Chapter 18

Mental Health Treatment in Criminal Justice Settings

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In any comprehensive discussion of persons with mental illness, criminal justice involvement is a necessary and defining issue. Over the past three decades, there is a clear and consistent body of evidence demonstrating that persons with serious mental illness (PSMI) are over-represented in the criminal justice system (e.g., James & Glaze, 2006; Lamb & Weinberger, 1998; Teplin, 1984, 2000; but see Engel & Silver, 2001). Both the number of individuals and the frequency with which they come into contact with the system is disproportionate. Compared to rates of serious mental illness in the general population, rates of SMI in the criminal justice system are at least two to five times higher (e.g., James & Glaze, 2006; Lamb & Weinberger, 1998; Munetz, Grande, & Chambers, 2001). In addition, the high volume of offenders involved in the criminal justice system with serious mental health issues often cycle repeatedly through the system earning them the title of “frequent flyers.” To further compound the problem, the majority (75-80%) of offenders with mental illness has co-occurring substance abuse or dependence disorders (Abram, Teplin & McClelland 2003; National GAINS Center, 2005).

In this chapter, the authors provide an overview of the prevalence of PSMI in the legal system, and then discuss the treatment and related issues of PSMI at various intercept points along the criminal justice system continuum. The focus in this chapter is on PSMI as offenders, not as victims to, or witnesses to crimes (see Silver, Arseneault, Langley, Caspi, & Moffitt, 2005; Teplin, McClelland, Abram, & Weiner, 2005 for more on the victimization of PSMI). Using a theoretically driven framework, the authors discuss five main intercept points: 1) Law Enforcement and Emergency Services; 2) Initial Detention and Initial Court Hearing; 3) Jails and Courts; 4) Prisons and Reentry; and 5) Community Corrections and Community Support. In addition to reviewing the historical and ‘usual’ treatment at these points of contact, the authors review innovative and more recent efforts aimed at reducing the recidivism cycle among this
population. Finally, the authors discuss policy issues, implications for mental health, and future challenges facing the field.

**Prevalence of Persons with Serious Mental Illness in the Criminal Justice System**

Today there are more than seven million people in the U.S. correctional system. Two point three million are incarcerated in local jails and state and federal prisons and five million are in the community being supervised by probation and parole agencies (Pew Center on the States, 2009). These numbers represent an astounding 500% increase in the last 35 years (Glaze & Bonczar, 2006). State spending on corrections has risen faster than spending on nearly every other State budget item, increasing from $9 billion to $48.6 billion a year from 1984 to 2007 (National Association of State Budget Officers, 1987, 2008).

Recent estimates are that about 1.1 million jail admissions annually are persons with serious mental illness (see Steadman, Robbins, Islam, & Osher, 2007). In 1978, at a national workshop on mental health services in the jails, Brodsky described jails as a “public health outpost.” Thirty years later, the same sentiment applies despite a steady acknowledgement of, and attention to, the problem. Today, urban jails, such as jails in Los Angeles, New York City, and Chicago, are the largest provider of inpatient mental health services, encountering more persons with serious mental illness than any hospital nationwide. Simply put, the presence of persons with serious mental illness in our nation’s criminal justice system overwhelms an already overburdened, fragile system, from contact with law enforcement through community supervision, and all points in between, making this problem one of the major public health issues of our time. The President’s New Freedom Commission on Mental Health (2003) recognized that
the combination of mental illness and substance use is a major public health problem. The addition of criminal justice involvement only intensifies the severity of the problems.

Because five of the seven million U.S. citizens under correctional supervision are in the community under probation or parole supervision (Glaze & Bonczar, 2006), and because when in the community, persons with mental illness have no constitutional right to treatment as they do when they are incarcerated, arguably the largest set of issues for justice-involved persons with mental illness is the generic problem of accessing appropriate community-based services. The accessing of services is often exacerbated by fear, stigma, and exclusionary policies associated with their criminal justice histories. In the discussion below, the authors review traditional and newer innovative interventions for offenders with mental illness in the community and in confinement.

**Mental Health Issues and Treatment in the Criminal Justice System**

The criminal justice system, at a basic level, is made up of three prongs: law enforcement, the courts, and corrections (jails and prisons, as well as probation and parole). Mental health issues can arise at any point in the criminal justice process. To frame a discussion of these issues and the responses that have been developed, the authors utilize the Sequential Intercept Model (SIM). The SIM, which was developed originally by the National GAINS Center\(^1\) and refined by Munetz and Griffin (2006), is a schematic of the criminal justice system’s processing of cases. At each point in the SIM (from community law enforcement involvement through community reentry and supervision), it is essential to design interventions that attend to...  

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\(^1\) The National GAINS Center originated in 1995 and has served as the national locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the criminal justice system (see [www.gainscenter.samhsa.gov](http://www.gainscenter.samhsa.gov))
these intercepts to ensure a comprehensive, systematic approach to problems associated with the over-representation and treatment of PSMI in the criminal justice system.

At each intercept point, there are a range of related problems that can greatly affect PSMI and affect the professionals and larger systems that process them, and at each point, interventions can be designed or refined to address these issues to avoid the basic issue of a PSMI unnecessarily penetrating deeper into the criminal justice system. As discussed by Munetz and Griffin (2006), best clinical practices are the “ultimate intercept.” This is the core goal of all interventions: to prevent people from penetrating more deeply at much higher costs (fiscally and ala human rights) simply because they are mentally ill and because there is an absence of appropriate community-based supports for their maintenance, improvement, and recovery.

**Intercept 1: Law Enforcement/Emergency Services**

In the community, police spend a disproportionate amount of time dealing with PSMI than non-PSMI. For example, Los Angeles Police Departments reported spending over 28,000 hours a month on calls involving people with mental illness (DeCuir & Lamb, 1996), and the New York City police reportedly respond to calls involving PSMI every 6.5 minutes (Council of State Governments, 2002). There are two primary ways to examine the frequency of PSMI interactions with law enforcement. First is to determine the percent of PSMI among all police-suspect interactions. Studies have shown that approximately 3 to 6% of suspects have a serious mental illness (Engel & Silver, 2001). In a more recent study in Canada, less than 1% of suspects had an
identifiable mental illness, although having a serious mental illness increased the risk of police contact as an offender two and one-half times (Crocker, Hartford, & Heslop, 2009). The second manner is to examine arrest rates among cohorts of people with serious mental illness. Recently, Fisher, Roy-Bujnowski, Grudzinskas, Clayfield, Banks, and Wolff (2006) examined the arrest histories of more than 13,000 Massachusetts mental health service utilizers over a 10-year period. They reported that 28% had at least one arrest, and that the most common charges were public order crimes, such as trespassing, and disorderly conduct. They also found that a small subset of individuals, 1.5% of the total sample or 5% of those with any arrest, accounted for 17% of all arrests.

When police officers interact with PSMI who are suspected of committing crimes, they generally have two discretionary options, depending on the severity and circumstances of the crime: a mental health option (e.g., hospitalization) or a criminal justice option (arrest). Research has demonstrated that police are much more likely to utilize the criminal justice option, as this is often the only viable and most convenient option from the police officer’s perspective (sometimes referred to as “mercy booking”; Lamb, Weinberger, & DeCuir, 2002; Green, 1997). Pursuing a mental health option can be frustrating, time-consuming, with long (e.g., 8 hour) waiting periods until the person is seen at the hospital which may or may not result in an admission. In communities that have instituted 24-hour crisis drop-off centers, police officers perceived their specialized response to mental disturbance calls as two to eight times more effective than officers without such centers (Borum, Deane, Steadman, & Morrissey, 1998). However, currently most communities do not have such resources and thus law enforcement often utilize their discretion to arrest (Lamb et al., 2002). Interestingly, Green (1997) found that more experienced officers were less likely to arrest persons with mental illness, particularly
when there was no evidence of a crime, or when the person was homeless, than less experienced officers.

Many law enforcement agencies, recognizing the overabundance of resources and potential for harm when officers deal with PSMI, have sought out solutions to the problem. The most notable solution is pre-arrest diversion, of which there are typically three models: 1) Police-based specialized police response; 2) Police-based specialized mental health response; and 3) Mental health-based specialized mental health response (Deane et al., 1999; Steadman, Deane, Borum & Morrissey, 2000). In the first model, police officers are specially trained in crisis intervention and act as liaisons to the mental health system. In the second model, mental health professionals work collaboratively with police to provide on-site or telephone consultation. In the third model, mental health professionals provide on-site help to the police in situations involving persons with mental illness (see Reuland & Cheney, 2005).

A growing and successful pre-arrest diversion program is Crisis Intervention Teams, or CIT, which conforms to the first model described above. CIT originated in Memphis, TN in 1988 and is focused on deescalating crisis situations between law enforcement and PSMI. A primary element of CIT is officer training. The Memphis CIT model prides itself on its initial 40-hour (plus refresher courses) intensive training. The curriculum includes information on mental illness, crisis skills, and a heavy concentration on interactive role playing. A second element of CIT is community outreach and collaboration, including forging mental health partnerships. A third element of CIT is re-conceptualizing police roles for the specialized diversion officers. That is, under the CIT model, officers volunteer or are specially selected (i.e., not randomly assigned), and the agency promotes bonding among them (Reuland & Cheney, 2005). In addition to these elements, Steadman et al. (2001) stressed that legal foundations and linkages to community
services are important aspects of pre-booking diversion. Legal foundations in the forms of statutes, codes, or policies, can help ensure that it is legally permissible for crisis facilities to accept and detain persons who may or may not have criminal charges pending.

In general, the research on the effectiveness of CIT and other specialized responses to PSMI is positive. Steadman and colleagues (2000) examined three such programs and reported 46% of mental disturbance calls resulted in the individuals being taken to treatment, 35% were resolved at the scene, and 13% were referred to treatment. Perhaps more importantly, only 7% of calls resulted in an arrest. Moreover, jurisdictions with specialized responses have seen decreases in the number of injuries to officers and citizens (Dupont & Cochran, 2000; Reuland, 2004).

**Intercept 2: Initial Detention/Initial Court Hearing**

In part, because of the lack of appropriate alternatives discussed above, compared to persons without mental illness, PSMI are more likely to be arrested. In fact, the odds of a PSMI being jailed are *significantly greater* than the odds of being hospitalized (Morrissey, Meyer & Cuddeback, 2005). In one study, individuals displaying symptoms characteristic of mental illness were found to have a 67% higher probability of being arrested than individuals not displaying such symptoms (Teplin, 1984, 2000). Moreover, after this initial arrest, PSMI are more likely to be detained in jail (as opposed to released on own recognizance or have cases dismissed), and once jailed, stay incarcerated 2 ½ to 8 times longer in comparison to their non-mentally ill counterparts (Council of State Governments, 2002). The rate of mental illness in jail is substantially higher for women than for men (James & Glaze, 2006; Teplin et al., 1996), and women detainees generally present with more complex issues in jail, such as child care, histories of violence, physical and sexual abuse, and posttraumatic stress disorder (PTSD) (Steadman & Naples, 2005). Although jails are required by law to provide mental health services, most have
inadequate mental health staffing to provide even the most basic services of screening and crisis intervention (see below). Further, some have suggested that the primary cause of criminal justice involvement is deinstitutionalization and fragmented community mental health systems (Abramson, 1972; Teplin, 1983; see Morabito, 2007 for a recent discussion), further pointing to the need to address the problem not in jails but in specialized community programs.

Recommendations for diversion programs date back at least to the 1970s, when the National Coalition for Jail Reform began advocating for new methods of addressing PSMI in jail. More recently, the National Alliance for the Mentally Ill (NAMI) reported on the misuse of jails as mental hospitals and called for the development of jail diversion programs (Torrey et al., 1992). Methods of reducing the numbers of PSMI in the criminal justice system require collaboration between two systems with a long history of little or no collaboration. Criminal justice and mental health systems have different goals (punishment vs. treatment), funding streams, as well as training backgrounds and expectations of personnel (Fagan, Morrissey, & Cocozza, 2007). However, despite these obstacles, jail diversion programs have proliferated since the 1990s in order to address the problem of PSMI cycling in and out of jail without proper mental health care. There are currently approximately 300 non-specialty court diversion programs in the U.S. (National GAINS Center, 2007).

The term “jail diversion” is actually made up of two distinct processes: 1) eliminating or reducing jail time by diverting the individual from the criminal justice system; and 2) linking these individuals with community-based treatment. Jail diversion programs are considered “prebooking” diversion if the intervention occurs before an arrest is made (e.g., see CIT above) or “postbooking” diversion if the intervention occurs after arrest but before prosecution or sentencing. At this stage in the Sequential Intercept Model, the goal is to reduce the length of
time under criminal justice supervision. Potential legal outcomes of postbooking diversion include alternative sentencing, conditional release, or dropped charges based on the assumption that well-supervised mental health treatment will be initiated and maintained in the community (Morrissey & Cuddeback, 2007). Steadman and colleagues (1994) identified what they consider the core elements of a post-booking jail diversion program. These include: 1) screening for the presence of a mental disorder; 2) evaluation by a mental health professional of those who screen positive; and 3) negotiation between the diversion program, prosecutors, defense attorneys and the courts to produce a disposition outside the jail with charges either dropped or reduced.

The proliferation of jail diversion programs across the county has significantly outpaced the research, such that many basic questions about jail diversion remain unanswered. For instance, it is unclear who is best served by jail diversion programs. However, in practice, studies have identified older age, female gender, and non-felony, non-violent charges as predictors of referral for diversion (Naples, Morris, & Steadman, 2007; Steadman et al., 1999).

Steadman and colleagues (1995) conducted on-site interviews with 18 programs that met the definition of a jail diversion program in order to determine characteristics associated with effective programs. Through these interviews they identified six central themes that appear to characterize effective programs. The first was providing integrated services for mental health, substance abuse, housing, etc., within the auspices of a single entity. The second included involving key stakeholders from multiple agencies early in the process and holding regular meetings to facilitate information sharing and discussion of concerns. The third included the presence of “boundary spanners,” individuals who serve as a liaison between the behavioral health and criminal justice systems. Effective programs were also defined by strong leadership for the program. Early identification of possible mental illness (i.e., screening within the first
24-48 hours) was seen as a critical component to effective programs. Finally, intensive, culturally diverse case management was considered one of the most critical factors.

Only a handful of studies have been conducted on outcomes associated with jail diversion programs, and most have utilized pre-post designs (Lamberti et al., 2001; National GAINS Center, 2002) or compared outcomes of diverted vs. non-diverted individuals in quasi-experimental designs (Lamb, Weinberger & Reston-Parham, 1996; Steadman, Cocozza, & Veysey, 1999; Steadman & Naples, 2005). Overall, findings from these studies indicate that participants in jail diversion spend less time in jail; do not have an increase in re-arrest rates; and are more likely to be linked to community based services. However, little or no improvement was noted in the areas of mental health symptoms and functioning, suggesting that participants may not be receiving the type and/or amount of services necessary. Finally, jail diversion programs appear to result in lower criminal justice costs and greater behavioral health costs (Steadman & Naples, 2005).

**Intercept 3: Jails and Courts**

Despite the popularity of jail diversion programs, these programs serve only a fraction of PSMI. There are many reasons why offenders with serious mental health problems are not diverted. For one, diversion programs often have maximum capacities and to our knowledge, there is no one program that could meet the need of the community. Further, not all offenders are eligible (e.g., committed a violent crime) and not all offenders are recognized and referred to programs even when eligible. As such, large urban jails necessarily must house and provide some treatment for offenders identified as having mental illnesses. While in jail (which are distinguishable from prisons in that they are most often county operated, short-term placements focusing on processing detainees and sentencing serving misdemeanants), PSMI often have
behavioral problems, decompensate, and generally do not fare well in these settings. For example, James and Glaze (2006) found that 19% of jail inmates with mental illness had been charged with breaking jail rules, in comparison to only 9% of jail inmates without mental illness. Violations of rules and other disciplinary infractions can lead to longer stays because of increased sanctions and/or, sadly enough, for the purposes of treatment.

Traditionally, treatment services provided by jails have widely varied, and are often dependent on the size of the jail, whether the jail is pre-trial detention only or houses sentenced inmates as well, and relations between outside treatment providers and jails. Morris, Steadman, and Veysey (1997) surveyed 1036 small and large jails about their mental health treatment services. They found that only 33% provided any counseling or therapy, 20% had inpatient care inside the jail (45% had the capacity for inpatient care outside the jail), and 45% had special housing areas for offenders with mental illness. On average, jails provided four different types of mental health services, though the larger jails provided an average of seven or eight services. Similarly, Anno (2001) reported that of eight large county jails, 50% had programs for aggressive mentally ill; 38% had programs for offenders with co-occurring disorders; 75% had inpatient beds for offenders with mental illness; and 88% had different levels of care for offenders with mental illness. In James and Glaze’s (2006) report on the mental health and treatment of offenders, they noted that only 17% of PSMI in jail had received any treatment since being admitted in contrast to 34% of PSMI in prison.

Inadequate accommodations and access to treatment in jail pre-trial can also have implications for court proceedings, particularly adjudicative competence issues. Competency to stand trial (CST) has been a primary issue among forensic researchers and forensic practitioners for decades. The American Bar Association’s Criminal Justice Mental Health Standards noted
that “the issue of present mental incompetence, qualitatively speaking, is the single most important issue in the criminal mental health field” (1994). Further, more resources are spent on competency evaluations and treatment than any other forensic service (Zapf, Hubbard, Cooper, Whelles, & Ronan, 2004). Estimates of competency evaluations in the U.S. range approximate 50,000 to 60,000 yearly (Mossman et al., 2007; Poythress et al., 1994).

There is a comprehensive research base indicating that, in comparison to persons without mental illness, PSMI are more likely to have deficits in adjudicative competence, such that they may not understand and appreciate the plea/trial process (Poythress, Bonnie, & Oberlander, 1994; Poythress, Hoge, Bonnie, Monahan, Eisenberg, & Feucht-Haviar, 1998; Rosenfeld & Wall, 1998). This lack of understanding and appreciation, which is constitutionally afforded to all defendants, can lead to increased lengths of incarceration, especially if defendants do not have access to effective defense counsel.

An important policy and legal issue that has emerged from this problem is the inability to evaluate (and potentially restore if necessary) competence in a timely manner, leaving many suspected incompetent offenders to languish in jail until an assessment can be conducted, often times longer than if they had simply pled out on “time served” (Pinals, 2005). After a finding of incompetence to stand trial, it is incumbent for the state to treat the defendant to restore competency. This treatment has almost always been in high cost, maximum security state forensic mental hospitals. Whereas competency evaluations underwent significant change in the late 1970s and 1980s from inpatient to outpatient settings, competency restorations did not follow suit (Miller, 2003). Most states have established outpatient pre-trial evaluation systems for court ordered defendants (Grisso, Cocozza, Steadman, Fisher, & Greer, 1994; Miller, 2003; Pinals, 2005).
Above the authors discussed pre-and post-booking jail diversion programs. Mental health courts (MHCs) are another form of post-booking jail diversion. A main difference between MHCs and other post-booking programs is that participants are required to return for status review hearings before the MHC judge. The first two courts appeared in 1997 and today there are estimated to be more than 150 courts (National GAINS Center, 2007). As addressed by Redlich (2005), there are five characteristics that operationally define the courts. First, the courts are part of the criminal justice system, and for offenders with mental health problems. All courts focus on non-violent offenders, though the gap between misdemeanant and felony offenders is closing (Redlich et al., 2005; 2006), and many handle only persons with serious mental illnesses. Second, as mentioned the courts are a form of diversion. Third, the courts mandate and monitor treatment in the community. Fourth, the courts tend to follow a therapeutic jurisprudence model, in that they are lenient (e.g., understand and expect relapses, have gradated sanctions) and informal (non-adversarial). And finally, all mental health courts are intended to be voluntary.

There are several notable research studies indicating that MHCs are effective in reducing recidivism and accessing treatment. For example, McNiel and Binder (2007) found that, in comparison to a treatment-as-usual group, clients in the San Francisco MHC were less likely to reoffend over 18 months; rates of re-offense were 56% for the comparison and 34% for the MHC samples (see also Moore & Hiday, 2006). Effectiveness has also been noted in regard to treatment. In a study of the MHC in Broward County, FL, Boothroyd and his colleagues (2003) found that, when compared to non-MHC defendants in another county, participants in the MHC were more likely to access services and when services had been accessed, have a higher volume of service encounters. Lastly, a recent study by Redlich, Hoover, Summers, and Steadman (2009) found that a significant minority of MHC clients from two courts lacked sufficient general legal
knowledge (adjudicative competence) and MHC-specific knowledge about court procedures and requirements. Whether knowledge is important for MHC success has not yet been addressed.

**Intercept 4: Prisons and Reentry**

State prisons face many of the same challenges as county jails regarding offenders with mental health problems. The data on the prevalence of mental illness in prisons is similar to those discussed in jails. James and Glaze (2006) reported a 56% prevalence rate of inmates with at least one mental problem in state prisons. Using a much more conservative definition of serious mental illness, Steadman, Fabisiak, Dvoskin, and Holohean (1987) discovered an 8% rate among New York state prison inmates.

In comparison to similar data on jails reported above, prisons are seemingly more likely to have mental health treatments in place, however. In light of the fact that jails are usually more temporary settings, it is not surprising that prisons were more likely to have these services available. In a survey concerning correctional health care (see Anno, 2001), state prisons were asked about the special services they provide to inmates. Data from twenty-eight prisons were collected: 79% had programs for aggressive mentally ill inmates; 75% had programs for inmates with co-occurring disorders; 100% had inpatient beds for offenders with mental illness; and 96% had different levels of care for offenders with mental illness. Of importance, the adequacy and effectiveness of services provided has received less scrutiny.

The continuity of care upon release from confinement settings has been a major area of concern and recent reform. After jail or prison terms, many PSMI are left on their own to determine how to successfully re-enter society. More than 7 million individuals will be released from jails and prisons annually, with the majority coming out of local and county jails (Hammett, Roberts, & Kennedy 2001). It has been suggested that many of these inmates with mental illness
and other serious health problems will likely return to jail without appropriate services to help them reintegrate into communities (Osher, 2007).

Inadequate transition planning puts people with mental and substance use disorders who were incarcerated in a state of crisis back on the streets in the middle of the same crisis. The outcomes of inadequate transition planning include the compromise of public safety, an increased incidence of psychiatric symptoms, relapse to substance abuse, hospitalization, suicide, homelessness, and re-arrest (Osher, Steadman, & Barr, 2002). Because of these known potential consequences and their high risk, re-entry of justice-involved PSMI is a pressing policy topic, one nearly devoid of theoretically-driven outcome research. Although the President’s New Freedom Commission highlighted the issue of reentry as a priority, few U.S. jails and prisons have adequate plans in place (Austin, 2001; Veysey, Steadman, Morrissey, & Johnsen, 1997). Without proper re-entry planning and subsequent community supervision and community support, the likelihood of a PSMI re-entering the criminal justice system is high. How infrequently these issues are addressed is apparent in the major federal reentry initiative (Serious and Violent Offender Reentry Initiative, SVORI) in which 88 programs were funded, but only six focused on inmates with mental illness (National GAINS Center, 2006).

In an effort to provide guidance on community reentry of offenders with mental illness from jails the National GAINS Center held meetings with jail administrators and reviewed programmatic reentry efforts around the country. As a result, a best practice approach to managing the early release and reentry of jail detainees known as the APIC Model (Assess, Plan, Identify, Coordinate) was developed (Osher et al., 2002). An important tenet of the APIC model is that the jail, jail-based mental health and substance abuse treatment providers, and community-based treatment providers must each play an important role in transition planning. At the Assess
stage it is recommended that the detainee’s psychosocial, medical, and behavioral needs as well as public safety risks be assessed. The Plan stage suggests making plans for critical periods, such as the first few hours or days post-release, plans for medication until follow-up appointments take place, and plans for benefits application or reinstatement. The Identify stage is concerned with specific service referrals that are appropriate to the detainee’s needs. Finally, the Coordinate stage involves coordinating the transition plan to ensure implementation and avoid gaps in care with community-based services.

The Identify and Coordinate stages pose some of the biggest challenges for communities attempting to divert PSMI away from jail and into effective mental health and substance abuse treatment. This is because despite the fact that approximately 500 diversion programs (pre- and post-booking, and MHCs combined) exist in the U.S. today, there is little empirical guidance regarding effective treatment to address the complex needs of this population.

**Intercept 5: Community Corrections/Community Support**

As noted above, approximately five million U.S. citizens are currently under community correctional supervision, of whom about 1 million are estimated to have mental illnesses (Crilly, Caine, Lamberti, Brown, & Friedman, 2009; Glaze & Bonczar, 2006). Compared with probationers or parolees without mental illness, those with mental illness are much more likely to fail supervision (i.e., have probation revoked for violating terms or for committing a new offense). These problems have widespread public health and public safety implications. One study found the re-arrest rate of probations with mental illness was nearly double that of probationers without mental illness (54% vs. 30%) (Dauphinot, 1997). Similarly, in a study that matched pairs of parolees with and without mental illness on age, offense, and sentence, parolees
with mental illness were twice as likely to have their parole suspended (65% vs. 30%) (Porporino & Motiuk, 1995).

The extent of this problem has led to explicit recommendations for probationers and parolees with mental illness to be assigned to specialized mental health probation agencies in order to provide assistance complying with the conditions of probation and parole (Council of State Governments, 2002). Specialty probation has been characterized by a number of features that distinguish it from traditional departments (Skeem, Emke-Francis, & Eno Louden, 2006). First, specialty probation officers have exclusive mental health caseloads. Another important feature is meaningfully reduced caseloads. Specialty probation officers carry caseloads that are roughly one-third that of traditional probation. Sustained officer training is another defining feature, where officers receive from 20 to 40 hours of mental health training a year. Specialty probation also integrates internal and external resources, meaning that probation officers work directly with probationers and coordinate with probationers’ treatment providers. Finally, specialty probation is characterized by the use of problem-solving strategies in working with probationers to remedy noncompliance issues (Skeem & Eno Louden, 2006). Not only are specialty probation agencies perceived as more effective by stakeholders (Skeem et al., 2006), but there is also some evidence to suggest their potential effectiveness in linking probationers with services, reducing risk of probation violation, and improving overall functioning (Skeem & Eno Louden, 2006). Recently, Skeem and colleagues found that probationers with co-occurring problems were less likely to receive future (8 months later) probation violations when they had a good rather than poor relationship with their probation officer (Skeem, Eno Louden, Manchak, Vidal, & Haddad, 2009), leading to their conclusion that relationship quality in addition to
traditional probation strategies are important in understanding why probationers with mental disorders may fail on probation.

Community-based interventions for mentally-ill offenders have generally fallen into three types: 1) services-as-usual; 2) evidence-based programs such as Assertive Community Treatment (ACT) or Integrated Dual Disorders Treatment (IDDT); and 3) forensic adaptations of evidence-based programs. Forensic adaptations of programs such as ACT include many of the same elements, yet have the added criteria of prior arrests, get referrals from criminal justice, have criminal justice partners, use court sanctions, often have probation officers as members of the treatment team, and have the explicit goal of preventing re-arrest (Lamberti et al, 2004).

Outcomes associated with diverting PSMI into services-as-usual come from the SAMHSA-funded jail diversion study (Broner et al., 2004; Steadman & Naples, 2005). Using a quasi-experimental design, PSMI who were diverted were compared with those not selected for diversion. Diverted individuals spent more days in the community (as opposed to jail, hospital, or residential care), had fewer days in jail, and reported more behavioral health service use. However, no clear improvements were noted for mental health symptoms or quality of life.

ACT is a well-established evidence-based practice for PSMI in the community, with over 40 randomized controlled trials conducted to date (Bond, Drake, Mueser, & Latimer, 2001; Marshall, Gray, Lockwood, & Green, 1998). ACT has been widely disseminated in order to help PSMI who are at high risk for repeated psychiatric hospitalization. However, despite the success of ACT in reducing hospitalization, there is considerable evidence that ACT is not effective in keeping PSMI who are involved in the criminal justice system out of jail (Bond, Drake, Mueser, & Latimer, 2001; Calsyn, Yonker, Lemming, Morse & Klinkenberg, 2005; Marshall & Lockwood, 2004). As a result, forensic adaptations of ACT (FACT) and other Intensive Case
Management (FICM) programs have developed. While the concept of FACT is rapidly catching on, there is no standardization of FACT in terms of program elements, client eligibility, or staffing (Cuddeback, Morrissey, & Cusack, 2007; Cuddeback, Morrissey, Cusack, & Meyer, 2009).

The evidence base for these forensic adaptations (FACT or FICM) can be described as preliminary at best. In two separate pre-post studies of FACT, significant reductions in arrests, jail days, hospitalizations, and hospital days were found (McCoy, Roberts, Hanrahan, Clay, & Luchins, 2004; Weisman, Lamberti, & Price, 2004). The California statewide Mentally Ill Offender Crime Reduction Grant (MIOCRG) program used randomized clinical trials to evaluate 20 programs (either FACT or FICM) designed to reduce the criminal justice involvement of PSMI (California Board of Corrections, 2004). Data were aggregated across the 20 sites. According to the statewide summary report, the intervention groups resulted in small but significant differences on bookings, convictions, and jail days, as well as some quality of life measures. The report further noted that programs with higher fidelity to the ACT model achieved better outcomes. A limitation of the aggregated statewide report is that there were many differences in the types of programs and how they were implemented, and no statistical controls were used to adjust for potential confounding variables.

Two randomized clinical trials have been reported of FICM programs. Solomon and Draine (1995) found no differences between FACT, FICM and usual care with regard to clinical or social outcomes. There was no benefit of the interventions on criminal justice outcomes. Interestingly, the FACT group actually had a higher re-arrest rate, although this was attributed to more intense supervision of clients via a probation officer on the team. Cosden, Ellens, Schnell & Yamini-Diouf (2005) evaluated a mental health court combined with a FICM-model versus
usual care. Improvements were seen at 24 months post-treatment for mental health symptoms, quality of life, and drug and alcohol problems. Regarding criminal justice outcomes, this study also found an increase in bookings for the intervention condition (perhaps for the same reason as the Solomon & Draine study), but no other criminal justice findings.

Overall, it is unclear to what extent intensive treatment programs such as FACT are needed, and whether FACT or the less intensive FICM is capable of achieving positive mental health and criminal justice outcomes. More research is needed to evaluate these interventions to determine their effectiveness in reducing criminal justice involvement and improving mental health functioning of PSMI.

In sum, at each Intercept along the criminal justice system, there are multiple and interrelated ways for a person with mental health problems to enter and remain in the web of the criminal justice system. Above, we attempted to demonstrate at each intercept how the relevant systems make it easier for people to enter than exit. Whereas the pathways into the system have been well-researched and are generally now well-understood, the factors associated with keeping people out of the system are much less clear.

**Policy Issues**

There are numerous policy issues at each point along the Sequential Intercept Model, many of which were alluded to above. In large part, theories on the criminalization of persons with mental illness surmise the problem began with the closings of and significant reductions in state mental hospitals (i.e., deinstitutionalization), as well as changes in civil commitment statutes (see Patch & Arrigo, 1999). The problem is further exacerbated by the numerous barriers to accessible and affordable mental health treatment in the community (see Chapter 14 in this volume). Morgan, Steffan, Shaw and Wilson (2007) surveyed over 400 adult male inmates about
the reasons for and against seeking mental health services in secure settings. They found four main types of barriers to willingness to seek help: 1) self-preservation concerns (confidentiality risks and perceptions of weakness); 2) procedural concerns (not knowing how to access services); 3) self-reliance (reliance on self or close others for help); and 4) professional service provider concerns (staff qualifications and prior dissatisfaction). Inmates with and without past community mental health treatment experiences did not significantly differ in regard to reported barriers. Many of these barriers overlap with barriers found in the community. Further, once released from confinement, PSMI with criminal histories face additional barriers, including limited access to housing and treatment programs. For example, convictions on drug charges can make one ineligible for government-supported housing (Section 8).

Another policy issue concerns Medicaid benefits and offenders with serious mental illness, particularly as it relates to confinement. Across a series of studies, Morrissey and colleagues have found several interesting trends and outcomes. First, although many states have written policy to terminate Medicaid benefits upon incarceration, Morrissey, Dalton, Steadman, Cuddeback, Haynes, and Cuellar (2006a) discovered in two counties (one in FL and one in WA) that Medicaid disenrollment was rare, occurring only 3% of the time. Second, using data from the same two counties, Morrissey and colleagues (Morrissey et al., 2006b, 2007) examined the impact of Medicaid benefits on future arrests and access to community services on jail detainees with severe mental illness. They found that in comparison to persons who had their benefits taken away, persons with intact Medicaid benefits had 16% fewer jail stays over 12 months, longer stays in the community before detention (Morrissey et al., 2007), and were more likely to utilize treatment services, and when used, accessed services quicker and more often (Morrissey
et al., 2006b). Thus, though disenrollment because of incarceration appears to be rare (at least in two counties), disenrollment has negative consequences associated with it.

**Implications for Behavioral Health**

Given the high rates of involvement of PSMI in the criminal justice system, communities will continue to be faced with finding new methods to address the problem. As noted by Morrissey and colleagues “the interface between criminal justice and mental health is the new frontier for innovative services and research in the community mental health field” (2007, p. 540). Developing programs that are effective and sustainable will require careful planning as well as early and strong collaboration from all key stakeholders within the behavioral health and criminal justice systems. Effective programming should include multiple points along the Sequential Intercept Model, including law enforcement, the courts, jail, and the community.

Studies of jail diversion programs indicate that such programs appear to be at least modestly successful in diverting people away from the criminal justice system (Steadman & Naples, 2005). However, given the lack of theoretically-driven and evidence-based interventions for this population, the ability to divert people into appropriate treatment for their mental illness, substance abuse, and other psychosocial needs is currently lacking. Despite the pressing need to quickly identify effective interventions to address PSMI in the criminal justice system, we suggest that there are a number of basic questions that should be addressed before interventions are rolled out. These include: What are the main reasons that PSMI are first entering the criminal justice system and what factors are responsible for a PSMI further penetrating the system? Are there distinct subgroups that would suggest distinct interventions? In what ways are the mental health and substance abuse needs of this population different from PSMI who are...
not criminal justice involved? Once these questions are addressed, interventions can then be developed and/or adapted to the unique needs of this population. Only at this point should such interventions be disseminated to communities engaged in addressing the needs of mentally ill offenders.

**Future Challenges**

In 2004, the Subcommittee on Criminal Justice for the New Freedom Commission on Mental Health concluded that three major responses were needed regarding PSMI in the criminal justice system. The first response was diversion programs, with an emphasis on distinguishing between people who do and do not need to be part of the criminal justice system. The second response was the provision of adequate treatment services in correctional institutions, and the third response was reentry transition programs to better link people reentering the community with appropriate services. Further, the Subcommittee endorsed nine policy options, many of which focused on evidence-based practices, such as supported housing and employment, and ensuring that treatment within jails and prisons are consistent with the current and best available evidence. A challenge related to implementing these policy options is the adaptation of evidence-based practices for forensic populations. Evidence-based practices that were devised on non-offender populations do not necessarily translate into effective interventions for offenders who may have similar mental health issues but different sets of surrounding issues. As described above, forensic adaptations, such as FACT and FICM, are not yet empirically supported.

An additional challenge echoed throughout this volume is the lack of adequate, accessible, and affordable mental health care in the community. Although the number of formal diversion programs continues to rise, the corresponding treatment in the community (the “to” in
diversion) remains stagnant. Reentry programs face a similar challenge. It is important to note that the majority of innovative solutions to handle the overrepresentation of PSMI in the criminal justice system, such as mental health courts and CIT, arise from, are created by, and operate out of the criminal justice system, not the mental health system. Without the criminal justice and mental health/substance abuse systems working in concert, persons with serious mental illness are likely to continue to be arrested, confined, and convicted at disproportionate rates.
References


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