

The Mentally Ill in the Criminal Justice System: An Overview of Historical Causes and Suggested Remedies

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This article examines the historical and contextual factors that are related to the growing numbers of persons with mental illness who are processed through the criminal justice system. The paper discusses five major mental health and criminal justice policies that frame the challenges associated with the mentally ill in the criminal justice system: deinstitutionalization (a shift in the locus of care from the state hospital to community-based treatment agencies); mental health law reform (notably more stringent criteria for involuntary admission to a psychiatric facility); fragmented care (little coordination between mental health and other treatment providers); drug enforcement (the war on drugs that resulted in the arrests of the mentally ill who use illicit substances); and public-order policing (the enforcement of arrest policies that target nuisance crimes). The article also presents recommendations for responding more effectively to the problems of the mentally ill in the criminal justice system.

During the past three decades, fundamental changes in mental health and law enforcement policies have brought criminal justice professionals into increasing contact with people with serious mental illness (PSMIs). This contact occurs at every stage of the criminal justice process. The police, who are the gatekeepers of the criminal justice system, interact frequently with PSMIs. For example, in New York City, police officers are dispatched every 6.5 minutes in response to service calls that involve PSMIs (Fyfe, 2002). In 2000, the number of PSMIs transported by Florida law enforcement officers for a 72-hour emergency psychiatric evaluation exceeded the number of persons who were arrested in the state for burglary or aggravated assault (McGaha & Stiles, 2001). In the absence of large-scale diversion programs, police officers often arrest PSMIs because few other options are readily available to handle their disruptive public behavior or to find them much-needed treatment or housing (Teplin & Voit, 1996).

As PSMIs move through the criminal justice process, other principal actors in the system must decide how to respond to their needs (Lurigio & Swartz, 2000). Specifically, judges grapple with limited sentencing alternatives for PSMIs who fall outside of specific forensic categories (e.g., guilty but mentally ill). Jail and prison administrators strain to attend to the care and safety of the mentally ill. Probation and parole officers scramble to obtain scarce community services and interventions for PSMIs. They also struggle to fit mentally ill offenders into standard correctional programs and to monitor them with traditional case management strategies. When mentally ill persons are sentenced to or placed on community supervision, their disorders complicate and impede their ability to comply with the conditions of release (Council of State Governments, 2002). When they are confined in jail or prison, they spend significantly more time locked up and are more expensive to house than detainees or prisoners without mental illness (Axelson & Wahl, 1992; Lamb & Weinberger, 2005; Sager, 2002).

Scope and Consequences of the Problem

PSMIs are abundant in the criminal justice system. Evidence suggests that between 15 and 20 percent of the correctional population suffers from serious mental illness—a percentage that is substantially higher than the representation of PSMIs in the general population. At the end of the 1990s, an estimated 320,000 individuals with serious mental illness were under some form of criminal justice supervision (Ditton, 1999). The number of PSMIs in the prison population is presently two to three times greater than the number of mentally ill individuals in psychiatric hospitals (Fazel & Danesh, 2002; Human Rights Watch, 2003). Moreover, the three largest psychiatric facilities in the United States are the Los Angeles County Jail, Cook County Jail in Chicago, and Riker's Island Jail in New York City (Torrey, 1999).

The consequences and costs of processing large numbers of PSMIs through the criminal justice system are profound in terms of the public safety and stability of communities (Fichtner & Cavanaugh & 2006; Lurigio, 2004). For more than two decades, PSMIs have been falling outside the country's social safety net—which has been steadily shrinking—and “landing in the criminal justice system at an alarming rate” (Council of State Governments, 2002). They often cycle repeatedly through the criminal justice system, in part because of the court's failure to recognize psychiatric illness as a factor that contributes to their continued criminal involvement (Draine, Salzer, Culhane, & Hadley, 2002; Lurigio & Swartz, 2000; Massaro, 2005; Petrila, Ridgely, & Borum, 2003). Gross racial and economic disparities in mental health care and increasingly punitive crime control policies also have resulted in the presence of more and more PSMIs in the criminal justice system (Mauer, 2006; United States Department of Health and Human Services, 1999). In the words of Fichtner and Cavanaugh (2006), “Unmet mental health needs are shaped by a broader national care crisis, and criminal justice involvement by persons with mental illness is embedded in a broader American criminalizing trajectory” (p. 1511).

The mental health and criminal systems have porous boundaries with respect to the people they serve and the professionals they employ to assist the mentally ill in the recovery process, particularly at the local level. What happens in one system affects what happens in the other. For example, the absence of emergency psychiatric services can lead to more PSMIs being arrested and detained. The availability of community-based care affects the ability of jails to comply with court orders that require them to release mentally ill detainees with a comprehensive discharge plan (*Brad H. v. City of New York* NY Slip Op 50597U [2005]). The treatment of mental illness can stem the tide of criminalizing PSMIs, thus keeping more mentally ill persons off ever-expanding court dockets and out of overcrowded jails (Massaro, 2005; Petrila, Ridgely, & Borum, 2003). However, as we discuss in this paper, mental health services are sparse and long-term psychiatric care is nonexistent in the criminal justice system.

The notable presence of the mentally ill in the criminal justice system also has created significant resource demands and clarion calls for specialized, cross-disciplinary approaches to serve the diverse needs of PSMIs. Mental health practitioners have been enlisted to play critical roles in police departments, jails, prisons, and probation and parole agencies. By the same token, criminal justice professionals now are learning new ways to case manage offenders who have psychiatric and behavioral disorders (Council of State Governments, 2002).

In most jails and prisons, which have become de facto the largest treatment settings for the mentally ill, correctional mental health care providers often contend with inadequate services and overwhelmingly large caseloads. Specialized programs for PSMIs, such as mental health courts, hold great

promise in diverting PSMIs from the criminal justice system and ensuring that they receive proper interventions (Bernstein & Seltzer, 2004; Watson, Hanrahan, Luchins, & Lurigio, 2001). Nonetheless, current resources for psychiatric treatment and other services rarely meet the demand for care (Council of State Governments, 2002). Highlighting the paucity of mental health resources for PSMIs in the criminal justice system, the Council of State Governments (2002) stated:

Every criminal justice professional would agree that the [criminal justice] system has inherited a problem of enormous scope and complexity. Police, courts, and corrections officials feel they're boxed in. Resources are stretched to the limit: they're tight on money and even tighter on time. Under the circumstances, many have tried to find a way to serve people with mental illness more efficiently. But with limited options and resources, especially in rural areas, many criminal justice practitioners are frustrated because they know what they're doing isn't enough (p. 10).

Current Article

This article is divided into two primary sections. In the first section, we briefly explicate the historical and contextual factors that are associated with the growing number of PSMIs processed through the criminal justice system. We discuss five major policies and procedures in the areas of mental health and criminal justice that have led to an influx of mentally ill persons into correctional settings and programs: deinstitutionalization, mental health law reform, fragmented care, drug enforcement, and public-order policing. In the second section, we describe the ideal circumstances that must be established in order to serve the PSMIs under the authority of law enforcement, courts, and corrections. We conclude with a few general recommendations for responding successfully to the problems of the mentally ill in the criminal justice system.

Pathways into the Criminal Justice System

Criminalization

More than 30 years ago, Abramson (1972) introduced the notion of the “criminalization” of the mentally ill. He observed that changes in California’s mental health policies—specifically, the revamping of the state’s involuntary commitment laws—unintentionally shifted responsibility for the care of PSMIs from the mental health system to the criminal justice system (also see Lamb & Weinberger, 1998; Teplin & Voit, 1996). Since the 1970s, the term “criminalization” has been applied to a wide variety of contexts and has received considerable attention from researchers and social commentators. Consistent with Abramson’s original analysis, the “criminalization” label has been reserved broadly to designate as “criminal” behaviors that have been handled formerly as manifestations of mental illness.

This interpretation of criminalization excludes more serious offenses and focuses on instances in which PSMIs are arrested, charged, and punished for publicly displaying the signs and symptoms of their disorders in ways that are not (or are minimally) harmful to people or property. Examples of such behaviors, known as public order or nuisance offenses, include shouting obscenities in a restaurant for no apparent reason, engaging in heated arguments with unseen, imaginary enemies on a busy street corner, and urinating on the bus. In general, interactions between PSMIs and criminal justice professionals are complex and multifaceted, varying from police interventions in cases of acute psychiatric crisis with no criminal activity, to arrests for low-level offenses that emanate from untreated mental illness, to instances of more serious offenses that necessitate felony prosecution (Teplin, 1983).

Although data suggest that the mentally ill are arrested and incarcerated at levels that exceed their representation in the general population and their tendencies to commit serious crimes (Council of State Governments, 2002), notions of “criminalization” that are defined and distinguished primarily on the basis of offense severity are limited both conceptually and practically for three essential reasons. First, the severity distinction is too simplistic. Offense “severity” and victim “harm” are highly subjective terms, and offenses committed by PSMIs often fall into “gray areas” along the severity spectrum.

Furthermore, a significant proportion of police contacts with PSMIs involve no criminal activity (although if improperly managed, such contacts can escalate into situations that result in an arrest) (Council of State Governments, 2002). Second, the severity distinction ignores the fact that the serious offenses

committed by PSMIs can stem from the same types of (criminal justice and mental health) systems' failures as the non-serious offenses. Third, the severity distinction obscures the extensive and complicated challenges that are faced by criminal justice professionals in their interactions with PSMIs, irrespective of offense type.

Considering these limitations, the traditional notion of "criminalization" should be replaced with a more comprehensive view of the factors that are related to the processing of PSMIs through the criminal justice system (Lurigio, 2004; Lurigio & Rodriguez, 2004; Rotter et al., 1999). Whether police are called to defuse a psychiatric crisis, respond to a relatively minor "public order" offense, or arrest a suspect with mental illness on a felony charge, the essential question is the same: How can the mental health and criminal justice systems respond effectively to the complicated needs of criminally involved PSMIs?

PSMIs' involvement in the criminal justice system can be explained by a convergence of policy developments that govern the delivery of public mental health services and the implementation of law enforcement practices. In the mental health domain, the key contributing factors include significant changes in psychiatric treatment paradigms (deinstitutionalization), involuntary commitment laws, and the structure and financing of mental health services. In the criminal justice domain, the key contributing factors are the enforcement of drug laws and a crackdown on "quality of life" offenses.

Deinstitutionalization

A transformation in mental health policy, known as deinstitutionalization, shifted the locus of care for PSMIs from psychiatric hospitals to community mental health centers and "was at the heart of what President John Kennedy called a bold new approach to the treatment of mental illness" (Durham, 1989, p. 119). This policy is the first major factor contributing to the processing of the mentally ill through the criminal justice system (Grob, 1991). The policy was delineated in 1961, when the Joint Commission on Mental Illness recommended the creation of a large-scale network of community-based facilities designed to care for psychiatric patients who formerly were treated in hospitals (Grob, 1991).

The Joint Commission's recommendations were actuated through the federal Community Mental Health Centers Act of 1964. The Act provided incentives for states to launch a community-based system of care that would facilitate the process of deinstitutionalization. Specifically, the Act transferred part of the financial burden of care from states and local communities to the federal government through the newly established Medicaid program (Grob, 1991).

In the wake of deinstitutionalization, state mental hospitals began to release thousands of psychiatric patients to community-based facilities designated to provide follow-up treatment and services. As a result, the census in state mental hospitals fell steadily from 559,000 patients in 1955 to 72,000 patients in 1994 and to 59,000 patients in 2000 (Manderscheid, Atay, Male, et al., 2002; U.S. Department of Health and Human Services, Center for Mental Health Services, 1994). The length of stay in psychiatric hospitals and the number of beds available for care also declined sharply (e.g., Kiesler, 1982; Kiesler & Sibulkin, 1987). The net effect of deinstitutionalization was "the ever-increasing presence of the mentally ill in the community" (Teplin, 1991a, p. 157).

The policy of deinstitutionalization was roundly assailed by social commentators, policy makers, and researchers; it never was fully funded and fell far short of realizing its ambitious goals (e.g., Bachrach, 1989; Dumont, 1982; Durham, 1989; *New York Times*, 1982, A. 28, 1984, A. 18). Although it reduced the use of state hospitals and transferred the costs of caring for PSMIs from the state to the federal government, it never succeeded in affording well-coordinated or comprehensive outpatient treatment for large percentages of PSMIs (Talbot, 1979). The financial strain of the Vietnam War during the 1960s and early 1970s, the economic crisis of the 1970s, and cuts in federal funding for mental health services in the 1980s, left fewer dollars for the community care of PSMIs (Miller, 1987; Teplin, 1991b; Thomas, 1998). Therefore, many PSMIs became de facto charges of the criminal justice system, arrested for vagrancy and other minor infractions, in part because of the paucity of treatment and services in the community (Barlow & Durand, 1999; Durham, 1989; Grob, 1991; Shadish, 1989; Teplin, 1991b).

As with many social reforms conceived during the 1960s, the implementation of the policy fell far short of its initial vision. Insufficient funding, limitations in evidence-based practices, and the lack of clear federal standards of care contributed to an extended period of neglect for the seriously mentally ill. Rather than replacing hospital care with extensive community-based facilities, states emptied their institutions without providing the requisite resources or infrastructure to meet the needs of the deinstitutionalized population (Grob, 1991). Although the policy of deinstitutionalization made available appropriate outpatient treatment for large percentages of the mentally ill, it often failed to care sufficiently for PSMIs who had limited financial resources or social support, especially those with the most severe and chronic mental disorders (Shadish, 1989).

Talbot (1975, p. 530) argued that the term "deinstitutionalization" should be replaced by "transinstitutionalization" to indicate that "the chronically mentally ill patient had his locus of living and care transferred from a single lousy institution to multiple wretched ones," such as nursing homes, jails, intermediate care facilities, board-and-care homes, and other group residences in which mental health care often is marginal (Bachrach, 1989; Goldman, Adams, & Taube, 1983; Lamb, 1997; Mechanic, 1998). Similarly, Mechanic (1998, p. 86) observed that, "deinstitutionalization and managed care have both contributed to a broad dispersion of persons with mental illness among residential facilities, making it difficult to monitor or even describe clearly the de facto mental health system" (p. 86).

An egregious shortcoming of deinstitutionalization was its failure to adequately treat chronic patients, who are less likely to comply with or respond to medications, and are more likely to suffer from intractable social and economic deficits (Shadish, Lurigio, & Lewis, 1989). In other words, the unsuccessful transition to community mental health care had the most tragic effects on patients least able to cope with the essential tasks of daily life (Grob, 1991). Public psychiatric hospitals became treatment settings for mostly poor persons. Their patients became younger because of the shorter lengths of hospital stays. Shorter stays were attributable to new medications and changes in hospital policies that were intended to save money by shifting the costs of care from state budgets, which paid for hospitalization, to federal budgets, which paid for community mental health services.

Reductions in federal expenditures for social welfare programs in the 1990s left even more PSMIs with few treatment options or ancillary services for such essentials as food, clothing, shelter, and medical

attention (Thomas, 1998). As a tragic result of their persistent economic hardships and political disfranchisement, the chronically mentally ill have become a stable part of the underclass (Auletta, 1982; Thomas, 1998). Unlike earlier generations of state mental patients, those hospitalized since the 1970s were more likely to have criminal histories, misuse drugs and alcohol, and tax the capacities of families and friends to care for their needs (Lurigio & Swartz, 2000). The characteristics of the mentally ill, therefore, began to resemble those of persons involved in the criminal justice system: they were poor, young, and estranged from the community (Steadman, Coccozza, & Melick, 1978).

Many PSMIs became unbidden "clients" of the criminal justice system because of the dearth of mental health treatment and other services in the community (Grob, 1991). Moreover, linkages between the criminal justice and mental health systems always have been tenuous, and the mentally ill who move from one system to the other often fail to receive enough treatment or services from either. As a result, their conditions are exacerbated and they frequently become both chronic arrestees and psychiatric patients (Lurigio & Lewis, 1987a; Lurigio & Lewis, 1987b).

In summary, deinstitutionalization moved services from a fairly centralized system, managed through a state mental health authority, to a more diffuse system that consists of a range of payers, funding streams, and service providers. Complicated systems of services, a general absence of service coordination, and a complex bureaucratic maze that interferes with access to services all are responsible for PSMIs "falling through the cracks." The legacy of deinstitutionalization continues to exert effects on today's mental health system. Formerly the prevailing model of long-term treatment for the chronically mentally ill, state psychiatric institutions today house populations of patients who are younger, more deeply disturbed, and far more likely to have histories of violence, substance use disorders, and previous criminal involvement, compared with their predecessors.

As we discuss in the next section, the changing nature of the psychiatric population also stemmed from tightened legal standards for involuntary psychiatric commitment. Although the recent (and somewhat controversial) trend toward outpatient commitment, in which community-based treatment compliance is enforced through court order, has altered the treatment and control landscape, the public mental health system's capacity to confine, treat, and case manage PSMIs has diminished greatly, leaving the correctional system as the primary (and often sole) agent for monitoring and treating PSMIs.

Mental Health Law

Mental health law reform has made it difficult to commit the mentally ill to psychiatric hospitals, and is the second major factor contributing to the apparent growth in the number of mentally ill persons in the criminal justice system (Torrey, 1997). Serious restrictions on the criteria and procedures for involuntary commitment sorely limit the use of psychiatric hospitalizations and increase the likelihood that PSMIs will be arrested and further processed through the courts. Most state mental health codes require psychiatric hospital staff to adduce clear and convincing evidence that patients being committed involuntarily are either a danger to themselves or others, or are so gravely disabled by their illnesses that they are unable to care for themselves.

Concerned that the homeless mentally ill and other PSMIs were living in the community without psychiatric or social services, mental health workers have recommended involuntary commitment as a

means of getting such persons into treatment (Thomas, 1998). Nevertheless, mental health codes strengthened patients' rights to due process, according patients many of the constitutional protections granted to defendants in criminal court proceedings (e.g., due process) (Miller, 1987). Thus, only the most dangerous or profoundly mentally ill are ever hospitalized, resulting "in greatly increased numbers of mentally ill persons in the community who may commit criminal acts and enter the criminal justice system" (Lamb & Weinberger, 1998, p. 48).

Case precedent. PSMIs cannot be hospitalized against their will without legal representation and a full judicial hearing. With these legal safeguards, the framers of reformed mental health codes hoped to eliminate capricious hospitalizations and to protect the freedom of patients (Durham, 1989). Moreover, as we mentioned earlier, they wanted to grant PSMIs many of the procedural advantages extended to defendants in the criminal justice system. Along with statutory reforms, case precedents such as *O'Connor v. Donaldson* (422 U.S. 563 [1975]), *Rennie v. Klein* (653 F. 2d 836 [3rd Gr., 1981]), *Addington v. Texas* (99 S.Ct. 1804 [1979]), *Rogers v. Okin* (634 F. 2d 650 [1st Cir. 1980]), and *Covington v. Harris* (419 F. 2d. 617 D.C. Cir. [1969]) further diminished the use of hospitalization by recognizing the right of PSMIs to refuse treatment or to receive treatment in the least restrictive settings, which often means that they receive no treatment at all (Thomas, 1998).

Many critics of these legal reforms have called for a relaxation of commitment standards so that PSMIs can be moved "off the streets and back in facilities designed for people in their condition" (Kanter, 1989; Perkins, 1985, p. 38). The American Psychiatric Association proposed a model commitment law that urged states to replace the criterion of "dangerous" with the criterion of being likely to suffer "substantial mental or physical deterioration" (Lamb, 1984, p. 47). This standard changes the focus of commitment decisions to whether individuals are capable of tending to their own needs, permits treatment of patients without their consent, and places commitment decisions in the hands of medical practitioners rather than legal practitioners (Kanter, 1989). The state of Washington, for example, revised its commitment standards in 1979 to allow the hospitalization of people who are judged to be in need of treatment (LaFond & Durham, 1992).

Outpatient commitment. Several states have enacted outpatient commitment laws for PSMIs who require no hospitalization (McCafferty & Dooley, 1990; Torrey, 1997). Outpatient commitment is a "form of civil commitment in which the court orders an individual to comply with a special outpatient treatment program" (Torrey & Kaplan, 1995, p. 278). Under such laws, the court can order individuals to receive mental health treatment in the community even if they do not meet the standard for civil commitment, offering the courts a greater choice of nonrestrictive alternatives (Stefan, 1986).

The first of the three primary types of outpatient commitment orders, which have been implemented by different states, is conditional release. It allows hospitals to impose treatment conditions upon discharge and to order rehospitalization if the orders are neglected. The second type permits the transferability of outpatient and inpatient commitment orders. In this approach, the criteria and procedures of inpatient and outpatient commitment are identical and can be employed interchangeably. The third type uses varying standards. Inpatient commitment is reserved for persons who have an essential need for hospitalization but who cannot understand the necessity for such treatment, whereas outpatient commitment

is for those who have lived successfully in the community but now are at high risk for rehospitalization or violent or destructive behavior (Petrila, Ridgely, & Borum, 2003).

Research has shown that outpatient commitment with intensive case management for PSMIs can significantly reduce the number of hospitalizations and arrests (Swartz, Swanson, Hiday, Wagner, Burns, & Borum, 2001). However, critics of outpatient commitment have been concerned that it can infringe on the civil liberties of the mentally ill, which has curbed the implementation of such laws (Hoge & Grottole, 2000). Hence, despite their flexibility, apparent effectiveness, and applicability in a variety of situations, outpatient commitment laws have been used rather sparingly (Torrey & Kaplan, 1995).

Changing Service Landscape

The third major factor that fostered growth in the percentage of mentally ill persons in the criminal justice system is the compartmentalized nature of the mental health and other treatment systems (Laberge & Morin, 1995). The mental health system consists of fragmented services for predetermined subsets of patients. The bulk of psychiatric programs, for example, are designed to treat "pure types" of clients, mentally ill or developmentally disabled, alcoholic or chemically dependant. By the same token, drug treatment professionals are unwilling or unable to serve persons with mental disorders, and often refuse to accept such clients. Furthermore, research has shown that offenders with co-occurring psychiatric and substance use disorders are difficult to engage in treatment and resistant to efforts to dissuade them from using alcohol and illicit drugs (Drake, Rosenberg, & Mueser, 1996).

Abstinence from substance use can be a prerequisite to being accepted into mental health and drug treatment programs. Therefore, persons with co-occurring disorders, who constitute a large percentage of the mentally ill in the criminal justice system, might be deprived entirely of services because they fail to meet stringent admission criteria (Abram & Teplin, 1991). In short, when persons with co-occurring disorders—most of them with serious mental illness and substance abuse and dependence disorders—come to the attention of the police officers, arrest is the only feasible response, given the dearth of available referrals within narrowly defined treatment systems (Brown, Ridgely, Pepper, Levine, & Ryglewicz, 1989).

Mental health centers can decline to treat alcoholics; PSMIs with drug abuse and dependence problems can be considered disruptive to the recovery of non-mentally ill drug addicts and refused entry into treatment; hospital emergency rooms can turn away PSMIs who appear intoxicated or threatening; and community mental health providers can reject PSMIs with criminal histories, labeling them as dangerous or resistant to treatment (Lamb & Weinberger, 1998; Teplin, 1991a). Thus, many of these "forfeited patients" (Whitmer, 1980) end up, by default, in the criminal justice system, the "asylum of last resort" (Belcher, 1988).

Beyond issues of service fragmentation, policymakers at the state and federal level have continued to struggle with the need to contain growth in public health care spending, particularly in the Medicaid program. Prompted by the provisions of the 2005 Deficit Reduction Act, which is expected to reduce federal Medicaid spending by \$4.8 billion over the next five years and \$26 billion over the next ten years, states have modified eligibility standards and excluded previously covered services, presenting significant fiscal challenges to public mental health systems that are primarily funded through Medicaid.

In the context of cost-containment, many states have adopted tighter restrictions on eligibility for services and have transitioned to managed care models in which companies are paid a fixed amount of money to care for each person in their service system. In these "risk-based" arrangements, companies often will try to avoid caring for PSMIs who are severely impaired and homeless and have substance use disorders and criminal histories, especially when correctional agencies are available to serve as a provider. Although many states and managed care providers have taken innovative steps to realign incentives and foster greater intersystem linkages, the criminal justice system has become a convenient home for the most expensive and difficult-to-manage cases.

Drug Enforcement

The fourth major factor associated with the growing pervasiveness of mentally ill offenders is the arrest and conviction of large numbers of persons for drug law violations. Significant growth in the volume of drug arrests and convictions stems largely from the war on drugs. Since the late 1980s, offenders convicted of drug possession and sales (who also have high rates of drug use) have been incarcerated with greater frequency and for longer prison terms than they were previously, and constitute one of the fastest rising subpopulations in the nation's prison and probation populations (Beck, 2000). A fairly large proportion of these individuals have co-occurring psychiatric disorders, increasing the number of mentally ill offenders in the nation's criminal justice system (Lurigio, 2004; Swartz & Lurigio, 1999).

Like dolphins among tuna, many mentally ill, drug-using persons have been caught in the net of rigorous drug enforcement policies (Lurigio & Swartz, 2000). Several studies show that PSMIs who use illicit drugs are more prone to violence and more likely to be arrested and incarcerated than those who do not (Clear, Byrne, & Dvoskin, 1993; Swanson, Estroff, Swartz, Borum, Lachinotte, Zimmer, & Wagner, 1997; Swartz, Swanson, Hiday, Borum, Wagner, & Burns, 1998). In a recent study, Junginger, Claypoole, Laygo, and Crisanti (2006) found that substance use disorders had a greater effect on criminal behavior than mental illness did in sample of PSMIs in jail. Hence, the current war on drugs, which started in 1988 with the passage of the Anti-Drug Abuse Act, and the high rate of comorbidity between drug use and psychiatric disorders, can account partially for the large numbers of PSMIs in our nation's jails and prisons. Fragmented drug and psychiatric treatment systems often fail to provide fully integrated care for persons with co-occurring disorders, compounding their problems in both areas and elevating their risk for arrest and incarceration (Lurigio & Swartz, 2000).

Police Tactics

The fifth major factor contributing to the processing of PSMIs through the criminal justice system is the recent adoption of law enforcement strategies that emphasize quality-of-life issues and zero tolerance policies in response to public-order offenses, including loitering, aggressive panhandling, trespassing, disturbing the peace, and urinating in public, which have brought into the criminal justice system large numbers of individuals for publicly displaying the signs and symptoms of untreated, serious mental illness (Borum, 2000). The implementation of public-order policing tactics has outpaced the development of diversionary programs for PSMIs (Ditton, 1999).

Beginning in the late 1980s and throughout the 1990s, police departments across the United States (especially in urban areas) launched “zero tolerance” initiatives to suppress public-order offenses. Intended to improve the quality of life in cities, these strategies have resulted in a substantial surge in the arrests of individuals who are homeless, suffering from mental illness, and addicted to substances. In many cases, the offenses that result in arrest are indicative of mental illness. Arrests for these relatively minor offenses also can lead to more serious charges, such as resisting arrest or assaulting a police officer. The unintended consequences of “zero tolerance” public-order enforcement strategies on PSMIs was noted in the early 1990s by several researchers whose findings contributed to the development of diversion programs, specialty courts, and specialized law enforcement training initiatives designed to keep the mentally ill from criminal justice processing (Massaro, 2005).

The arrest of a mentally ill person can have long-term consequences. Specifically, the arrest will be noted on a computerized criminal record that can influence future law enforcement and court decisions. A permanent “criminal” label can make police officers and judges more willing to subject these persons to future criminal justice processing. This concern applies especially to persons who commit fewer, rather than more, serious crimes (Lamb & Weinberger, 2005).

PSMIs and Criminal Justice Involvement: Suggested Remedies

Largely in response to the growing interest in the presence of PSMIs in the criminal justice system, several promising models have been developed, involving collaboration between the mental health and the criminal justice system, at the local, state, and federal levels (Massaro, 2005). These include specialized policing models (Borum, 2000), mental health courts (Watson, Hanrahan, Luchins, & Lurigio, 2001), professional standards for correctional-based mental health services, and intensive community-based service models for high-risk populations, such as Forensic Assertive Community Treatment (Council of State Governments, 2002). In addition, major national efforts, such as the federally funded GAINS Center and the Criminal Justice/Mental Health Consensus Project, have promoted an ambitious research and service agenda and facilitated the sharing of evidence-based practices among jurisdictions.

The common thread running through all of these initiatives is the recognition that traditional barriers between the mental health and criminal justice system must be transcended through the identification of common goals and the adoption of cross-disciplinary approaches for the case management and care of PSMIs. Consistent with these themes and with the innovations that have emerged in recent years, in the final section of this article, we describe a framework to help guide policy and practices at the interface of the mental health and criminal justice systems.

Primary Prevention: Community-Based Services

The human services and criminal justice systems in the United States have operated historically in a reactive mode. Our nation's health care system's response to disease is dominated by case-by-case interventions. Similarly, our criminal justice system is equipped to respond to individual instances of crime. Even our prevention practices are designed largely in reaction to pending crises. For example, our public health system actuates when confronted with the specter of an epidemic (e.g., SARS or avian flu), or legislation is passed to protect children in the wake of a heinous sexual murder (e.g., Megan's Law). In

either case, the shortsighted nature of our criminal justice and medical institutions exemplifies the country's reactive orientation toward public health and social problems.

Forward-thinking, proactive strategies in the public health domain address the root causes of disease in the physical and social environment. In the criminal justice domain, they concentrate resources (especially law enforcement) in the community, and work with schools and human service agencies to evaluate and respond to emerging risks in vulnerable populations. These are defined as primary prevention strategies.

Primary prevention is the starting point of our recommendations for confronting the problem of the mentally ill in the criminal justice system. Such an approach would attenuate the link between mental illness and crime by providing prevention and early intervention services for youth with serious mental illness. The factors that impede progress in the area of juvenile mental health treatment include a paucity children's mental health services, uncoordinated social service systems, and poorly funded clinical and evaluation research (United States Public Health Service, 2000).

After primary prevention and early intervention efforts, the next line of defense against PSMIs' involvement in the criminal justice system is the provision of community-based services that control the symptoms of mental illness, address the various social and economic challenges faced by PSMIs, and respond to the warning signs that lead to criminal activities. These are examples of secondary prevention efforts. The basic goal of secondary prevention is to work with a subset of the population (poor PSMIs) who are at high risk of getting caught up in the criminal justice system, and to pursue strategies that prevent (or at least mitigate the impact of) criminal justice processing. What does secondary prevention require?

In an ideal world, PSMIs would have unimpeded access to clinical and habilitation services. Clinicians would provide evidence-based treatment that controls the symptoms of mental illness. Case managers would have low caseloads, linkages with law enforcement, and appropriate training to identify the precursors of potential criminal involvement. PSMIs' entanglements in the criminal justice system, which are related to their mental illness, would be eliminated.

Universal access to services remains elusive because of financial hardships, cultural obstacles, the stigmatization of the mentally ill, workforce issues, and geographic barriers that limit access to treatment. The unavailability of services, the shortcomings of current treatments, and poor compliance with medication means that only a small proportion of PSMIs will have their symptoms controlled. Moreover, the shortage of "wraparound" services, such as housing, employment, and life skills training, hampers the recovery process. Finally, promising case management models (e.g., assertive community treatment) have been poorly funded or fail to meet the overall demand for such services.

Role of Law Enforcement and Courts

Law enforcement personnel are frequently the "frontline" responders to PSMIs in diverse situations that range from self-harm, to public order offenses, to more serious nonviolent offenses, such as breaking and entering, to varying degrees of actual or threatened violence. Reflecting this diversity of situations, the roles that law enforcement officers play in their contacts with PSMIs also are highly varied. Depending on

the circumstances, police officers' responses to PSMIs can include the de-escalation of volatile interactions (sometimes in conjunction with mental health professionals), transportation to an emergency room or other clinical setting, or taking the person into custody.

The outcome of police encounters with PSMIs depends on the officers' level of mental health-related training, the implementation of policies on police-based mental health responses, and a mechanism that refers PSMIs to appropriate clinical services. In an ideal world, with these resources and strategies, officers would be able to appropriately divert PSMIs away from the criminal justice system and into the mental health system, limiting arrests to incidents that involve serious criminal activity.

After PSMIs are arrested, they can appear before a judge to face criminal charges. At arraignment, the process can be complicated profoundly by psychotic symptoms, which frequently are exacerbated by the use of illicit substances. In these instances, judges, prosecutors, and defense counsels must be able to understand the person's rendition of events, ascertain the facts of the case, and arrive at a temporary case disposition. As the legal process moves forward, these parties must confront issues, such as competency to stand trial, criminal responsibility, and dangerousness, and make complex determinations about treatment, sentencing, and release to the community.

In an ideal world, the courts and other components of the legal system would render decisions that protect public safety and improve the quality of life for PSMIs. They would have foolproof methods for predicting dangerousness and apply those predictions in a legal framework. Judges and juries would have a solid understanding of how their sentencing decisions affect the mentally ill, and the courts would have access to sufficient community services. Finally, the court system would operate in tandem with the mental health system in efforts to improve healing and recovery—a concept known as therapeutic jurisprudence (Wexler & Winick, 1996).

Role of Institutional Corrections

As we noted earlier, jails and prisons house nearly three times as many PSMIs as state psychiatric institutions do (Human Rights Watch, 2003). Jails process nearly one million newly admitted detainees with serious mental illness each year. In many cases, they are the final stop on the "institutional circuit" that includes homeless shelters, psychiatric institutions, and substance abuse residences (Bernstein & Seltzer, 2004).

The functions of jails and prisons in the mental health service delivery system are diverse, and include initial screening and assessment, crisis intervention, long-term treatment, specialized housing, suicide prevention, and community linkages for reentry. Although practice standards have been developed in these areas, the quality and level of mental health services vary considerably in the nation's jails and prisons (Human Rights Watch, 2003). Many jurisdictions modified their mental health case services only after litigation compelled them to do so (Lurigio & Snowden, in press).

In an ideal world, newly admitted jail inmates would be screened for mental illness by a qualified professional within hours of admission. Detainees with serious disorders would be diverted to the mental health system. Treatment programs would be integrated with specialized housing, evidence-based

medication regimens, and psychosocial rehabilitation services, which improve individual adjustment and facilitate recovery. Corrections-based mental health systems would coordinate with community-based mental health systems and share treatment protocols and reentry resources. Although these program practices have been adopted in many jurisdictions, implementation is uneven. Issues that can compromise care include funding limitations, mission conflicts, security considerations, insufficient physical plant capacity, and a host of treatment-related difficulties.

Role of Community Corrections

For the general offender population without mental illness, community reintegration represents a major challenge—problems such as employment, housing, education, and social support loom large in the lives of ex-offenders. Failure to address such fundamental issues places these individuals at considerable risk of future involvement with the criminal justice system. For those with mental illness, the seriousness of these issues is greatly compounded. Beyond the barriers presented by their ex-offender status, they are faced with the considerable obstacles that are related to their psychiatric condition. These obstacles include communication problems, diminished insight, and disturbances of mood and perception. In light of these circumstances, PSMIs present particular challenges to the probation and parole officers who are responsible for supervising them and facilitating the community reintegration process.

In an ideal world, PSMIs under community supervision would receive supportive housing and related services. Specially trained probation and parole officers with mental health backgrounds would monitor specialized, reduced caseloads that permit intensive case management. Information systems and cross-agency collaboration would foster communication and integrated service planning with treatment providers and parole and probation personnel. These practices have been evaluated with promising results, but they have been implemented on only a small scale.

Conclusion

The continually growing numbers of PSMIs in the criminal justice system present many challenges to mental health and criminal justice professionals. The care of the mentally ill in court and correctional settings must be improved in at least four general areas. The first lies in our ability to construct and administer more efficient and precise tools and strategies to screen and assess psychiatric disorders, which will enhance our ability to keep pace with the steady and often torrential flow of PSMIs entering our courts, jails, and prisons.

The second lies in our ability to adopt treatment approaches that are designed expressly to respond to the complex and multifarious problems that afflict criminally involved PSMIs. They frequently suffer from co-occurring substance use disorders and require a combination of therapeutic, habilitative, and rehabilitative services to help them reintegrate successfully in the community and avoid further criminal entanglements.

The third lies in our ability to create and support legislation that will allocate the necessary dollars to fund sufficiently the services that are needed to respond to the mental health needs of criminally involved PSMIs (e.g., the Law Enforcement and Mental Health Project Bill). In many jails and prisons, a paucity of

resources leads to exorbitantly high caseloads, which interfere with the proper assessment and treatment of inmates' mental illness.

The fourth lies in our ability to study and evaluate what works best in treating the problems of PSMIs in the criminal justice system. We must use methodological and statistical skills to identify and refine evidence-based practices to treat the mentally ill in the criminal justice system. The special characteristics and needs of criminally involved PSMIs, and the exigencies of operating correctional institutions, complicate and limit the care of the mentally ill. Through research, we can examine the impact of current programs and facilitate the development of new programs to effectively and humanely care for PSMIs in correctional settings. Our professional, legal, and moral obligations demand that we engage in assessment, treatment, advocacy, and research activities. Failure to do so would be criminal.

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