullets were the only way to stop them. A psychiatrist testified that Clark was suffering from paranoid schizophrenia with delusions about "aliens" when he killed Officer Moritz, and he concluded that Clark was incapable of luring the officer or understanding right from wrong, and that he was thus insane at the time of the killing. In rebuttal, a psychiatrist for the State gave his opinion that Clark's paranoid schizophrenia did not keep him from appreciating the wrongfulness of his conduct, as shown by his actions before and after the shooting (e.g., circling the residential block with music blaring as if to lure the police to intervene, evading the police after the shooting, and hiding the gun) (p. 745).

At trial, Clark admitted that he shot and killed Moritz, but contended that he should be excused from criminal responsibility because he suffered from paranoid schizophrenia. Specifically, Clark sought to offer psychiatric evidence both to support an insanity-based defense and to prove that he failed to act with the *mens rea* required for a murder conviction because he delusionally thought he was shooting an alien. Relying on Arizona state precedent that prohibited diminished capacity evidence, the trial court refused to allow Clark to present evidence of mental illness to rebut *mens rea*, limiting such evidence strictly to consideration of his insanity claim.

Although the trial court determined that Clark "was indisputably afflicted with paranoid schizophrenia at the time of the shooting," it found him guilty nonetheless, concluding that his mental illness "did not . . . distort his perception of reality so severely that he did not know his actions were wrong" (p. 746). The court thus determined Clark had failed to prove he was insane by clear and convincing evidence as required under Arizona's narrow formulation of the "guilty except insane" defense. Moreover, given the state of Arizona's bar on diminished capacity evidence, Clark was convicted and sentenced to life in prison with the possibility of parole only after serving 25 years.

Clark challenged his conviction on due process grounds, arguing that Arizona's bar on relevant psychiatric evidence interferes with a criminal defendant's "meaningful opportunity to present a complete defense" (p. 789). Over a strong dissent, a majority of the U.S. Supreme Court rejected this argument and affirmed Clark's conviction. The Court reasoned the nature of mental-disease and capacity evidence gives rise to several risks that can be diminished "by channeling the consideration of such evidence to the insanity"—namely the "controversial character of some categories of mental

(Continued)

disease," "the potential of mental-disease evidence to mislead," and "the danger of according greater certainty to capacity evidence than experts claim for it" (p. 774).

Source: Schug & Fradella (2014).

In summary, a wide range of factors contributes to the high incarceration rates of the mentally ill: the failure of many CMH initiatives in the wake of mass deinstitutionalization; decreased funding for public psychiatric services; tight restrictions on the involuntary civil commitment of the mentally ill; and get-tough on crime and disorder policies, ranging from Broken Windows policing to the narrowing of criminal defenses of excuse. Collectively, these factors led many to conclude that people with SMIs are "criminalized"—a phenomenon often referred to as *the criminalization of the mentally ill* or *the criminalization of mental illness* (see Abramson, 1972; Fisher, Silver, & Wolff, 2006; PrisonPolicy.org., 2011; Slate & Johnson, 2008; Torrey et al., 2010). In essence, behaviors caused by mental illness that were once managed in the mental health system have now become behaviors that are referred to the criminal justice system.

It should be noted that some scholars have questioned the criminalization hypothesis, arguing that the criminal behavior exhibited by only a small, albeit important, minority of offenders (estimated as just under 10%) is a direct result of either psychosis or survival crimes related to poverty (Junginger, Claypoole, Laygo, & Crisanti, 2006; Peterson, Skeem, Hart, Vidal, & Keith, 2010). But these studies suffer from some methodological limitations insofar as they focus primarily on those convicted of only serious offenses and on those with SMIs. The researchers readily acknowledge that less serious offenses are often driven by hostility, disinhibition, and emotional reactivity that might be exacerbated by mental illnesses that do not rise to the level of being labeled "serious" (i.e., those that do not involve psychosis). For example, Junginger and colleagues (2006) concluded that co-occurring substance abuse disorders led to a sizable minority of offenses in the population they studied. Thus, although there are limited data to suggest that SMIs are not "criminalized" per se, there is little doubt that mentally ill offenders are in need of treatment that not only can reduce recidivism but also promote successful community reentry for this population of offenders. Consider the following data.

Upon release from prison, mentally ill offenders recidivate at high rates (e.g., Messina, Burdon, Hagopian, & Prendergast, 2004). In fact, parolees with mental illness are nearly twice as likely as their non-mentally ill counterparts to return to prison within one year of release (Eno-Louden & Skeem, 2011), and between 39% and 70% reoffended within 27 to 55 months, depending on the type of crime for which they were originally convicted (Case, Steadman, Dupuis, & Morris, 2009; Lovell, Gagliardi, & Peterson, 2002; Theurer & Lovell, 2008). Since one of the primary goals of the criminal justice system is to reduce recidivism rates, a number of initiatives attempted to reduce recidivism in this population of offenders; many of these initiatives were funded by a federal grant program established under the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) of 2004.

The Mentally Ill Offender Treatment and Crime Reduction Act of 2004

The *Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA)* was signed into law in 2004 by President George W. Bush. The law created the *Justice and Mental Health*

Collaboration Program (JMHCP) to assist state and local governments create collaboratives between criminal justice and mental health systems. Congress reauthorized the Act in 2008 for an additional period of five years and expanded opportunities for training aimed at assisting law enforcement in the identification of persons and response to persons with mental illness and assessment of those in custody for mental health and/or substance abuse treatment needs.

Under the Act's grant program, \$50 million was available for state and local government use. The grant application process requires collaborative efforts between law enforcement or criminal justice agencies and mental health services in an effort to most effectively deal with the intersection of the two systems when dealing with deviant behaviors that occur as a result of mental illness. According to the Criminal Justice/Mental Health Consensus Project of the Council of State Governments (2012), this grant money was used to develop and implement training programs for law enforcement, *mental health courts*, and a variety of corrections-based treatment initiatives. Evaluation research on a number of these programs suggests that some are more effective than others. Before exploring such research, it should be noted that MIOTCRA was criticized for limiting grant money to diversion programs that serve only *nonviolent* criminal offenders; money to assist people with SMIs who committed violent offenses was limited to correctional-based treatments in jails or prisons or reentry programs after release (e.g., Danjczek, 2007).

What Research Has Taught Us

Skeem, Manchak, and Peterson (2010) conducted a meta-analysis of the effectiveness of a number of programs aimed at reducing recidivism rates of mentally ill offenders. They focused on six types of programs, including four employing criminal justice models (jail diversion, mental health courts, specialty mental health probation/parole programs, and aftercare/re-entry programs) and two utilizing mental health models (Forensic Assertive Community Treatment [F-ACT] programs and Forensic Intensive Case Management [FICM] programs). Overall, they found mixed evidence that these programs reduce recidivism, with the evidence for both mental health-based programs and jail-diversion programs showing little to no effectiveness in reducing recidivism. They speculated that this may be due, in part, to these programs' heavy reliance on case management services. In contrast, three of the criminal justice-based programs demonstrated varying levels of success and, therefore, deserve some explanation.

Mental Health Courts

Perhaps because evaluation research generally indicated significant levels of success in reducing recidivism through mental health courts compared to most of the other policies targeted at reducing the recidivism by mentally ill offenders, these specialty courts have grown in use and popularity since the first one was established in 1997. By 2012, roughly 250 mental health courts were established and that number is consistently growing. These courts are staffed by specially trained personnel experienced in working with mentally ill offenders and are based on a therapeutic jurisprudence model rather than an adversarial justice style (Council of State Governments, 2012; Mann, 2011). The mental health courts typically include judges, social workers, probation officers, and attorneys who have received special training regarding mental illness, psychotropic medication, and substance abuse, in direct contrast to the "mixed bag" of training and education normally found in non-mental health court adjudication.

Mental health courts are remarkably diverse. The clinical diagnoses that qualify arrestees for participation in mental health court vary significantly across the country, as do court procedures and

completion requirements (Mann, 2011; Redlich, Hoover, Summers, & Steadman, 2010). The types of cases mental health courts adjudicate also vary: 85% accept misdemeanor cases; 75% handle felony cases; however, only 20% accept violent felony cases; and only 1% handle seriously violent felony cases (Mann, 2011).

Technically, participation in mental health court programs is supposed to be voluntary. Upon agreeing to participate, new participants are required to sign contracts that typically include commitments to take prescribed medications, attend and engage in treatment appointments, return to the court for status review hearings, come to court on time, meet with case managers or probation officers, and to follow any other individual requirements deemed necessary (Mann, 2011; Redlich et al., 2010). The use of sanctions to enforce these provisions varies significantly across mental health courts. However, Redlich and colleagues (2010) found that although between 65 and 76% of mental health court participants reported that they chose to enroll in the programs, most indicated that they did not know the court was voluntary, had not been informed of the program requirements prior to enrolling, and were unaware that they could stop participation if they so desired.

Community-based treatment is the defining characteristic of these courts (Almquist & Dodd, 2009). Yet, “despite being common, outpatient care appears not to have been intensive” (Luskin, 2012, p. 9). Nonetheless, the increased number and kinds of treatments mental health court participants receive decrease both inpatient and emergency room treatments (Luskin, 2012).

Empirical evaluations of mental health courts generally found them to be effective at reducing recidivism (Herinckx, Swart, Ama, Dolezal, & King, 2005; Moore & Hiday, 2006; Trupin & Richards, 2003). McNiel and Binder (2007) reported that mental health court participants experienced longer periods before any new charges for both violent and nonviolent offenses were filed against them than a comparison group processed through criminal courts—a pattern that persisted after completion of the mental health court program. Dirks-Linhorst and Linhorst (2012) found that the rearrest rate of 351 defendants who successfully completed a mental health court program was 14.5%, as compared to 38% among defendants who were negatively terminated from the program and 25.8% of defendants who chose not to participate. These results are similar to the decrease in rearrest rates that Herinckx and his colleagues (2005) found where the average number of arrests prior to mental health court participation was 1.99, but one year after entry into a mental health court program, the mean number of arrests dropped to 0.48. In part, determining the person who reoffends may be a function of program completion. Moore and Hiday (2006) found that 26.9% of participants who completed mental health court were rearrested within one year, compared to the rearrest rate of 70.0% for those who did not complete the program. Moore and Hiday also examined the factors associated with recidivism. They found that demographic factors and most criminal history factors were not significant related to reoffending; however, one criminal history factor proved salient: More severe prior offenses significantly increased the odds of rearrest.

In contrast, at least two studies concluded that there is little difference in reoffending levels between mental health court graduates and those who do not complete such programs. Although Christy, Poythress, Boothroyd, Petrila, and Mehra (2005) reported that 47% of mental health court participants were rearrested within a year of the initial court appearance compared to 56% in the comparison group, this difference was not statistically significant. Cosden, Ellens, Schnell, and Yamini-Diouf (2005) similarly reported small, nonsignificant differences in rearrests, convictions leading to imprisonment, and number of days spent in jail over a four-year period (two years before and after initial admission to a mental health court program). The intense variations in mental health court policies and programs may be responsible for these divergent findings.

Specialty Mental Health Probation

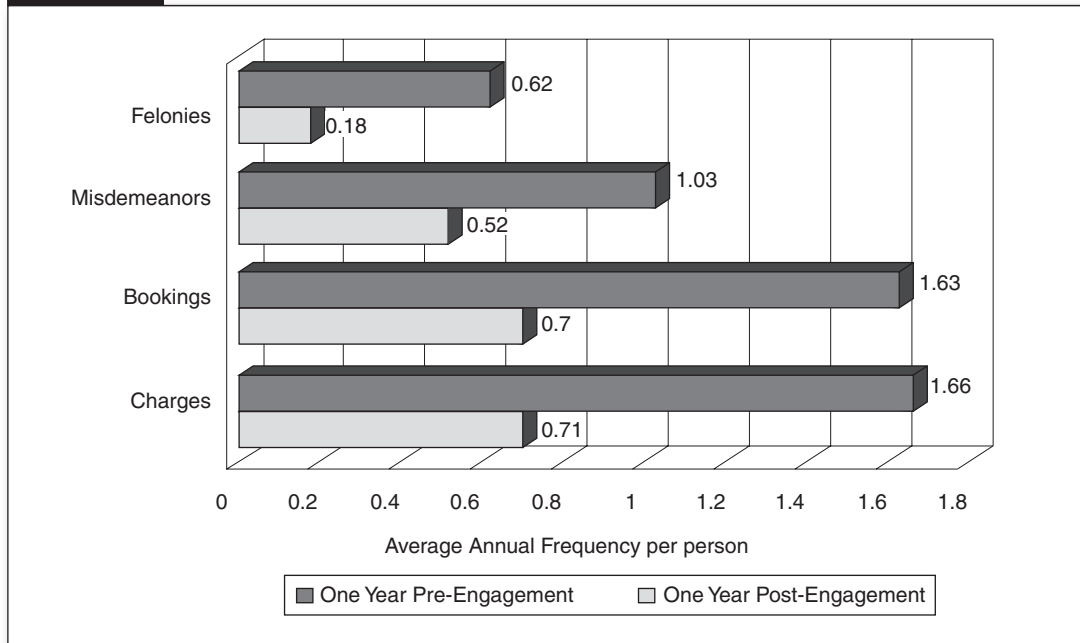
More than 100 U.S. jurisdictions created programs where probation officers manage specialized, reduced size caseloads of mentally ill probationers working directly with treatment providers (Eno-Louden, Skeem, Camp, Vidal, & Peterson, 2012). Because these specialty probation officers “more frequently discussed probationers’ general mental health than any individual criminogenic need”; “chiefly questioned, directed, affirmed, and supported (rather than confronted) probationers”; and “relied more heavily on neutral strategies and positive pressures (e.g., inducements) rather than negative pressures (e.g., threats of incarceration) to monitor and enforce compliance” (p. 109), specialty probationers were modestly less likely to be rearrested or have their probation revoked over a one-year period than offenders assigned to traditional probation. But, given the modest levels of success associated with most of the specialty probation programs that have been empirically evaluated, the third option of reentry and an aftercare program might be a better approach as this alternative was found to have support by which Skeem and colleagues (2010).

Prisoner Reentry and Aftercare Programs

The first year after release from jail or prison is a particularly salient time for monitoring offenders with SMIs since 77% of reoffending occurs within this time (Lovell et al., 2002). High rates of reoffending can be tied to a number of factors, including medication non-compliance, lack of treatment services, a return to disorganized community settings, and poor support services. Accordingly, a number of jurisdictions formed collaborative programs between correctional and mental health services to provide some continuity of care, many of which have been effective at reducing recidivism rates, even for those with co-occurring substance abuse disorders (Kesten et al., 2012; Sacks, Chaple, Sacks, McKendrick, & Cleland, 2012). For example, a study by Sacks, Sacks, McKendrick, Banks, and Stommel (2004), which randomly assigned male inmates with co-occurring serious mental illness and chemical abuse (MICA) disorders to either modified therapeutic community (MTC) or mental health (MH) treatment programs, found that mentally-ill offenders receiving aftercare and reentry services were three times less likely to be reincarcerated within a year than those who received no such treatment interventions (5% vs. 16%). Similarly, a comprehensive jail aftercare and reentry program in Harris County, Texas, was found by Held, Brown, Frost, Hickey, and Buck (2012) to reduce the total number of rearrests significantly for both felonies and misdemeanors (see Figure 13.2).

The most promising reentry and aftercare programs are those that combine “interagency collaboration, housing support, and intensive, integrated clinical attention to mental health and substance abuse problems” (Theurer & Lovell, 2008, p. 400). As the Council of State Governments (2002) stated, “[w]ithout housing that is integrated with mental health, substance abuse, employment, and other services, many people with mental illness end up being homeless, disconnected from community supports, and thus more likely to . . . become involved with the criminal justice system” (p. 8). It should come as no surprise that such comprehensive programs can be quite expensive, reaching an annual cost of approximately \$20,000 per person in some jurisdictions (Frisman, Swanson, Marín, & Leavitt-Smith, 2010). However, given that the average cost of incarcerating an inmate ranges between \$18,000 to \$50,000 per year with an average cost per inmate of \$36,000 (*The Economist*, 2010), such reentry programs represent a solid investment from a cost-benefit standpoint (Torrey, 2011). Moreover, even in jurisdictions where the cost of reentry programs exceeds incarceration costs, such an investment protects the public from future crime associated with untreated mental illness while simultaneously providing “a better set of mental health and justice outcomes for people with mental health problems and their communities” (Wolff, Bjerklie, & Maschi, 2005, p. 38).

Figure 13.2 Decrease in Recidivism Between January 1, 2007, and April 14, 2011, for Participants in the Harris County, Texas, Reentry Program for Mentally Ill Offenders



Source: Held, Brown, Frost, Hickey, & Buck (2012).

Differences Involving Race, Ethnicity, Gender, and Class

As explored in several other chapters of this book, there are significant race, gender, and class disparities in U.S. incarceration rates that are separate from any issues surrounding mental illness. But these disparities may be amplified in mentally ill arrestees since many factors that are generally correlated with arrest decisions are also correlated with the presence of mental illness.

Race and Ethnicity

“Cultural factors affect how individuals define, evaluate, seek help for, and present their health problems to family members, friends, and service providers” (U.S. Department of Health and Human Services, 2001, p. 18). This can not only lead members of different racial and ethnic groups to express symptoms differently, but also can lead clinicians to misinterpret these differences (Peters, Bartoi, & Sherman, 2008).

There is remarkably little research on racial/ethnic differences in the way police interact with the mentally ill. In one of the few such studies, Cooper, McLearn, and Zapf (2004) found no racial differences in the decision to arrest people who presented with psychiatric symptoms. However, police were more likely to seek involuntary psychiatric commitment of Whites than Blacks. The implications of this research

are troubling insofar as it suggests that Whites “will be diverted to the mental health system, whereas African Americans will find themselves in jail for the same actions” (p. 306). Moreover, another research finding suggests that once taken to jail, minority suspects may not be properly screened for mental illness. Certain screening instruments used on arrestees, such as Brief Jail Mental Health Screen, are more likely to miss symptoms in Blacks and Latinos than Whites, resulting in underreferrals for these racial and ethnic minorities for psychiatric services (Prins, Osher, Steadman, Robbins, & Case, 2012). Thus, not only does there appear to be a racial disparity in terms of who is initially treated as a psychiatric case (rather than a criminal justice one), but also it appears that racial and ethnic minorities are less likely to receive treatment for mental illness after arrest, which, in turn, can lead to higher rates of reoffending and rearrest. At least one study provides evidence for this outcome in areas with high minority populations. Grekin, Jemelka, and Trupin (1994) found that

counties with a high proportion of a particular minority send more mentally ill members of that minority to prison and fewer to state hospitals than expected. This trend was strongest for Hispanics, but was also strong for Blacks and Native Americans. (p. 417)

Gender

Both men and women with SMIs present with similar risks of aggression, psychosocial characteristics, mental health histories, mental health problems, and criminogenic needs (Nicholls, Brink, Greaves, Lussier, & Verdun-Jones, 2009). Yet, incarcerated women with SMIs outnumber incarcerated men with SMIs by a ratio of more than two to one (Steadman et al., 2009). Although this is somewhat surprising in light of the fact that females are more likely to be diverted into treatment than their male counterparts (see Albonetti & Hepburn, 1996), it may be explained as a function of interaction between gender and age. Luskin (2001) found that younger women were the beneficiaries of diversion in mental health treatment programs in comparison to younger men, but older women were disadvantaged. She explained this finding by speculating for females, “youth indicates someone who is not yet committed to a criminal identity” whereas a youthful male who commits crimes “signals danger” (p. 231). As women age, however, whatever benefits they experience as a function of discretionary decision-making concerning diversion disappear.

Age differences among women notwithstanding, there are significant gender differences between male and female offenders with mental illnesses. Females tend to be

more likely to have a history of engagement with social services, and report more trauma. Although more than half of both male and female mentally ill offenders (61% of the men and 56% of the women) did not complete high school, 20% of the mentally ill female offenders report some college education in comparison to 4% of the men. . . . [N]early three-fourths of the female mentally ill offenders (72%) report substance abuse problems in comparison to only half (48%) of the men. From a correctional standpoint, this is not counterintuitive considering the majority of female offenders are serving time for drug-related offenses and also have substance abuse problems. (Hartwell, 2001, p. 4)

As a result of these differences, gender-specific treatment programs for female offenders with SMIs are warranted. “Monitoring women who return home to families and children post release is prudent given their abuse histories” (Hartwell, 2001, p. 7). And females’ higher incidence of co-occurring substance abuse

disorders should result in their working with clinicians who possess “expertise in integrated or dual diagnosis treatment in prison, during their transition, and while living in the community” (p. 7). Finally, Hartwell found that men with SMIs who commit serious crimes, such as rape and murder, tend to be “transitioned immediately to inpatient hospitalization” after their release from prison and subsequently receive more “intensive and collaborative treatment and monitoring across several agencies (mental health and criminal justice) to assure public safety” (p. 7). The same is not true for women, who tend to be released into the community. As Hartwell pointed out, this raises “the question as to whether or not the mental health system responds similarly across gender and if the risk potential to others by males is perceived more seriously” (p. 8).

Socioeconomic Status

Poverty and declining economic status have long been important themes in research on the social consequences of mental disorders. Studies consistently found that those people from lower socioeconomic backgrounds are more likely to be diagnosed with SMIs than those of more economically privileged backgrounds (e.g., Lurigio, 2011). But SMIs can actually cause (or at least contribute significantly to) poverty. Consider that in 1939, Faris and Dunham (as cited in Fisher et al., 2006) described a “downward drift” of schizophrenic patients, leading them to increasingly worsening socioeconomic positions; a situation that persists today. People with untreated SMIs experience symptoms that can interfere significantly with daily functioning, making it difficult, if not impossible, to hold down a job, maintain housing, and obtain medical and mental health care. These factors often coalesce in ways that result in homelessness and the commission of “survival crimes,” such as theft, trespassing, and panhandling (Fisher et al., 2006).

Even when subsidized housing or group-home living is made available to those with SMIs, such facilities tend to be located in low-income areas because people in middle class or affluent neighborhoods often block efforts to locate this type of housing near their homes (Fisher et al., 2006). Thus, those with SMIs tend to live in low-income areas where illicit drugs are prevalent. Given the high co-occurrence of SMIs and substance abuse disorders, this combination can lead to the commission of other illegal activities, “including larceny, drug trafficking, and prostitution” in an effort to support drug use (Fisher et al., 2006, p. 552). Moreover, high crime rates in low-income neighborhoods can lead to additional violence. For example, Silver, Mulvey, and Monahan (1999) found that patients who resided in high-poverty neighborhoods following discharge were more likely to engage in violence than patients discharged into neighborhoods with less poverty.

Unintended Consequences of the Policy

Given the comparative effectiveness of several of the criminal justice interventions discussed previously which leverage access to much needed community services, these programs can inadvertently increase police willingness to make “mercy bookings.” In other words, the structured treatment that mental health courts and reentry/aftercare programs offer can create incentives for police to arrest those with SMIs in order to get them the services they need (Bazelon Center for Mental Health Law, 2012). At first blush, one might be tempted to conclude that since the humanitarian motivations underlying such mercy arrests result in people with SMIs obtaining the services they need, justice system involvement is not necessarily a bad thing. But there are numerous, serious unintended consequences to using the criminal justice system to address the public health need of people with SMIs.

First, there are several negative consequences stemming directly from arrest and incarceration. These traumas can aggravate the symptoms of many SMIs, causing not only an unnecessary increase in suffering for the affected person, but also manifesting in behaviors that lead to violence that can injure those with SMIs, police officers, innocent bystanders, correctional officers, and other inmates in jails and prisons (see Gur, 2010). And arrests have collateral social consequences as well, which range from “stigmatization based on a criminal record” to the “resulting denial of housing or employment or treatment services—even if charges are dropped” (Bazelon Center for Mental Health, 2003, p. 2).

Second, because police often serve as the first responders to situations involving people with SMIs, significant resources must be devoted to training police to interact with this population to avoid unnecessary victimization. Today, many police departments have established a *Crisis Intervention Team* (CIT) to avoid situations where officers mistake the symptoms of SMIs and respond using unnecessary levels of force, sometimes resulting in preventable deaths (Gur, 2010; Stephey, 2007). But CIT programs are not cure-alls. Certainly it costs a significant amount of money to establish these programs and then train officers. But, perhaps more importantly, we do not know if CITs actually reduce violence and victimization experiences by both police and people with SMIs during encounters between the two, nor has it been established that CIT programs are actually effective in reducing the arrests of persons with SMIs (see Watson et al., 2010).

Third, using the criminal justice system as the “front door to access mental health care” (Seltzer, 2005, p. 583) places enormous financial burdens on state and local governments forced to increase budgets to accommodate the expenditures required to deal with these complex problems. According to Johnson (2011), states with large populations of prisoners must commit large portions of their state budgets to operating criminal justice services. The implications of these increasing criminal justice budgets are cuts to other programs in the state, when ironically these same cuts to public health or housing programs may help prevent some offenses from occurring that lead to incarceration.

State and city-wide expenditures continue to rise as more and more offenders requiring psychiatric treatment are relegated to the care and custody of jails and prisons. For instance, the Los Angeles County Jail spent \$10 million on psychiatric medication in 2001, and the State of Ohio in 2005 was treating 8,371 mentally ill offenders at a cost of \$67 million a year. In Florida the number of mentally ill inmates in jails and prisons is believed to outnumber those in state run psychiatric facilities by 5 to 1; yet, the minimum cost to care for a mentally ill person in a Florida jail costs in excess of \$40,000 and \$60,000 in a Florida prison. Compare those figures to the roughly \$20,000 cost of providing intensive CMH treatment for those with SMIs (www.PrisonPolicy.org). Overall, it is calculated that imprisoning mentally ill offenders costs the United States roughly \$9 billion per year (Slate & Johnson, 2008).

Fourth, mentally ill inmates create enormous problems for the corrections system. The three largest providers of psychiatric care in the United States are New York’s Rikers Island Jail, Illinois’ Cook County Jail, and California’s Los Angeles Jail (Slate & Johnson, 2008). The fact that so many mentally ill offenders are being held in our jails and prisons means that many of these prisoners are in daily contact with corrections officers who have not received proper training in effectively and safely dealing with psychiatric populations (Gur, 2010). This lack of training and understanding can lead to increases in conflicts, physical altercations, and injuries of both corrections officers and inmates (Steadman et al., 2009). Indeed, people with SMIs are often victimized while incarcerated (Gur, 2010; Human Rights Watch, 2009). Failing to provide incarcerated inmates with constitutionally minimum levels of medical care, as well as failing to protect these inmates from foreseeable victimization while incarcerated, further adds to the budgetary strain local and state governments experience as a result of the criminalization of mental illness. “Perhaps the best example of this is Sheriff Joe Arpaio who, claiming to be the toughest sheriff in the country, has

cost taxpayers of Phoenix millions of dollars in lawsuit settlements for violating the civil rights of inmates with mental and medical needs” (Johnson, 2011, p. 19).

At great cost, some larger correctional facilities have special units devoted to housing “special needs” populations and staff receive at least some training in working with the mentally ill. But, even in such units, those with SMIs face a number of risks, not the least of which is decompensation, where the severity of the mental illness or the associated symptoms increases. The incarceration environment is one where inmates with SMIs “are more likely to violate rules or be injured in fights (Gur, 2010, p. 228; James & Glaze, 2006).

Finally, the funding consequences linked with the criminalization of mental illness offenders produces an untenable situation because in some U.S. jurisdictions, funds are no longer available to support public mental health outside of the correctional setting. As a result, some states, like Iowa, have turned to re-committing offenders with SMIs after serving their sentences back into the same prison system that released them because the state has no other facility for referral (Fuller, 2011). The beginning of 2011 saw 75 mentally ill offenders committed to prisons under this arrangement, some of whom had been civilly committed to the prison for a period of several years (Fuller, 2011). In essence, this means that citizens who have served their sentences are still being remanded to prison as the result of their mental illness, because there are no adequate mental health treatment facilities left where they can be civilly committed for treatment. This is the purest example of our jails and prisons becoming de facto psychiatric facilities, and it raises the question that the due process rights of these mentally ill offenders are being violated by virtue of the fact they have “served their time” and yet are not being released from prison.

How Do We Fix It? Suggestions for Policy Reform

There is no shortage of calls for changes in policy to address the many problems with the revolving-door cycle of incarcerating those with SMIs in jails and prisons and then releasing them only to have them return to the criminal justice system (e.g., Torrey et al., 2010; Vitiello, 2010). In the final section of this chapter, we explore some of the most common recommendations.

Legislative Changes to Address Financial Problems

Two legislative changes could go a long way toward improving policies to assist mentally ill offenders. First, as noted earlier, MIOTCRA limited its diversion programs to serve only non-violent criminal offenders. If MIOTCRA were amended to fund diversion programs that reached violent offenders as well, that many more people with SMIs could benefit from mental health court supervision.

Second, the statutory restriction for using Medicaid funds to support mentally ill individuals in “institutions for mental diseases” should be lifted. This ban encourages states “to empty hospitals, even if the patients end up in jails or homeless” (Torrey et al., 2010, p. 12). Moreover, “there are no fiscal incentives to follow up and make sure the patients receive care once they leave the hospitals (p. 12). Accordingly, this restriction on Medicaid use should be repealed.

Increased Diversion Efforts by Expanding the Number and Scope of Mental Health Courts

As previously summarized, most of the studies evaluating the effectiveness of mental health courts finds them to be effective at reducing recidivism (Dirks-Linhorst & Linhorst, 2012; Herinckx et al. (2005);

McNiel & Binder, 2007; Moore & Hiday, 2006; Trupin & Richards, 2003) and improving mental health functioning (Boothroyd, Poythress, McGaha, & Petrila, 2003). But there are many communities without this option available. Therefore, it presumes good public policy to advocate for the increase of the number of mental health courts. But care must be taken to ensure that these courts are properly staffed and funded, lest the courts become so backlogged and unable to provide services that their effectiveness is compromised. But adequate court resources are not sufficient since the success or failure of any mental health court program depends “on the ability of the mental health system to treat effectively those diverted from the criminal justice system (Litschge & Vaughn, 2009, p. 550). Thus, as discussed more fully below, inadequacies in the mental health system must also be addressed.

Regardless of the availability of mental health courts, there is a question of whether any criminal justice system involvement is necessary at all, especially in many misdemeanor cases. Consider that Fisher and colleagues (2006) noted that a review of records of mentally ill offenders arrested for nuisance crimes and referred to the forensic evaluation unit of a state hospital in Massachusetts found that many of these offenders would have met criteria for an involuntary hospitalization if the police had not arrested them and instead taken them for psychiatric emergency services. If that’s the case, does the criminal justice system need to be involved at all? As Skeem and colleagues (2010) suggested, providing psychiatric treatment to those with SMIs before they violate the criminal law could prevent the criminal justice system from even being involved with people who should be treated as patients rather than offenders. Thus, the best public policy options may lie outside the criminal justice system.

Reform Civil Commitment Laws

Torrey and colleagues (2010) called for significant changes in civil commitment laws. Specifically, they seek the statutory authority to commit those who need treatment without regard to their *dangerousness*. “Many times, it is this very dangerousness standard that necessitates law enforcement involvement. Mentally ill individuals should be able to access treatment before they become dangerous or commit a crime, not after” (p. 12). At first blush, this proposal seems logical and warranted. But, two concerns threaten its viability.

First, lax due process protections in the civil commitment arena were one of the reasons that civil liberties activists championed the tightening of these laws in the 1960s and 1970s. Legislators need to vote to loosen these laws over the objections of both civil libertarians and advocates for the mentally ill who oppose involuntary hospitalization. Moreover, when such laws are challenged in the courts, judges not only have to decide if the autonomy and privacy rights of the individual are outweighed by societal interests in caring for the mentally ill against their wishes, but also have to ensure that statutes provide sufficient safeguards are in place to guarantee due process. This is not, however, a difficult task; New York appears to have done so quite successfully (see Litschge & Vaughn, 2009; New York State Office of Mental Health, 2005).

Second, even if better laws could be enacted that eased the dangerousness criteria for commitment while still honoring due process rights, increasing the number of civil commitments is not possible if there are insufficient beds in psychiatric facilities to care for the civilly committed patients. Given how few beds are available, and in light of the incredible budgetary pressures on most states since the Great Recession of 2008, it is highly unlikely that most states can afford to expand the number of psychiatric beds available to accommodate need. Moreover, although there is an argument to be made that the funds currently used to pay for the incarceration of mentally ill offenders in jails in prisons could be shifted out of the criminal justice system and into the public health system to pay for these beds, the politics of doing so is likely a

significant obstacle. Consider that many other social services, most notably education, have been cut as public budgets have diminished. Reasonable arguments can certainly be made that education and other services need to be funded before expanded access to psychiatric hospital beds.

However, there may be a middle ground. In the past few years, many states have modified their civil commitment laws to allow for outpatient civil commitments of mentally ill people in crisis (Slate, 2009, p. 21). Outpatient civil commitment is more commonly referred to as assisted outpatient treatment (AOT). AOT “requires selected seriously mentally ill persons to take medication under court order as a condition for living in the community” (Torrey et al., 2010, p. 12). According to the Treatment Advocacy Center (2012), 44 states have laws that authorize AOT. Empirical studies of AOT lend significant support to this policy recommendation, as AOT has been demonstrated not only to reduce dramatically the arrest rate of the mentally ill (New York State Office of Mental Health, 2005; Swanson et al., 2000), but also to significantly decrease their use of alcohol and drugs, psychiatric rehospitalizations, homelessness, suicides, and violent behaviors (Fernandez & Nygard, 1990; Munetz, Grande, Kleist, & Peterson, 1996; Phelan et al., 2010; Rohland, 1998; Swartz et al., 2010; Zanni & deVeau, 1986). Moreover, there is evidence that several of these positive outcomes continue even after court supervision ends (Van Dorn et al., 2010).

Improve Services for the Mentally Ill Within and Beyond the Criminal Justice System

Offenders with SMIs generally fall into three categories: those who were arrested for “simply displaying the signs and symptoms of mental illness in public”; those who committed petty, nuisance, or survival crimes; and those who commit serious crimes, including those that are violent (Lurigio, 2011, p. 12). Those who fall within the first group do not belong in the criminal justice system at all. They need psychiatric services that need to be offered through an improved public health system. When police encounter such individuals, they should be able to take them for treatment without ever making a formal arrest. The aforementioned improvements in outpatient civil commitment laws vis-à-vis AOT gives police the authority to do so and improves the public health outcomes for the mentally ill without ever involving them in the criminal justice system.

The second group of offenders should be diverted to mental health courts. But, we need to conceptualize the primary purpose of these specialized courts as serving a public health function, not a criminal justice role. Measures of success need to go beyond mere recidivism statistics. Indeed, the myth that treating psychiatric systems can improve recidivism rates must be dispelled. There are no studies which empirically demonstrate that alleviating psychiatric symptoms—in and of itself—affects recidivism among offenders with SMIs (Lurigio, 2011). Thus, improvements which address only the treatment of psychiatric systems are not likely to reduce recidivism. To accomplish the goal of reducing recidivism, psychiatric treatments need to be paired with other interventions aimed at criminogenic factors (Skeem et al., 2010), such as substance abuse, lack of education, lack of employment, and community disorganization. Toward that end, mental health courts need to pair offenders with a variety of social service agencies in much the same way that prison parolees are paired in the comprehensive reentry and aftercare programs that demonstrated so much success at rehabilitating the whole person. This would not only help these people “get back on their feet,” but also help them avoid subsequent involvement in the criminal justice system (Council of State Governments, 2002; Kesten et al., 2012; Sacks et al., 2004, 2012; Skeem et al., 2010; Theurer & Lovell, 2008; Wolff et al., 2005).

The third group of offenders—those who commit serious crimes—pose the most significant policy challenges. To be sure, those who are imprisoned need treatment while incarcerated and, after release, they must be placed into comprehensive reentry and aftercare programs that help them comply with rules governing their release, thereby avoiding probation and parole violations and reducing the incidence of new offenses. But those correctionally based treatment, reentry, and aftercare programs do not address the true problem of incarcerating offenders with SMIs in jails or prisons in the first place. Three changes to law and policy could make a significant difference in reducing the number of people with SMIs in correctional institutions, and the final proposal might even serve to reduce the commission of crime by this population.

Initially, the narrowing of the criminal defenses of excuse that began in the 1970s and accelerated dramatically in the wake of John Hinckley Jr.'s case must be revisited. In *Clark v. Arizona* (2006), the U.S. Supreme Court upheld the authority of states to severely limit a mentally ill criminal defendant from offering some of the most probative evidence concerning his or her guilt. To prove that Eric Clark committed murder, the prosecution in the *Clark* case introduced evidence that the defendant spoke of wanting to kill police and then argued that to carry out this plan, the defendant lured police to the scene by blaring music from his truck while circling a block in a residential neighborhood. The defendant, however, was barred from introducing largely undisputed evidence about the nature of paranoid schizophrenia and how the disease caused, or could have caused, his actions. Specifically, the trial court was barred from considering expert testimony that people with schizophrenia often play music loudly to drown out the voices in their heads, which would have directly undercut the assertion that Clark did so to lure police officers to his car. The unworkable evidentiary framework upheld in *Clark* prevent the defense from arguing what should have been straightforward defense, namely that the defendant “did not commit the crime with which he was charged” because he lacked the requisite *mens rea* (*Clark v. Arizona*, 2006, p. 801, Kennedy, J., dissenting). The Supreme Court must revisit this misguided result and hold that barring the admissibility of such evidence violates due process (Fradella, 2007). Of course, dangerous people with SMIs like Eric Clark do not belong on the streets where they are free to maim or kill. But they do not belong in prisons either where they burden the correctional system and receive little or no treatment for their SMIs. Rather, such defendants should be remanded for treatment to secure psychiatric hospitals.

Next, the jurisdiction of mental health courts should be expanded to include the authority to adjudicate violent felony offenses. As Mann (2011) pointed out, 80% of mental health court systems do not accept any violent felony cases and only 1% handle those involving serious crimes of violence. If defendants who commit crimes like robbery and aggravated assault as a function of their SMIs had their cases handled through a system that subscribed to a therapeutic jurisprudence model, these offenders could get the comprehensive help they need while being monitored for compliance in ways that help to increase public safety.

Finally, and most importantly, we must make improvements to the mental health system and related social services so that people with SMIs do not commit serious crimes in the first place. Significantly expanded use of AOT can help to effectuate this desirable outcome. Those with SMIs need both psychiatric care (including access to psychotropic medications, when appropriate) and interventions aimed at criminogenic factors, such as job training, substance abuse treatment, and housing assistance (Skeem et al., 2010). Such multimodal services are likely to bring significant secondary benefits largely unrelated to the narrow metric of recidivism. Providing better treatment for the mentally ill likely reduces psychiatric symptoms in ways that allow the mentally ill to “become sober and employed, find and retain stable housing, develop better self-control, return to school, [and] mend relationships with family” (Lurigio, 2011, p. 15). These benefits, in turn, reduce calls to police and correspondingly reduce the number of inmates

with SMIs, because mentally ill people receiving mentally appropriate treatment and adequate social services are better able to follow societal rules so that they do not run afoul of the law to begin with.

KEY TERMS

Asylum	Deinstitutionalization	Mental hospital
Community-based treatment	Justice and Mental Health Collaboration Program (JMHCPC)	Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA)
Community Mental Health (CMH)		
Crisis Intervention Team (CIT)	<i>Lessard v. Schmidt</i>	“Mercy booking”
Dangerousness	Mental health courts	Serious mental illness (SMI)

DISCUSSION QUESTIONS

1. Compare and contrast the first- and second-wave efforts to reform the criminal justice system’s treatment of offenders with mental illness with the efforts of the community mental health movement. How were these efforts alike? How did they differ? Which, in your opinion, was the most successful? Why?
2. What are the primary reasons offered to explain why there are so many people with serious mental illness in U.S. correctional facilities?
3. Explain the criminalization hypothesis. What evidence supports it? What evidence calls it into question?
4. In your opinion, which two of the four criminal justice-based programs aimed at reducing recidivism rates of mentally ill offenders are the most promising? Evaluate the effectiveness of these programs using empirical evidence. How might these programs be expanded to further reduce recidivism rates of mentally ill offenders?
5. What do you think is the most effective noncriminal justice policy that, if implemented, would most improve services for people with serious mental illnesses? Explain your reasoning.

WEBSITES FOR ADDITIONAL RESEARCH

Substance Abuse and Mental Health Services Administration: <http://www.samhsa.gov/>

U.S. Substance Abuse & Mental Health Services Administration National Registry of Evidence-Based Programs and Practices: <http://www.nrepp.samhsa.gov/>

California Courts: <http://www.courts.ca.gov/5982.htm>

Bureau of Justice Assistance, <https://www.bja.gov/>

National Center for State Courts: <http://www.ncsc.org/Topics/Problem-Solving-Courts/Mental-Health-Courts/Resource-Guide.aspx>

Center for Court Innovation: <http://www.courtinnovation.org/>

Council of State Governments Consensus Project: <http://consensusproject.org/>

National Council for Community Behavioral Healthcare: <http://www.thenationalcouncil.org/cs/home>

Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA): <http://www.gpo.gov/fdsys/pkg/PLAW-108pub1414/html/PLAW-108pub1414.htm>

Treatment Advocacy Center: <http://www.treatmentadvocacycenter.org/>

National Institute of Mental Health: <http://www.nimh.nih.gov/index.shtml>