

# IMPRISONMENT OF THE MENTALLY ILL: A CALL FOR DIVERSION TO THE COMMUNITY MENTAL HEALTH SYSTEM

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INTRODUCTION.....	406
I. TRANSINSTITUTIONALIZATION OF INDIVIDUALS WITH SEVERE MENTAL ILLNESS.....	409
II. ILLNESS IN THE UNITED STATES CORRECTIONAL POPULATION.....	412
III. VULNERABILITY OF THE MENTALLY ILL IN CORRECTIONAL SETTINGS .....	417
IV. TREATMENT NEEDS OF INMATES WITH MENTAL ILLNESS .	421
V. TREATMENT NEEDS OF INMATES WITH ADDICTIONS.....	426
VI. REENTRY CHALLENGES FOR INDIVIDUALS WITH MENTAL ILLNESS .....	428
VII. CREATING A NEW PATH FOR INDIVIDUALS WITH MENTAL ILLNESS WHO FACE IMPRISONMENT – DIVERSION FROM CORRECTIONS TO THE MENTAL HEALTH SYSTEM .....	429
A. <i>Prebooking Diversion</i> .....	430
B. <i>Postbooking Diversion</i> .....	432
VIII. RECOMMENDATIONS FOR SYSTEM REFORM.....	435
CONCLUSION .....	438

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## INTRODUCTION

“Mental illness,” a term that will be used in this review to refer collectively to all mental disorders, is common. In his 1999 report, Surgeon General David Satcher defined “mental disorders” as “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) . . . .”<sup>1</sup> Sources state that approximately one in five Americans will meet diagnostic criteria for a mental disorder every year, a significant minority of whom (about one in seven) will also pick up drug or alcohol use habits.<sup>2</sup> Many of us will develop depressed mood or experience difficulty adjusting after a traumatic event.<sup>3</sup> Others will struggle with intrusive thoughts, excessive anxiety, or panic attacks.<sup>4</sup> The common feature of mental illness, regardless of the symptoms with which it manifests, is that it causes distress, impaired social and occupational functioning, and is associated with an increased risk of pain, death, and loss of freedom.<sup>5</sup>

*Severe mental illness*, a term that will be used in this review to refer to the psychotic disorders only (schizophrenia and bipolar disorder—formerly known as “manic depression”), is much less common, occurring in only two to three out of every hundred Americans.<sup>6</sup> Some people with severe mental illness have mood disturbances, ranging from severe depression and preoccupation with suicide, to mania with incredible euphoria and gross impairment of judgment.<sup>7</sup> Others become preoccupied with fixed false beliefs (delusions) or with voices that they hear even when

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<sup>1</sup> David S. Satcher, *Executive Summary: A Report of the Surgeon General on Mental Health*, 115 PUB. HEALTH REP. 89, 89 (2000).

<sup>2</sup> *Id.* at 93.

<sup>3</sup> See *Coping with a Traumatic Event*, MEDICINENET.COM, <http://www.medicinenet.com/script/main/art.asp?articlekey=63583> (last visited Feb. 26, 2015).

<sup>4</sup> See *id.*

<sup>5</sup> See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS xxi, 7 (4th ed. 1994).

<sup>6</sup> See Cameron Quanbeck et al., *Mania and the Law in California: Understanding the Criminalization of the Mentally Ill*, 160 AM. J. PSYCHIATRY 1245, 1245 (2003).

<sup>7</sup> See *Chapter 13 – Psychological Disorders*, MERCER COUNTY COMMUNITY C., <http://www.mccc.edu/~jennin角度/Courses/documents/Handout-PsychologicalDisorders.pdf>.

no one is around.<sup>8</sup> One in four individuals with severe mental illness develop alcohol and drug addictions.<sup>9</sup>

Advances in medicine during the latter half of the twentieth century have done a lot to demystify mental illness. There is now consensus in the medical community that mental disorders and addictions are diseases of the brain that can be treated.<sup>10</sup> Unfortunately, many individuals with mental illness go untreated, despite availability of medications, therapies and psychosocial interventions that can alleviate symptoms, improve functioning, and decrease disability.<sup>11</sup> Societal stigma against individuals with mental illness is prevalent in America, and many people do not seek help from mental health professionals due to fear of being labeled as mentally ill, judged, rejected, and marginalized.<sup>12</sup>

Individuals with severe mental illness are more likely than those with other mental disorders to get referred to mental health treatment, but a large proportion of them do not consistently comply with mental health treatment.<sup>13</sup> Studies show that 20% to 50% of people who are prescribed medication to treat bipolar disorder do not take their medication as prescribed.<sup>14</sup> Individuals with schizophrenia, especially if they are experiencing paranoid delusions, are highly likely to be noncompliant with antipsychotic medications.<sup>15</sup> Some people with severe mental illness do not

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<sup>8</sup> *See id.*

<sup>9</sup> Pamela K. Lattimore et al., *A Comparison of Prebooking and Postbooking Diversion Programs for Mentally Ill Substance-Using Individuals with Justice Involvement*, 19 J. CONTEMP. CRIM. JUST. 30, 31 (2003).

<sup>10</sup> *See, e.g.*, Brendan McLean, *The Hope for Mental Illness: Research*, NAMI, [http://www2.nami.org/Content/NavigationMenu/Top\\_Story/The\\_Hope\\_for\\_Mental\\_Illness\\_Research.htm](http://www2.nami.org/Content/NavigationMenu/Top_Story/The_Hope_for_Mental_Illness_Research.htm) (last visited Feb. 28, 2015).

<sup>11</sup> *See* Mayo Clinic Staff, *Treatments and Drugs*, MAYO CLINIC, <http://www.mayoclinic.org/diseases-conditions/mental-illness/basics/treatment/con-20033813> (last visited Feb. 28, 2015); McLean, *supra* note 10.

<sup>12</sup> *See* McLean, *supra* note 10.

<sup>13</sup> *See* Am. Pharmacists Ass'n, *Improving Medication Adherence in Patients with Severe Mental Illness*, 19 PHARMACY TODAY 69, 70 (2013). *See generally* Robert Kohn et al., *The Treatment Gap in Mental Health Care*, 82 BULL. WORLD HEALTH ORG. 858, 860–61 (2004) (illustrating that those with severe mental illnesses receive more treatment in some instances).

<sup>14</sup> Megan J. Ehret et al., *Medication Adherence Among Female Inmates with Bipolar Disorder: Results From a Randomized Controlled Trial*, 10 PSYCHOL. SERVICES 106, 110 (2013).

<sup>15</sup> D. Shelton et al., *Psychotropic Medication Adherence in Correctional Facilities: A Review of the Literature*, 17 J. PSYCHIATRIC & MENTAL HEALTH NURSING 603, 603–06 (2010).

take their medications because they simply do not believe they need them.<sup>16</sup> Fifty percent of individuals with bipolar disorder and schizophrenia have poor insight, in other words, they are unable to recognize the severity, or even the presence, of their mental disorders.<sup>17</sup> Others may fully understand that they are ill, but still refuse medications because they are wary of side-effects or have negative feelings about taking “mind-altering” medications.<sup>18</sup>

Individuals with untreated mental illness, particularly those with severe mental illness, have high rates of arrest, and when arrested they are charged with more serious crimes and sentenced to longer punishments than are individuals without mental illness.<sup>19</sup> They can have difficulty understanding and participating in their legal proceedings, and evaluations of adjudicative competencies with court-ordered restoration when necessary, can significantly slow their progression through the criminal justice system.<sup>20</sup> They have rates of recidivism of approximately 50%, and end up stuck in what has been called a “revolving-door” phenomenon” between the criminal justice system and the community, where they have difficulty achieving stability.<sup>21</sup>

This article will discuss historical factors that have led to the criminalization of mental illness and the current day state of U.S. correctional facilities as modern day asylums. Alternative models for adjudication of law-breaking individuals with mental illness will be presented, and recommendations will be made for reforms of the medical, legal, and criminal justice systems to address the societal problem of imprisonment of the mentally ill.

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<sup>16</sup> Ehret et al., *supra* note 14, at 110–11.

<sup>17</sup> Quanbeck et al., *supra* note 6, at 1247, 1249.

<sup>18</sup> Shelton et al., *supra* note 15, at 608–09.

<sup>19</sup> Sarah E. Abbott, *Evaluating the Impact of a Jail Diversion Program on Police Officer's Attitudes Toward the Mentally Ill* 8 (May 1, 2011) (unpublished Ph.D. dissertation, Northeastern University), *available at* <http://hdl.handle.net/2047/d20000838>.

<sup>20</sup> Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 *PSYCHIATRY MMC* 30, 38 (2010), *available at* <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3392176/>. *See generally* Douglas Mossman et al., *AAPL Practice Guidelines for the Forensic Psychiatric Evaluation of Competence to Stand Trial*, 35 *J. AM. ACAD. PSYCHIATRY & L. (SUPPLEMENT)* s3, s4, s6, s7, s55–58 (2007) (discussing the procedure to deem persons competent, incompetent or restore their competence to stand trial).

<sup>21</sup> Shelton et al., *supra* note 15, at 604; Quanbeck et al., *supra* note 6, at 1248.

## I. TRANSINSTITUTIONALIZATION OF INDIVIDUALS WITH SEVERE MENTAL ILLNESS

Americans with severe mental illness have historically moved back and forth between institutions in droves. In the beginning of the nineteenth century individuals with severe mental illness were relegated to shelters and prisons, where they were often warehoused due to concern for public safety.<sup>22</sup> In 1841, after reportedly being horrified by witnessing the abuse of mentally ill inmates in a U.S. jail, Dorothea Dix embarked on a campaign to establish facilities for the provision of residential care to people with severe mental illness.<sup>23</sup> She was ultimately successful, as her lobbying and advocacy was instrumental in the establishment of thirty asylums across the United States.<sup>24</sup> During the mid-1800's mass numbers of individuals with severe mental illness were admitted to asylums, and by the end of the nineteenth century the percentage of U.S. correctional inmates with severe mental illness had dropped to less than 1%.<sup>25</sup>

Institutionalization became the standard of care for individuals with severe mental illness, and the institutional model of care predominated for the better half of the twentieth century.<sup>26</sup> Little could be done for individuals with mental disorders and it was believed that separating them from the stressors and demands of society would be therapeutic.<sup>27</sup> By 1955 there were 559,000 people living in state psychiatric hospitals.<sup>28</sup> There were 339 asylum beds for every 100,000 individuals in the country.<sup>29</sup>

A confluence of forces in the middle of the twentieth century led to a dramatic historical event known as deinstitutionalization, in which state hospitals were shut down and massive numbers of people with severe mental illness were released into communities.<sup>30</sup> The discovery of antipsychotic medications that could alleviate symptoms of psychotic disorders brought optimism

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<sup>22</sup> Testa & West, *supra* note 20, at 31–32.

<sup>23</sup> Quanbeck et al., *supra* note 6, at 1245.

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> Testa & West, *supra* note 20, at 32.

<sup>27</sup> *Id.*

<sup>28</sup> Quanbeck et al., *supra* note 6, at 1245.

<sup>29</sup> *Id.*

<sup>30</sup> Shelton et al., *supra* note 15, at 603.

to the field of psychiatry.<sup>31</sup> This occurred during the civil rights movement in America, when the values of freedom, autonomy, and community integration prevailed in society.<sup>32</sup> Lawmakers called for state hospitals to shut their doors and release their residents to the community, and envisioned the establishment of community mental health centers that would provide for the psychiatric and social needs of those with severe mental illness.<sup>33</sup>

State hospitals complied with society's mandate and began closing their doors in the 1960's.<sup>34</sup> Hundreds of thousands of individuals with severe mental illness were discharged during the subsequent several decades.<sup>35</sup> Unfortunately, the Community Mental Health Centers Act of 1963, which Congress passed to create the infrastructure to facilitate community integration and provide office-based psychiatric care, was never funded.<sup>36</sup> Most individuals who were discharged from state hospitals were uninsured or underinsured and were unable to access psychiatric care.<sup>37</sup> Additionally, changes were made to mental health law, which raised the bar for involuntary hospitalization of individuals with mental illness by adopting dangerousness standards for civil commitment proceedings.<sup>38</sup> The Lanterman-Petris-Short Act in California in 1969 laid out the change in California's involuntary commitment statute that greatly increased patient liberty and ability to refuse treatment, and it served as a model statute that was quickly adopted across the country.<sup>39</sup>

As a result, individuals with severe mental illnesses who were discharged from asylums found themselves in the community, and most went without treatment.<sup>40</sup> Many became homeless.<sup>41</sup>

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<sup>31</sup> Testa & West, *supra* note 20, at 33.

<sup>32</sup> *Id.*; *Civil Rights*, STANFORD ENCYCLOPEDIA PHIL. (Aug 1, 2012), <http://plato.stanford.edu/entries/civil-rights/>.

<sup>33</sup> Quanbeck et al., *supra* note 6, at 1245.

<sup>34</sup> *Id.*

<sup>35</sup> Lynne Lamberg, *Efforts Grow to Keep Mentally Ill Out of Jails*, 292 J. AM. MED. ASS'N 555, 555 (2004).

<sup>36</sup> Michelle R. Smith, *50 Years Later, Kennedy's Vision for Mental Health Not Realized*, SEATTLE TIMES (Oct. 21, 2013), <http://www.seattletimes.com/nation-world/50-years-later-kennedys-quot-vision-for-mental-health-not-realized/>.

<sup>37</sup> Abigail S. Tucker et al., *Crisis Intervention Team (CIT) Training in the Jail/Detention Setting: A Case Illustration*, 14 INT'L J. EMERGENCY MENTAL HEALTH 209, 210 (2012).

<sup>38</sup> Testa & West, *supra* note 20, at 33; Quanbeck et al., *supra* note 6, at 1246–47.

<sup>39</sup> Quanbeck et al., *supra* note 6, at 1247–48.

<sup>40</sup> *Impacting Homelessness in America: Housing First*, HARVARD L. SCH. WEBLOG, <http://blogs.law.harvard.edu/homeless/housing-first/> (last visited Feb.

They frequently came into contact with police, most often because they themselves needed assistance due to victimization or crisis, or because they were engaging in publicly disruptive or annoying behavior.<sup>42</sup> Sometimes, the police encounters resulted in arrest.<sup>43</sup> Individual factors that increase the likelihood of arrest are a prior history of police encounters and displaying arrestable behavior during the instant encounter.<sup>44</sup> Officers also have used arrest to get individuals who they believe will not be admitted to a psychiatric hospital or nursing home off the streets.<sup>45</sup> A study performed in California showed that after deinstitutionalization, former state hospital residents without prior legal histories were arrested at rates triple those that would have been expected based on community arrest rates.<sup>46</sup>

By 1994 the state hospital census had dropped from 559,000 to 72,000 and the number of asylum beds per 100,000 citizens dropped from 339 to 29.<sup>47</sup> In 1995, 92% of individuals who, forty years earlier, would have been housed and cared for in state hospitals no longer were.<sup>48</sup> During the same time period the prison population increased from approximately 502,000 to 1,590,000.<sup>49</sup> With this explosion in the correctional population came a dramatic increase in the proportion of inmates with mental illness.<sup>50</sup> By the year 2002, the U.S. was spending three times more money on criminal justice system costs for individuals with schizophrenia than on provision of care for their psychiatric needs.<sup>51</sup> Today, there are more individuals with mental illness in jails and prisons than there are in psychiatric hospitals in the U.S.<sup>52</sup>

Concurrent with deinstitutionalization, changes in law enforcement policy in the late twentieth century also played a

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28, 2015).

<sup>41</sup> *Id.*

<sup>42</sup> Abbott, *supra* note 19, at 15.

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

<sup>45</sup> Amy C. Watson & Beth Angell, *Applying Procedural Justice Theory to Law Enforcement's Response to Persons with Mental Illness*, 58 PSYCHIATRIC SERVICES 787, 788 (2007).

<sup>46</sup> Quanbeck et al., *supra* note 6, at 1245, 1248.

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*; Testa & West, *supra* note 20, at 35.

<sup>51</sup> Tucker et al., *supra* note 37, at 209.

<sup>52</sup> Kenneth L. Appelbaum, *Commentary: The Use of Restraint and Seclusion in Correctional Mental Health*, 35 J. AM. ACAD. PSYCHIATRY L. 431, 431 (2007).

significant role in increasing the size of the prison population.<sup>53</sup> The “War on Drugs” was declared in the late 1980s, and led to criminalization of addiction.<sup>54</sup> Between 1980 and 1993 the number of drug offenders who were sent to prison rose dramatically.<sup>55</sup> Due to co-morbidity of drug addiction and mental illness, when more drug offenders were sentenced to prison, the number of inmates with mental illness rose.<sup>56</sup> “[Z]ero tolerance policies” for public nuisance offenses, also enacted in the same time period, led to criminalization of mental illness, because many individuals with mental disorders were then subject to arrest due to displaying symptoms of their disorders.<sup>57</sup> Other crimes for which they are arrested relate to poverty and homelessness.<sup>58</sup> A study citing data from two states on opposite sides of the country showed that the majority of offenses for which persons with mental illness were arrested were minor offenses; offenses such as disturbing the peace, aggressive panhandling, minor thefts and other survival crimes made up more than 65% of the crimes the individuals studied committed, and less than 25% of their crimes could be described as violent crimes.<sup>59</sup>

## II. ILLNESS IN THE UNITED STATES CORRECTIONAL POPULATION

Of a worldwide prison population totaling just over 10 million, a staggering 2.3 million inmates are housed in United States prisons.<sup>60</sup> The U.S. imprisons the greatest proportion of citizens, with an imprisonment rate of 756 per 100,000 individuals that

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<sup>53</sup> Tucker et al., *supra* note 37, at 210.

<sup>54</sup> *A Brief History of the Drug War*, DRUG POL’Y ALLIANCE, <http://www.drugpolicy.org/new-solutions-drug-policy/brief-history-drug-war> (last visited Mar. 5, 2015).

<sup>55</sup> Howard J. Osofsky, *Psychiatry Behind the Walls: Mental Health Services in Jails and Prisons*, 60 BULL. MENNINGER CLINIC 464, 465–66 (1996).

<sup>56</sup> Joseph P. Morrissey et al., *New Models of Collaboration Between Criminal Justice and Mental Health Systems*, 166 AM. J. PSYCHIATRY 1121, 1121 (2009).

<sup>57</sup> Arthur J. Lurigio & Andrew Harris, *The Mentally Ill in the Criminal Justice System: An Overview of Historical Causes and Suggested Remedies*, 2 PROF. ISSUES CRIM. JUST. 145, 156–57 (2007).

<sup>58</sup> *Id.*

<sup>59</sup> Joseph P. Morrissey et al., *The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness*, 58 PSYCHIATRIC SERVICES 794, 800 (2007).

<sup>60</sup> *Criminal Justice Fact Sheet*, NAACP, <http://www.naacp.org/pages/criminal-justice-fact-sheet> (last visited Feb. 28, 2015).

dwarfs the worldwide average of 145 per 100,000.<sup>61</sup> Even during an era of declining crime, which the U.S. has seen over the past several decades, incarceration rates have increased.<sup>62</sup> Today, one can find more African American men in prisons than in American colleges and universities.<sup>63</sup> Approximately 2% of U.S. children have an incarcerated parent, most often (91% of the time) a father, but over the past several decades mothers have been incarcerated at increasing rates.<sup>64</sup> About 100,000 people younger than eighteen years old are prisoners in the U.S.<sup>65</sup> These youth account for one-half a percent of the correctional population and are typically housed in separate prisons.<sup>66</sup> The annual cost to U.S. tax-payers to fund the imprisonment of one citizen is approximately \$25,000.<sup>67</sup> Our government spent \$49 billion on incarceration costs in 2007.<sup>68</sup>

U.S. prisons hold a population that is disproportionately ill, both physically and mentally, when compared to the overall population, and contains a high percentage of individuals with substance use disorders.<sup>69</sup>

Individuals who are imprisoned, compared to those who are free, have higher rates of physical ailments,<sup>70</sup> likely due to their higher likelihood of poor addictive substance use. Incarcerated juveniles have high rates of sexually-transmitted infections, traumatic injuries, and pregnancy.<sup>71</sup> They have high rates of undiagnosed and untreated medical issues when compared to youth who are not involved with the criminal justice system.<sup>72</sup>

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<sup>61</sup> Seena Fazel & Jacques Baillargeon, *The Health of Prisoners*, 377 LANCET 956, 956 (2011); Joseph Murray et al., *Children's Antisocial Behavior, Mental Health, Drug Use, and Educational Performance After Parental Incarceration: A Systematic Review and Meta-Analysis*, 138 PSYCHOL. BULL. 175, 176 (2012).

<sup>62</sup> David C. Peters, II, *Personality Disorders and Biosocial Trait Theories: The Argument for Radical Legal Reform*, 28 BEHAV. SCI. & L. 289, 289 (2010).

<sup>63</sup> *Id.*

<sup>64</sup> Murray et al., *supra* note 61, at 176.

<sup>65</sup> David Gottesman & Susan Wile Schwarz, *Juvenile Justice in the US: Facts for Policymakers*, NCCP (July 2011), [http://nccp.org/publications/pdf/text\\_1038.pdf](http://nccp.org/publications/pdf/text_1038.pdf).

<sup>66</sup> JAMES AUSTIN ET AL., BUREAU JUST. ASSISTANCE, JUVENILES IN ADULT PRISONS AND JAILS: A NATIONAL ASSESSMENT 36–38 (2000).

<sup>67</sup> Peters, *supra* note 62, at 291.

<sup>68</sup> *Id.*

<sup>69</sup> Fazel & Baillargeon, *supra* note 61, at 956.

<sup>70</sup> *Id.*

<sup>71</sup> *Id.* at 961.

<sup>72</sup> Seena Fazel et al., *Mental Disorders Among Adolescents in Juvenile Detention and Correctional Facilities: A Systematic Review and Metaregression Analysis of 25 Surveys*, 47 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 1010,

Due to combined forces of longer sentencing and restrictive parole policies, there are many adults over the age of fifty-five in prisons, and they have high rates of serious medical illnesses such as cardiovascular disease, liver disease, cancer, and HIV.<sup>73</sup> Their illnesses cause a great degree of functional impairment and are expensive to treat. The annual cost to the U.S. to imprison a person over the age of fifty-five is approximately \$70,000—two to three times the cost of housing a younger inmate.<sup>74</sup>

Mental illness, like physical illness, is very common in correctional settings.<sup>75</sup> It is estimated that, at any given moment, one in seven prisoners is suffering from a mental illness that requires treatment.<sup>76</sup> The lifetime prevalence of mental illness among adults who are incarcerated is between 60% and 80%, and approximately 50% to 70% of incarcerated women and 30% of incarcerated men have experienced mental illness within the past six months.<sup>77</sup> There are an estimated one million bookings of individuals with severe mental illness every year in the U.S.<sup>78</sup> Among the correctional population, approximately 15% of men and 31% of women carry diagnoses of severe mental illness.<sup>79</sup> Studies demonstrate prevalence rates for psychosis of 3% to 4% in prisons,<sup>80</sup> which is three times the community prevalence.<sup>81</sup> The prevalence of major depression in prisons is approximately 10%,<sup>82</sup> and that of personality disorders is 40% to 70%.<sup>83</sup> A high proportion of individuals who are incarcerated have survived severe trauma, and the incidence of Post-traumatic Stress

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1016 (2008).

<sup>73</sup> Fazel & Baillargeon, *supra* note 61, at 956, 961.

<sup>74</sup> *Id.*; see also Steven J. Caverley, *Older Mentally Ill Inmates: A Descriptive Study*, 12 J. CORRECTIONAL HEALTH CARE 262, 262 (2006) (discussing the related financial and policy issues of elderly mentally ill inmates).

<sup>75</sup> Fazel & Baillargeon, *supra* note 61, at 956.

<sup>76</sup> *Id.*

<sup>77</sup> Shelton et al., *supra* note 15, at 603.

<sup>78</sup> Morrissey et al., *supra* note 59, at 794.

<sup>79</sup> Annette S. Crisanti & B. Christopher Frueh, *Risk of Trauma Exposure Among Persons with Mental Illness in Jails and Prisons: What Do We Really Know?*, 24 CURRENT OPINION PSYCHIATRY 431, 431 (2011).

<sup>80</sup> Fazel & Baillargeon, *supra* note 61, at 956–58.

<sup>81</sup> Quanbeck et al., *supra* note 6, at 1245.

<sup>82</sup> Fazel & Baillargeon, *supra* note 61, at 956; see also Olivier Colins et al., *Psychiatric Disorders in Detained Male Adolescents: A Systematic Literature Review*, 55 CAN. J. PSYCHIATRY 255, 256 (2010) (discussing statistics of males only).

<sup>83</sup> Fazel & Baillargeon, *supra* note 61, at 956.

Disorder is very high among inmates, at approximately 20%.<sup>84</sup> Ten percent of the death row population is estimated to have mental disorders including Bipolar Disorder, Schizophrenia, Post-traumatic Stress Disorder, and Schizoaffective Disorder (a disorder with prominent features of both Schizophrenia and Bipolar Disorder).<sup>85</sup>

Mental illness is also concentrated among adolescent inmates, with rates of mental illnesses rising substantially above what would be expected based upon community prevalence rates for mental illnesses.<sup>86</sup> Among youth who are imprisoned, 40% to 70% meet criteria for a psychiatric disorder.<sup>87</sup> Three percent of juvenile detainees suffer with psychotic disorders.<sup>88</sup> Attention Deficit Hyperactivity Disorder is found in an estimated 10% of incarcerated boys and 20% of incarcerated girls<sup>89</sup> and has been shown to occur at a rate twice that found in the community.<sup>90</sup> Depression is also twice as common among juveniles who are in prison,<sup>91</sup> with male detainees experiencing depression in approximately 11% of cases and female detainees experiencing depression at rates as high as 29%.<sup>92</sup> Conduct disorder is diagnosable in about 50% of juvenile detainees,<sup>93</sup> a rate ten times higher than the prevalence rate in the community,<sup>94</sup> and repeat offending is seen in individuals with this disorder.<sup>95</sup> Self-injurious behavior, such as cutting or burning of one's own skin, is also common among juvenile detainees.<sup>96</sup> Post-traumatic Stress Disorder occurs at a rate of approximately 10% in the juvenile correctional population.<sup>97</sup>

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<sup>84</sup> *Id.* at 956, 958.

<sup>85</sup> Jessica E. Plichta, *Exploring Ethical, Legal, and Professional Issues with the Mentally Ill on Death Row*, 4 J. FORENSIC NURSING 143, 144 (2008); Psych Central Staff, *Schizoaffective Disorder Symptoms*, PSYCHCENTRAL, <http://psychcentral.com/disorders/schizoaffective-disorder-symptoms/> (last updated Mar. 12, 2015).

<sup>86</sup> See Fazel et al., *supra* note 72, at 1016.

<sup>87</sup> Colins et al., *supra* note 82, at 257; Fazel et al., *supra* note 72, at 1010.

<sup>88</sup> Fazel et al., *supra* note 72, at 1015.

<sup>89</sup> *Id.*

<sup>90</sup> Fazel & Baillargeon, *supra* note 61, at 961.

<sup>91</sup> *Id.*

<sup>92</sup> Fazel et al., *supra* note 72, at 1015.

<sup>93</sup> *Id.* at 1015–16.

<sup>94</sup> Fazel & Baillargeon, *supra* note 61, at 961.

<sup>95</sup> Fazel et al., *supra* note 72, at 1010.

<sup>96</sup> *Id.*

<sup>97</sup> Karen M. Abram et al., *Posttraumatic Stress Disorder and Trauma in Youth in Juvenile Detention*, 61 ARCH GEN. PSYCHIATRY (2004), available at

Many who are imprisoned have addictions.<sup>98</sup> Sixty percent of prisoners test positive for drug use at the time they are incarcerated; 17% to 30% of incarcerated men and 10% to 24% of incarcerated women are identified as problematic users of alcohol, and nearly 10% to 48% of men and 30% to 60% of women are identified as having drug addictions.<sup>99</sup> Addictions occur in 45% of detained youth.<sup>100</sup> Furthermore, addictions are very common ailments among individuals who are repeat criminal offenders, whether juveniles or adults.<sup>101</sup>

In addition to housing a disproportionately high number of individuals with mental illness, jails and prisons commonly house individuals with “complex types of psychiatric impairment . . . .”<sup>102</sup> This means that many inmates have several co-occurring mental disorders, or a mental disorder plus a personality disorder.<sup>103</sup> Many also carry dual-diagnosis; 20% to 44% of prisoners with any psychiatric diagnosis also meet criteria for Substance Use Disorders.<sup>104</sup> Dual-diagnosis rates among prisoners with psychotic disorders are as high as 95%, while up to 82% of those with mood disorders carry the complexity of dual-diagnosis.<sup>105</sup> Incarcerated women are found to have higher rates of complex mental illnesses and comorbidities than incarcerated men, and nearly one third were found to experience recurrent thoughts of death, suicidal impulses, and to have made prior suicide attempts.<sup>106</sup> Of the subset of correctional inmates who are parents, 77% of them have mental illness, 67% have drug

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<http://archpsyc.jamanetwork.com/article.aspx?articleid=481985>.

<sup>98</sup> See Alexander J. Cowell et al., *The Cost-Effectiveness of Criminal Justice Diversion Programs for People with Serious Mental Illness Co-Occurring with Substance Abuse*, 20 J. CONTEMP. CRIM. JUST. 292, 293 (2004).

<sup>99</sup> *Id.*; Fazel & Baillargeon, *supra* note 61, at 956.

<sup>100</sup> Colins et al., *supra* note 82, at 255.

<sup>101</sup> See Fazel et al., *supra* note 72, at 1010 (discussing drug addiction impact on recidivism in juveniles); see also Elias Abdalla-Filho et al., *Mental Disorders in Prisons*, 23 CURRENT OPINION PSYCHIATRY 463, 463 (2010).

<sup>102</sup> Shelton et al., *supra* note 15, at 603.

<sup>103</sup> See *id.* at 603–04; see also Jennifer Skeem et al., *Social Networks and Social Control of Probationers with Co-Occurring Mental and Substance Abuse Problems*, 33 LAW HUM. BEHAV. 122, 122 (2008).

<sup>104</sup> Seena Fazel & Katharina Seewald, *Severe Mental Illness in 33,588 Prisoners Worldwide: Systematic Review and Metaregression Analysis*, 200 BRIT. J. PSYCHIATRY 364, 366 (2012).

<sup>105</sup> *Id.*

<sup>106</sup> Kathryn J. Kellogg et al., *Suicide in Corrections: An Overview*, 60 DISEASE-A-MONTH 215, 217 (2014); see Shelton et al., *supra* note 15, at 603 (noting that the prevalence in women is much higher than in men).

addictions,<sup>107</sup> and a large number of them are dual-diagnosis individuals.<sup>108</sup>

Many of the inmates with severe mental illness who are found in correctional settings are individuals with a particular variety of complex psychiatric impairment consisting of psychotic illness, antisocial personality traits, and substance abuse, who also have a tendency towards aggression and violence.<sup>109</sup> They are patients whose difficulties with behavioral regulation and impulse control alienate mental health and social service providers, and can lead to them being expelled from community mental health agencies.<sup>110</sup> Unfortunately, the very behavior that makes it difficult for them to engage in community mental health services is the behavior that leads them to be jailed.<sup>111</sup> Without adequate psychiatric support these individuals cycle in and out of jail and prison frequently.<sup>112</sup>

### III. VULNERABILITY OF THE MENTALLY ILL IN CORRECTIONAL SETTINGS

Individuals with mental illness are at risk in correctional settings, in which violence among inmates is common and often perpetuated to enforce codes of behavior.<sup>113</sup> Inmates with mental illness experience symptoms such as mood swings, paranoid ideas, and visual or auditory hallucinations, all of which have the potential for behavioral manifestations that disrupt other inmates.<sup>114</sup> Thus, mentally ill inmates are vulnerable to attack by other inmates who want them to stop disruptive behavior (such as emotional outbursts, head-banging, suspicious behavior, or talking to oneself) stemming from symptoms over which they

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<sup>107</sup> Murray et al., *supra* note 61, at 177.

<sup>108</sup> See generally Skeem et al., *supra* note 103, at 122 (for description of high instances of dual diagnosis in all inmates).

<sup>109</sup> Gunnar Holmberg & Marianne Kristiansson, *Contacts with Public Services, with Special Reference to Mental Health Care, Preceding a Serious Crime: A Retrospective Study of 268 Subjects of Forensic Psychiatric Investigations*, 29 INT'L J.L. & PSYCHIATRY 281, 282 (2006).

<sup>110</sup> *Id.*

<sup>111</sup> See *id.*

<sup>112</sup> See *id.*

<sup>113</sup> See Crisanti & Frueh, *supra* note 79, at 431–32.

<sup>114</sup> See HUMAN RIGHTS WATCH, ILL EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 31–32 (2003), available at <http://www.hrw.org/reports/2003/usa1003/usa1003.pdf>.

have no control.<sup>115</sup> Furthermore, psychotropic medications themselves, though beneficial for relieving symptoms, carry side effects that can enhance a person's vulnerability to physical assault,<sup>116</sup> such as sedation or cognitive slowing.<sup>117</sup>

Inmates with severe mental illness are up to eight times more likely to be physically abused in correctional settings than are other inmates, and they experience sexual abuse at a higher rate as well.<sup>118</sup> Research has shown a positive association between the severity of psychiatric symptoms and abuse.<sup>119</sup> Assaults are under-reported because inmates are ashamed, struggle with guilt about the assault, and worry that correctional staff (or administration in the event of staff on inmate violence) may not believe them or that perpetrators may retaliate if they are reported.<sup>120</sup>

Mortality among individuals with mental illness who are incarcerated is high, both during the time they are imprisoned and after their release.<sup>121</sup> Suicide, defined as "death caused by self-directed harmful behavior with the intent to die as a result of the behavior[,]'" is a leading cause of death among those imprisoned in correctional settings.<sup>122</sup> Of deaths that occur in prison, suicide is the number one cause; it accounts for half of lives lost.<sup>123</sup> Prison inmates die by their own hands twice as often as do people who are not locked up, with suicides claiming the lives of 14 out of every 100,000 prison inmates.<sup>124</sup> Jail inmates are up to nine times more likely to kill themselves than people in the community.<sup>125</sup> Approximately 400 suicides occur in jails every year, costing lives at a rate of 47 per 100,000 inmates.<sup>126</sup> The most common methods are hanging (44%), typically by clothing and linens, or lethal cutting (30%).<sup>127</sup> In two-thirds of correctional

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<sup>115</sup> See Crisanti & Frueh, *supra* note 79, at 431–32.

<sup>116</sup> See *id.* at 431.

<sup>117</sup> *Antidepressant Medications*, GOODTHERAPY.ORG, <http://www.goodtherapy.org/drugs/antidepressants.html> (last visited Mar. 3, 2015).

<sup>118</sup> Crisanti & Frueh, *supra* note 79, at 433.

<sup>119</sup> *Id.*

<sup>120</sup> *Id.*

<sup>121</sup> See Fazel & Baillargeon, *supra* note 61, at 960.

<sup>122</sup> Kellogg et al., *supra* note 106, at 215.

<sup>123</sup> Fazel & Baillargeon, *supra* note 61, at 959; Tucker et al., *supra* note 37, at 209–10.

<sup>124</sup> Kellogg et al., *supra* note 106, at 215.

<sup>125</sup> *Id.*

<sup>126</sup> *Id.*

<sup>127</sup> See *id.* at 216.

suicides, mental health issues were identifiable upon review of the cases.<sup>128</sup> In some cases, inmates had voiced mental health concerns but did not report symptoms sufficient for diagnosis of a mental illness, and received minimal to no mental health services as a result.<sup>129</sup>

Risk factors for suicide in correctional institutions include severe mental illness, dual-diagnosis, acute life stressors, prior suicide attempts, and single-cell occupancy.<sup>130</sup> Arrest circumstances increase risk for suicide, as life crises and hopelessness are known suicide risk factors.<sup>131</sup> In fact, some offenders engage in intentionally provocative behavior during encounters with police with intent to cause officers to use lethal force against them, and this phenomenon has been termed “suicide by cop[.]”<sup>132</sup> Many others kill themselves within sixty days of their arrests.<sup>133</sup> Social and family issues were identified as contributing factors in nearly 10% of correctional suicides.<sup>134</sup> Maladjustment to the correctional environment and staff increase risk for suicide, and these problems can typically be identified in a little over half of prison suicides.<sup>135</sup> Studies show that nearly half of prison suicides occur within the first two weeks of incarceration, with a large number occurring within the first forty-eight hours.<sup>136</sup> High-security offenders who have been sentenced to long prison terms are at a very high risk for suicide.<sup>137</sup> In jails, individuals at highest risk for suicide are young, white men.<sup>138</sup> Intoxication, homelessness, prior incarceration and being older than forty years of age are all factors that increase risk for jail suicide.<sup>139</sup>

Penal isolation, otherwise known as administrative segregation, or by the lay term “solitary confinement,” heightens

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<sup>128</sup> *Id.*

<sup>129</sup> *See generally id.* at 217 (noting that inmates with nondiagnosable mental illness receive little necessary medical attention, exacerbating their condition).

<sup>130</sup> Seena Fazel et al., *Suicide in Prisoners with Bipolar Disorder and Other Psychiatric Disorders: A Systematic Review*, 15 BIPOLAR DISORDERS 491, 494 (2013).

<sup>131</sup> Kellogg et al., *supra* note 106, at 215.

<sup>132</sup> Tucker et al., *supra* note 37, at 210.

<sup>133</sup> Kellogg et al., *supra* note 106, at 216.

<sup>134</sup> *Id.*

<sup>135</sup> *Id.*

<sup>136</sup> *Id.*

<sup>137</sup> *Id.*

<sup>138</sup> *Id.*

<sup>139</sup> *Id.*

the probability that an at-risk inmate will commit suicide.<sup>140</sup> Studies have shown that approximately 50% of correctional suicides occur in isolation, often during the first day an inmate is placed in segregation.<sup>141</sup> Administrative segregation is the process by which inmates are separated from others for punitive purposes, not due to risk classification, and it is one of a number of punishments that can be imposed as a result of correctional rule infractions.<sup>142</sup> An inmate in administrative segregation is placed in a single cell with a solid door for twenty-three hours a day for the duration of the time they are given to spend in isolation.<sup>143</sup> Isolation, created for punitive purposes, is meant to be unpleasant.<sup>144</sup> A high rate of depression is known to occur in inmates who are placed in segregation.<sup>145</sup>

Prisoners with mental illness are prone, due to having conditions that impair their thinking and emotional regulation, to exhibit behaviors that could constitute rule violations.<sup>146</sup> Jail staff members do not receive the level of mental health training that would be required to recognize when symptoms of mental illness are being exhibited rather than simply volitional rule-breaking behavior, and they are often resentful if mental health staff attempt to intervene in inmate disciplinary procedures.<sup>147</sup> This results in ongoing criminalization of mental illness in jails

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<sup>140</sup> See Fred Cohen, *Penal Isolation: Beyond the Mentally Ill*, 35 CRIM. JUST. & BEHAV. 1017, 1028 (2008) (discussing the degrees and effects of solitary confinement); see also E. FULLER TORREY ET AL., NAT'L SHERIFFS' ASS'N, THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 19 (Apr. 8, 2014), available at <http://www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf> (noting that solitary confinement is also referred to as administrative segregation, among other things); Kellogg et al., *supra* note 106, at 216 (discussing confinement as a heightening factor often leading a prisoner to commit suicide).

<sup>141</sup> Kellogg et al., *supra* note 106, at 216; see Lindsay M. Hayes, *Suicide Prevention in Correctional Facilities: Reflections and Next Steps*, NCIA, <http://www.ncianet.org/suicide-prevention-in-correctional-facilities-reflections-and-next-steps/> (last visited Mar. 22, 2015).

<sup>142</sup> Michael S. Krelstein, *The Role of Mental Health in the Inmate Disciplinary Process: A National Survey*, 30 J. AM. ACAD. PSYCHIATRIC L. 488, 488 (2002).

<sup>143</sup> Cohen, *supra* note 140, at 1028.

<sup>144</sup> *Solitary Confinement Facts*, AM. FRIENDS SERVICE COMMITTEE, <http://www.afsc.org/resource/solitary-confinement-facts> (last visited Mar. 14, 2015).

<sup>145</sup> Kellogg et al., *supra* note 106, at 216.

<sup>146</sup> Richard Belitsky, *Commentary: Mental Health in the Inmate Disciplinary Process*, 30 J. AM. ACAD. PSYCHIATRY & L. 500, 500 (2002).

<sup>147</sup> *Id.*

and prisons, with an over-representation of those with mental illnesses in disciplinary proceedings.<sup>148</sup> Individuals with schizophrenia have been placed in segregation for extended periods of time without consideration of the effect that isolation could have on their mental state and many times without access to psychiatric treatment during isolation.<sup>149</sup> Historically, courts have found that provided segregation was not continued for more than a year, and provided inmates were afforded basic due process rights at disciplinary hearings (limited to notification of charges, notice of proceedings, and a limited right to bring witnesses), neither their Eighth or Fourteenth Amendment constitutional rights were violated.<sup>150</sup>

#### IV. TREATMENT NEEDS OF INMATES WITH MENTAL ILLNESS

Correctional facilities are mandated by the Constitution to provide treatment for mental illness to inmates who require such care.<sup>151</sup> The Supreme Court has determined that prisoners have a right to psychiatric treatment that flows from the Eighth and Fourteenth Amendments.<sup>152</sup> In *Estelle v. Gamble*, the Supreme Court ruled that individuals who are imprisoned are rendered unable to satisfy their healthcare needs without the assistance of those who deprive them of their liberty, and that if their captors show deliberate indifference to such needs they would be doing so in violation of the constitutional prohibition against cruel and unusual punishment.<sup>153</sup> Despite the fact that correctional facilities house large numbers of individuals with mental illness and face a constitutional mandate requiring them to provide for the medical needs of prisoners, the U.S. correctional system faces many challenges in providing psychiatric care to prisoners. The correctional system was not designed to function as a treatment center, but was created to fulfill a punitive function in society.<sup>154</sup> The principles of criminal justice detention include punishment of offenders, deterrence of future crime, confinement of individuals who pose a risk of harm to others in society, and rehabilitation

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<sup>148</sup> Krelstein, *supra* note 142, at 488.

<sup>149</sup> *See id.*

<sup>150</sup> *Id.* at 490.

<sup>151</sup> Osofsky, *supra* note 55, at 467.

<sup>152</sup> *See, e.g., Estelle v. Gamble*, 429 U.S. 97, 101, 103–05 (1976).

<sup>153</sup> *Id.* at 103–05.

<sup>154</sup> Melvin Hinton, *Mentally Ill Offenders Impact on the Prison System*, 60 DISEASE-A-MONTH 213, 213 (2014).

(meaning the transforming of criminals into individuals who can participate in a lawful society).<sup>155</sup> Furthermore, jails and prisons are tasked principally with protecting society at large from those who are imprisoned, not with advancing the well-being and interests of the individuals housed within their walls.<sup>156</sup>

The treatment needs of people who have mental illness are many and varied. First and foremost, people need to be identified. Screening is critical. Many people require diagnostic evaluations because they are not aware that the dysfunctional thoughts and emotions that they experienced prior to arrest represented a mental illness.<sup>157</sup> Individuals who are diagnosed with severe mental illness invariably require mood-stabilizing and/or antipsychotic medications to treat their illnesses, and the medications that they require pose risks for serious side-effects; patients must be seen regularly for safe and effective treatment with psychiatric medications.<sup>158</sup> Many people with non-psychotic mental disorders also require medications to ameliorate disabling symptoms and facilitate their ability to meet the behavioral expectations of the correctional setting.<sup>159</sup> Other people with mental illness need therapeutic interventions including coping skills training or therapy to process past trauma.<sup>160</sup> In the community, psychiatrists train patients in lifestyle modification, emphasizing the importance of healthy diet, exercise and sleep habits, and optimal treatment of mental illness incorporates lifestyle modification along with psychopharmacological and therapeutic interventions.<sup>161</sup>

When faced with the treatment demands of individuals with

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<sup>155</sup> Peters, II, *supra* note 62, at 290.

<sup>156</sup> Appelbaum, *supra* note 52, at 431.

<sup>157</sup> See Mary Ann Bernard, *How California Can Safely Release 33,000 Prisoners*, NAT'L REV. (June 2, 2011, 4:00 AM), <http://www.nationalreview.com/article/268623/how-california-can-safely-release-33000-prisoners-mary-ann-bernard?target=author&tid=902801>.

<sup>158</sup> See U.S. DEPARTMENT OF HEALTH & HUMAN SERVS., MENTAL HEALTH MEDICATIONS I, 1–3, 7–9 (2012); Shelton et al., *supra* note 15, at 610.

<sup>159</sup> See U.S. DEPARTMENT OF HEALTH & HUMAN SERVS., *supra* note 158, at 1, 12; see also *Term: Non-Psychotic Disorder*, UNIV. MANITOBA, <http://mchp-appserv.cpe.umanitoba.ca/viewDefinition.php?definitionID=103166> (last updated Sept. 26, 2007).

<sup>160</sup> See generally Appelbaum, *supra* note 52, at 432.

<sup>161</sup> See Shelton et al., *supra* note 15, at 610. See generally J. Sarris et al., *Integrative Mental Healthcare White Paper: Establishing a New Paradigm Through Research, Education, and Clinical Guidelines*, ADVANCES INTEGRATIVE MED. 1, 1, 2 (2013), available at <http://www.inimh.org/files/IMH%20White%20Paper.pdf>.

mental illness, correctional settings are simply overwhelmed. Jails and prisons are not equipped with the staff or resources to operate as psychiatric treatment facilities.<sup>162</sup> The screening processes that are utilized in many correctional settings lack the sensitivity to identify all of those in need of mental health services.<sup>163</sup> One study showed that two-thirds of individuals who passed through prison intake screening and were not identified as having current mental health issues actually met criteria for at least one lifetime psychiatric disorder.<sup>164</sup> When screening does pick up individuals with mental illness, jails and prisons often lack adequate resources to treat those they identify.<sup>165</sup> Surveys of administrators in correctional facilities have found that 64% of them cited services for mental illness as their biggest needs, and 84% of parole and probation officers agreed.<sup>166</sup> Data from 2002 to 2004 show that one out of every three individuals diagnosed with schizophrenia or bipolar disorder was not provided with psychiatric medication, the mainstay of treatment for these severe mental illnesses.<sup>167</sup> Additionally, women are less likely than men to receive psychiatric treatment in correctional settings,<sup>168</sup> despite their high incidence of mental illnesses.<sup>169</sup>

Even in an ideal situation in which screening identifies individuals with mental illness and they are referred to well-staffed mental health units for treatment, jails and prisons can fail to achieve good mental health outcomes for inmates due to barriers to recovery that exist in the correctional environment.<sup>170</sup> “[J]ails and prisons are not therapeutic environments.”<sup>171</sup> Individuals who are incarcerated are not at liberty to make lifestyle modifications that are known to improve mental health outcomes.<sup>172</sup> Furthermore, environmental stressors including prolonged idleness, constant threat of violence, and social isolation can exacerbate symptoms of mental illness.<sup>173</sup>

Prescribing and administering psychiatric medications can also

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<sup>162</sup> Quanbeck et al., *supra* note 6, at 1249.

<sup>163</sup> See Shelton et al., *supra* note 15, at 603.

<sup>164</sup> *Id.*

<sup>165</sup> Quanbeck et al., *supra* note 6, at 1245, 1249.

<sup>166</sup> *Id.* at 1249.

<sup>167</sup> Fazel & Baillargeon, *supra* note 61, at 957.

<sup>168</sup> Kellogg et al., *supra* note 106, at 219.

<sup>169</sup> *Id.*

<sup>170</sup> See Shelton et al., *supra* note 15, at 608.

<sup>171</sup> Appelbaum, *supra* note 52, at 431.

<sup>172</sup> See *id.* at 433.

<sup>173</sup> Belitsky, *supra* note 146, at 500.

be difficult in the correctional setting. Often, jails and prisons have access to a limited and restricted repertoire of medications,<sup>174</sup> and the psychiatrist's difficult task of finding a medication that is both likely to help a patient and have a side-effect profile that will be acceptable to him or her, is made even harder. When medications are prescribed, there are barriers to medication compliance that are inherent to the correctional environment itself and can prevent people who want to take their medications from doing so.<sup>175</sup> Mode of administration of medications can impede an inmate's ability or willingness to take medication that he or she is prescribed.<sup>176</sup> For example, in some prisons, inmates must present to a particular location at a particular time to receive their medications, and medication calls often conflict with inmate obligations such as work or programming; this can lead to missed doses.<sup>177</sup> In some jails, medication carts come to individual pods, and inmates must go to the cart in view of the others in their pod to take their medications.<sup>178</sup> While bringing medications to inmates is more convenient, stigma and fear of victimization can lead individuals to forgo medications that are administered in this manner.

Occasionally, mental health professionals who work in correctional settings that house death row inmates face ethical dilemmas that threaten their ability to provide medically appropriate treatment to their patients.<sup>179</sup> The U.S. Constitution has been interpreted to prevent the execution of mentally incompetent persons as a violation of the Eighth Amendment, though it has been determined that providing treatment to

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<sup>174</sup> See generally Anasseril E. Daniel, *Care of the Mentally Ill in Prisons: Challenges and Solutions*, 35 J. AM. ACAD. PSYCHIATRY L. 406 (2007), available at <http://www.jaapl.org/content/35/4/406.full> (explaining that access to some medications is often impeded due to cost-cutting).

<sup>175</sup> Shelton et al., *supra* note 15, at 608.

<sup>176</sup> Ehret et al., *supra* note 14, at 111.

<sup>177</sup> *Id.* at 112 (noting that inmates were potentially unable to get to a medication window several times per day). See generally Lorry Schoenly, *Personal Safety During Medication Administration*, CORRECTIONALNURSE.NET, <http://correctionalnurse.net/personal-safety-during-meication-administration/> (last visited Mar. 7, 2015) (explaining that dispensing medication from a central location was a more common practice in prisons).

<sup>178</sup> See Schoenly, *supra* note 177; see also Phil Hirschhorn & Russ Mitchell, *Mentally Ill Crowd America's Jails*, CBS NEWS (Jan. 22, 2011, 7:22 PM), <http://www.cbsnews.com/news/mentally-ill-crod-americas-jails/> (stating that a nurse dispenses medication twice a day to the mental health pod in the Summit County Jail in Ohio).

<sup>179</sup> See Plichta, *supra* note 85, at 145.

acutely psychotic patients to restore their competence does not amount to cruel and unusual punishment.<sup>180</sup> Faced with a situation in which prescribing medication to a patient will clear their psychosis and relieve their mental anguish, but in which bringing about this recovery will also lead to the patient regaining competency for execution, doctors have been known to refuse to treat patients or to purposefully prescribe helpful, though inadequate, treatments for patients to avoid having the blood of the execution on their hands.<sup>181</sup>

In correctional settings, patient refusal to accept treatment is far more common than these rare instances in which providers refuse to treat patients.<sup>182</sup> Many incarcerated individuals with severe mental illness refuse to take their medications.<sup>183</sup> As a result, the individuals suffer with uncontrolled symptoms, and evaluating physicians—believing that the medications are ineffective—are likely to unnecessarily increase medication dosages, change to more powerful medications (often with more serious side-effects), or prescribe numerous medications in combination (again raising the risk for adverse effects when the medications are taken).<sup>184</sup> Refusal to take prescribed psychotropic medication in jail or prison is not just a problem for the person refusing medications, however, but also for other inmates and correctional staff. Medication refusal is associated with violence.<sup>185</sup> Furthermore, inmates who refuse to take prescribed psychiatric medications are more likely than those who comply with doctor's orders to be convicted of serious felonies and to serve longer prison sentences.<sup>186</sup> Many of those who refuse medication while imprisoned go on to refuse medication on release,<sup>187</sup> and they are highly likely not only to return to jail and

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<sup>180</sup> See *id.* at 144.

<sup>181</sup> See generally *id.* at 145 (noting that a doctor in a case involving a man named Claude Maturana refused to restore a mentally ill offender on death row to sanity).

<sup>182</sup> See generally TORREY ET AL., *supra* note 140 (noting that inmates who refuse psychotropic medication are prevalent no matter how robust a facility's resources and protocols are).

<sup>183</sup> See Ehret et al., *supra* note 14, at 111–12; see also H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness In Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVICES 483, 489 (1998).

<sup>184</sup> Shelton et al., *supra* note 15, at 604.

<sup>185</sup> Ehret et al., *supra* note 14, at 106; Shelton et al., *supra* note 15, at 604.

<sup>186</sup> See Ehret et al., *supra* note 14, at 106; Shelton et al., *supra* note 15, at 604.

<sup>187</sup> See generally Shelton et al., *supra* note 15, at 604 (noting that unsuccessful treatment in prisons continues into the community after their

prison, but to come back with ongoing untreated psychiatric symptoms. The longer that psychotic symptoms remain uncontrolled the more difficult to treat they become, so they become repeat problematic inmates.<sup>188</sup> Individuals who fall into this pattern become very heavy utilizers of both psychiatric and correctional resources.<sup>189</sup>

#### V. TREATMENT NEEDS OF INMATES WITH ADDICTIONS

Untreated addiction is a major cause of criminal offending in the U.S.<sup>190</sup> One study of 4700 U.S. arrestees showed that while more than half of men tested positive for at least one instance of substance abuse while on court monitoring, only 10%, at most, had received substance abuse treatment of any intensity during the past year, and only 3%, at most, had received psychiatric care that year.<sup>191</sup> Those who have drug and alcohol addictions require several services including, in many instances, mental health services, as detailed above, as well as addiction treatment services.<sup>192</sup> It is known that addiction services for individuals who get caught up in the criminal justice system are inadequate.<sup>193</sup> Correctional settings traditionally do fairly well at providing detoxification and rehabilitation services using the therapeutic community model, but the settings have not done well at

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incarceration ends, usually leading to recidivism).

<sup>188</sup> *Early Signs of Psychosis*, CEDAR, [www.cedarclinic.org/index.php/understanding-early-psychosis/early-signs-of-psychosis](http://www.cedarclinic.org/index.php/understanding-early-psychosis/early-signs-of-psychosis) (last visited Mar. 7, 2015) (explaining that untreated signs of mental health problems get worse if they are left untreated). See generally Shelton et al., *supra* note 15, at 604 (noting that high levels of recidivism among the mentally ill are often problematic for community and mental health systems).

<sup>189</sup> Ehret et al., *supra* note 14, at 106–07.

<sup>190</sup> Steven Belenko et al., *Treating Substance Use Disorders in the Criminal Justice System*, 15 CURRENT PSYCHIATRY REP. 1, 2 (2013), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3859122/pdf/nihms532476.pdf>; *Drug Addiction Treatment in the Criminal Justice System*, NAT'L INST. ON DRUG ABUSE, <http://www.drugabuse.gov/related-topics/criminal-justice/drug-addiction-treatment-in-criminal-justice-system> (last updated Apr. 2014); *Drugs and Crime*, NAT'L COUNCIL ON ALCOHOLISM & DRUG DEPENDENCE, INC., <http://ncadd.org/index.php/learn-about-drugs/drugs-and-crime> (last visited Mar. 17, 2015).

<sup>191</sup> Mary Jeanne Kreek, *Extreme Marginalization: Addiction and Other Mental Health Disorders, Stigma, and Imprisonment*, 1231 ANNALS N.Y. ACAD. SCI. 1, 7 (2011), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3716375/pdf/nihms486243.pdf>.

<sup>192</sup> Abdalla-Filho et al., *supra* note 101, at 464.

<sup>193</sup> See *id.*; Belenko et al., *supra* note 190, at 3; Kreek, *supra* note 191, at 7.

providing other evidence-based services to individuals with addictions.<sup>194</sup>

Individuals with addictions are a heterogeneous group with regard to readiness to change their addictive behaviors, and interventions should be employed at each and every stage of change in order to effectively treat addiction.<sup>195</sup> Many individuals with addictions who are imprisoned will not be ready to quit, and drug use is known to continue even when individuals are detained in correctional settings.<sup>196</sup> Injection drug use that occurs in prisons is very risky because it is associated with a high incidence of sharing needles with individuals who carry infectious diseases such as Hepatitis C and HIV that can be spread through blood.<sup>197</sup> The harm reduction strategy of needle exchange—or the provision of sterile needles to individuals in exchange for dirty needles—has shown to be effective in reducing HIV transmission when implemented in prisons, provided that needles are available in sufficient quantities and anonymity is assured.<sup>198</sup> It has also been shown to increase referrals to treatment for injection drug users, and to be able to be safely implemented in correctional settings.<sup>199</sup> The World Health Organization recommends its use in correctional settings.<sup>200</sup> Unfortunately, it is rarely implemented in jails and prisons.<sup>201</sup>

Medication-assisted treatment for individuals with opioid addictions—providing medications that substitute for the

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<sup>194</sup> See generally Belenko et al., *supra* note 190, at 7 (noting the lack of treatment penetration into the target population and the underutilization of treatment programs with a strong evidence base); 8 *Treatment Issues Specific to Jails*, NCBI, <http://www.ncbi.nlm.nih.gov/books/NBK64145/> (last visited Mar. 26, 2015) (noting that jails often serve as the first place for offenders to have their substance use disorders identified and be offered detoxification programs).

<sup>195</sup> See generally Barbara C. Wallace, *Controversies in Knowledge Translation for Community-Based Drug Treatment: The Need to the End Policies of the War on Drugs and Mass Incarceration of Drug Offenders to Achieve Health Equity*, 89 J. URB. HEALTH 894, 900–01 (2012) (advocating for comprehensive intervention at each stage).

<sup>196</sup> Ralf Jürgens et al., *Interventions to Reduce HIV Transmission Related to Injecting Drug Use in Prison*, 9 LANCET 57, 58 (2009).

<sup>197</sup> Abdalla-Filho et al., *supra* note 101, at 465; Jürgens et al., *supra* note 196, at 58.

<sup>198</sup> Abdalla-Filho et al., *supra* note 101, at 465; Jürgens et al., *supra* note 196, at 59.

<sup>199</sup> Abdalla-Filho et al., *supra* note 101, at 465; Jürgens et al., *supra* note 196, at 59.

<sup>200</sup> World Health Organization, *Europe: Status Paper on Prisons, Drugs and Harm Reduction*, EUR/05/5049062 (May 2005).

<sup>201</sup> Jürgens et al., *supra* note 196, at 59.

addictive substance and/or block its euphoric effect—is very effective, and has been shown to improve retention in prison-based treatment, improve linkage to community-based treatment upon release and also reduce recidivism.<sup>202</sup> Opioid substitution in the form of methadone maintenance and buprenorphine treatment has proven effective in correctional settings, and without adverse events such as abuse or diversion of medications.<sup>203</sup> Programs in which naltrexone, an opioid blocking medication, was provided to offenders with addictions have also been shown to help offenders.<sup>204</sup> Despite the evidence supporting the implementation of medication-assisted treatment, like needle exchange, it is underutilized in correctional settings.<sup>205</sup> In correctional settings, methadone and buprenorphine are used mostly for detoxification purposes, and often only in pregnant women.<sup>206</sup> Furthermore, only 37% of Drug Courts refer to medication-assisted treatment, and such treatment is only offered to probationers by 17% of probation departments.<sup>207</sup>

#### VI. REENTRY CHALLENGES FOR INDIVIDUALS WITH MENTAL ILLNESS

Reentry is a difficult period for all individuals, but for those who have to address mental health issues and addictions in addition to navigating post-release difficulties including finding housing, work, and rebuilding social connections, it can be an overwhelming time.<sup>208</sup> Individuals who have mental illness, addictions, and legal histories are highly marginalized due to

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<sup>202</sup> Belenko et al., *supra* note 190, at 7; Jürgens et al., *supra* note 196, at 60. See generally Jeffrey Stuckert, *How is Suboxone Treatment Different than Drug Abuse?*, PSYCHCENTRAL, <http://psychcentral.com/lib/how-is-suboxone-treatment-different-than-drug-abuse/0008583> (last visited Mar. 12, 2015) (for information regarding medications that substitute for an addictive substance or block its euphoric effect).

<sup>203</sup> Belenko et al., *supra* note 190, at 7; Jürgens et al., *supra* note 196, at 60. See generally Stuckert, *supra* note 202 (for background information on types of opioid substitution).

<sup>204</sup> Michael L. Prendergast, *Interventions to Promote Successful Re-Entry among Drug-Abusing Parolees*, 2009 ADDICTION SCI. & CLINICAL PRAC. 4, 9, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2797118/pdf/ascp-05-1-4.pdf>.

<sup>205</sup> Belenko et al., *supra* note 190, at 7.

<sup>206</sup> *Id.* at 7–8.

<sup>207</sup> *Id.* at 8.

<sup>208</sup> Fazel & Baillargeon, *supra* note 61, at 960.

cumulative stigmatization.<sup>209</sup> They are judged on the basis of legal history even after they have served sentences, and carry the stigma of mental illness and addiction even after recovery.<sup>210</sup> Many people with mental illness leave correctional facilities having received no treatment, and those who did receive treatment often leave with limited supplies of medications.<sup>211</sup> Sometimes they are not linked with community mental health providers, or they are ineffectively linked.<sup>212</sup> Studies have shown that nearly two-thirds of individuals with mental illness are rearrested, and one-third to one-half are hospitalized in the first eighteen months after being released from prison, and that these rates are significantly higher than respective rates for individuals without mental illness.<sup>213</sup>

Individuals with serious mental illness are at a high risk for mortality during the early post-release period.<sup>214</sup> A study in Washington state found that recently released men were at a twenty-nine times higher risk for unnatural death than matched community controls, and for women the risk was sixty-nine times higher.<sup>215</sup> Some individuals die from suicide, and others die from homicide.<sup>216</sup> Many others die from drug overdose, and the effects of forced abstinence on drug tolerance plays a role in this phenomenon.<sup>217</sup>

#### VII. CREATING A NEW PATH FOR INDIVIDUALS WITH MENTAL ILLNESS WHO FACE IMPRISONMENT – DIVERSION FROM CORRECTIONS TO THE MENTAL HEALTH SYSTEM

Given that individuals with mental illness are arrested at high rates, fare poorly in correctional settings, and face many challenges to successful reentry, there is much interest in creating a path for individuals with mental illness that leads away from the criminal justice system. Diversion is a strategy that creates a path for particular law-breaking individuals that

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<sup>209</sup> Lamberg, *supra* note 35, at 556.

<sup>210</sup> Kreek, *supra* note 191, at 2.

<sup>211</sup> See Fazel & Baillargeon, *supra* note 61, at 957.

<sup>212</sup> *Id.* at 957, 962.

<sup>213</sup> Shelton et al., *supra* note 15, at 604.

<sup>214</sup> Fazel & Baillargeon, *supra* note 61, at 960.

<sup>215</sup> *Id.*

<sup>216</sup> *Id.*

<sup>217</sup> *Id.*

leads away from prison and towards interventions.<sup>218</sup> Programs that divert people with mental illness and addictions to treatment were created based on the philosophy that when an individual's offending behavior is representative of mental illness or related to addiction rather than being criminally motivated, society is best served by sending that individual to treatment rather than jail or prison.<sup>219</sup>

#### A. Prebooking Diversion

There are several different models of diversion.<sup>220</sup> In prebooking diversion models, individuals are diverted from the criminal justice system before criminal charges are even filed.<sup>221</sup> Police officers are critical in prebooking diversion models because they are the individuals who have been tasked by society with responding to crime and enforcing the law.<sup>222</sup> Additionally, it is estimated that between 7% and 10% of police calls involve an individual with mental illness.<sup>223</sup> If police are savvy, they can respond with a number of actions other than arrest<sup>224</sup> and many cases of criminalization of mental illness can be avoided. However, in order for this to occur, officers must be trained to recognize mental illness. A study of Los Angeles police officers showed that without the benefit of mental health training, officers underestimated the rate of mental illness in arrestees, estimating that only 5% of arrestees were mentally ill among a sample in which 10% had mental illness.<sup>225</sup> Studies show that

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<sup>218</sup> Marcus T. Boccaccini et al., *Rediversion in Two Postbooking Jail Diversion Programs in Florida*, 56 PSYCHIATRIC SERVICES 835, 835 (2005).

<sup>219</sup> *Id.*

<sup>220</sup> See Frank Sirotich, *The Criminal Justice Outcomes of Jail Diversion Programs for Persons with Mental Illness: A Review of the Evidence*, 37 J. AM. ACAD. PSYCHIATRY L. 461, 462 (2009).

<sup>221</sup> *See id.*

<sup>222</sup> See JOEL B. PLANT & MICHAEL S. SCOTT, U.S. DEP'T OF JUSTICE, EFFECTIVE POLICING AND CRIME PREVENTION 13, 50 (2009), available at <http://www.popcenter.org/library/reading/pdfs/mayorsguide.pdf>; see also Tucker et al., *supra* note 37, at 210 (noting that in taking action against mentally ill persons, officers are motivated by their duty to protect and serve their communities and their power to involuntarily protect a person who has become a danger to themselves or others).

<sup>223</sup> Abbott, *supra* note 19, at 8.

<sup>224</sup> Tucker et al., *supra* note 37, at 210.

<sup>225</sup> See Quanbeck et al., *supra* note 6, at 1246 (“[W]hile the prevalence of serious mental illness in arrestees is 10%, the majority of police officers surveyed believed that less than 5% of arrestees were mentally ill and in need of treatment.”).

less experienced police officers arrest individuals with mental illness more often than officers who have worked in the field for longer periods of time.<sup>226</sup>

Crisis Intervention Training (CIT) is an example of prebooking diversion.<sup>227</sup> In this model, specialized police forces, known as CIT teams, are created which consist of officers trained to recognize signs and symptoms of mental illness among offenders and use discretion to determine the most appropriate disposition for such individuals.<sup>228</sup> Research has shown that when police interact with civilians with respect, from the initial stages of the interaction, and did not use an approach in which threats or force predominated, citizens were more likely to perceive that procedural justice had occurred and comply with police directives.<sup>229</sup> Additionally, “irrational” citizens were particularly amenable to the compliance-encouraging effects of respectful approach by authorities.<sup>230</sup> CIT officers learn communication and de-escalation skills that enable them to turn situations that have the potential to end in arrest to end with a mentally ill offender being taken to a hospital emergency room or psychiatric unit for treatment instead.<sup>231</sup> Critical elements that lead to CIT program effectiveness include intensive training (standard is forty hours), voluntary participation, involvement of police dispatchers in training, twenty-four hour a day availability of trained officers, and assignment of a lead officer with CIT training on every team responding on all mental health calls.<sup>232</sup>

In addition to CIT training, some cities achieve prebooking diversion through the creation of joint police/mental health crisis

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<sup>226</sup> Amy C. Watson & Beth Angell, *Applying Procedural Justice Theory to Law Enforcement's Response to Persons with Mental Illness*, 58 PSYCHIATRIC SERVICES 787, 788 (2007).

<sup>227</sup> See Sirotych, *supra* note 220, at 462.

<sup>228</sup> *Id.*

<sup>229</sup> See Watson & Angell, *supra* note 229, at 789.

<sup>230</sup> *Id.* at 790.

<sup>231</sup> Sirotych, *supra* note 220, at 467.

<sup>232</sup> See Michael T. Compton et al., *Crisis Intervention Team Training: Changes in Knowledge, Attitudes, and Stigma Related to Schizophrenia*, 57 PSYCHIATRIC SERVICES 1199, 1199 (2006); Henry J. Steadman et al., *Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies*, 51 PSYCHIATRIC SERVICES 645, 646–47 (2000); see also Jennifer L. S. Teller et al., *Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls*, 57 PSYCHIATRIC SERVICES 232, 236 (2006) (noting that the implementation of CIT programs has led to dispatchers better recognizing calls as potentially involving mental illness).

response teams.<sup>233</sup> And other cities have created law enforcement reception centers that have co-located mental health and law enforcement services.<sup>234</sup> Officers can bring offenders to these specialized reception centers for law enforcement and mental health assessments, and many of the centers offer detoxification and treatment referrals as well.<sup>235</sup>

Prebooking diversion has been shown to produce good effects.<sup>236</sup> These strategies lead to increased referrals to psychiatric care for individuals in need, and positive mental health and quality-of-life outcomes have been demonstrated.<sup>237</sup> Implementation of CIT teams has been shown to lead to less arrests of mentally ill individuals, improved access to psychiatric care, fewer injuries among mentally ill individuals who come into contact with police, and fewer jail suicides.<sup>238</sup> Availability of psychiatric emergency rooms or crisis centers with police-friendly policies, such as no refusal rules for police-assisted referrals, has been shown to improve effectiveness of prebooking diversion programs.<sup>239</sup>

### *B. Postbooking Diversion*

Postbooking diversion models also exist, and through these programs individuals are diverted to the mental health system from the criminal justice system after they have been arrested and charged with offenses.<sup>240</sup> The key elements of effective postbooking diversion programs are mental health assessment, development of individualized treatment plans for defendants, and collaboration between the prosecutor, defense attorney, and judge.<sup>241</sup> When defendants are granted diversion they receive incentives for completing treatment, which can range from dismissal of charges to lowering of sentencing.<sup>242</sup>

Examples include jail-based and court-based diversion programs that identify offenders who have mental illness and/or

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<sup>233</sup> Sirotych, *supra* note 220, at 462.

<sup>234</sup> *Id.* at 462–63.

<sup>235</sup> Sirotych, *supra* note 220, at 462–63.

<sup>236</sup> *Id.* at 466–67.

<sup>237</sup> Alan B. McGuire & Gary R. Bond, *Critical Elements of the Crisis Intervention Team Model of Jail Diversion: An Expert Survey*, 29 BEHAV. SCI. & L. 81, 82 (2011).

<sup>238</sup> Tucker et al., *supra* note 37, at 211.

<sup>239</sup> Steadman et al., *supra* note 232, at 645, 648–49.

<sup>240</sup> *Id.* at 645.

<sup>241</sup> Sirotych, *supra* note 220, at 463.

<sup>242</sup> *Id.*

addictions and refer them for treatment rather than impose jail or prison sentences.<sup>243</sup>

Jail-based diversion programs employ mental health liaisons in jails, whose job it is to identify, screen, and assess individuals with mental illness who have been arrested and detained.<sup>244</sup> Liaisons develop recommendations for mental health treatment for individuals whom they assess, and they communicate their recommendations with prosecutors, defense attorneys, and judges, with the goal of securing release to treatment for individuals.<sup>245</sup>

Court-based diversion occurs when the defense, prosecution, and judge in a case collaborate on cases in which defendants have mental illness and devise plea agreements that are favorable for defendants and include conditions for mental health and/or substance abuse treatment.<sup>246</sup> The programs can be decentralized or specialized.<sup>247</sup> In decentralized programs, any attorney in any court can argue for mental health provisions to be included in a plea agreement, and any judge can decide to include treatment as a condition of a plea agreement.<sup>248</sup> In specialized court-based diversion programs, separate courts are set up in which attorneys and judges receive mental health training and maintain separate court dockets and calendars.<sup>249</sup> A number of different specialized courts have been created to provide individualized disposition plans for individuals with mental illness.<sup>250</sup>

Mental Health Courts emerged in the late 1990s, in response to enormous growth in the numbers of defendants with mental illness.<sup>251</sup> Mental Health Court participation is voluntary for defendants.<sup>252</sup> Cases are resolved through collaboration of prosecutors, defense attorneys, and judges, with input from mental health professionals who make recommendations

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<sup>243</sup> *Id.* at 463, 467.

<sup>244</sup> *Id.* at 463.

<sup>245</sup> Lattimore et al., *supra* note 9, at 33–34, 39.

<sup>246</sup> Sirotich, *supra* note 220, at 463.

<sup>247</sup> Lattimore et al., *supra* note 9, at 33.

<sup>248</sup> *Id.*; Sirotich, *supra* note 220, at 463.

<sup>249</sup> Lattimore et al., *supra* note 9, at 33.

<sup>250</sup> Jim Mann, *Delivering Justice to the Mentally Ill: Characteristics of Mental Health Courts*, 8 SOUTHWEST J. CRIM. JUST. 45, 48 (2011).

<sup>251</sup> See COUNCIL OF STATE GOV'T JUSTICE CTR., MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS AND PRACTITIONERS 1 (2008).

<sup>252</sup> Susan Stefan & Bruce J. Winick, *A Dialogue on Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 507, 519 (2005).

regarding what type of treatment would benefit the defendant.<sup>253</sup> At the disposition of their cases, defendants have individualized treatment plans that they are mandated to follow under court supervision, typically through specialized Mental Health Probation in coordination with a community psychiatric team.<sup>254</sup>

Drug Courts have been in operation since 1989, and have been shown to reduce recidivism and improve referral to, retention in, and completion of drug treatment.<sup>255</sup> Drug courts bring adversarial forces together for coordinated problem-solving and harness the resources of the community including psychiatric, social service, and rehabilitation professionals to help people who have been arrested for addiction-related crimes recover from their addictions.<sup>256</sup> They have been shown to be highly cost-effective and to promote prosocial change in individuals who without treatment would be at risk for recidivism.<sup>257</sup> Domestic Violence Courts represent a third type of specialized court.<sup>258</sup> They emerged after evidence of a high prevalence of serious and fatal assaults of women by intimate partners emerged in the 1990s.<sup>259</sup> In Domestic Violence Courts, criminal sentences are imposed, but can be negotiated down if an offender completes an individualized batterer intervention plan which includes elements such as mental health evaluation, treatment, addiction treatment, and anger management classes.<sup>260</sup> Domestic Violence Courts also make provisions for victims, including protection orders and

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<sup>253</sup> See Lattimore et al., *supra* note 9, at 31–32; Sirocich, *supra* note 220, at 463.

<sup>254</sup> See Morrissey et al., *supra* note 56, at 1212.

<sup>255</sup> Bridget M. Kuehn, *Mental Health Courts Show Promise*, 297 JAMA 1641, 1641 (2007), available at <http://addictionstudies.org/pdfs/Bridget%20Kuehn/mentalhealthcourts.pdf>

<sup>256</sup> See Kathryn C. Sammon, Note, *Therapeutic Jurisprudence: An Examination of Problem-Solving Justice in New York*, 23 ST. JOHN'S J.L. COMM. 923, 932–33, 939 (2008).

<sup>257</sup> See Bruce J. Winick et al., *Dealing with Mentally Ill Domestic Violence Perpetrators: A Therapeutic Jurisprudence Judicial Model*, 33 INT'L J.L. & PSYCHIATRY 428, 429 (2010), available at [http://www.law.arizona.edu/depts/uprintj/pdf/Winick\\_2010\\_International-Journal-of-Law-and-Psychiatry\\_1.pdf](http://www.law.arizona.edu/depts/uprintj/pdf/Winick_2010_International-Journal-of-Law-and-Psychiatry_1.pdf).

<sup>258</sup> See Kathryn Gillespie Wellman, *Taking the Next Step in the Legal Response to Domestic Violence: The Need to Reexamine Specialized Domestic Violence Courts from a Victim Perspective*, 24 COLUM. J. GENDER & L. 444, 460 (2013).

<sup>259</sup> See Beverly Balos, *Creating a Constitutional Right to Counsel in the Civil Context: Domestic Violence Matters: the Case for Appointed Counsel in Protective Order Proceedings*, 15 TEMP. POL. & CIV. RTS. L. REV. 557, 560–61 (2006).

<sup>260</sup> See Wellman, *supra* note 258, at 462.

trauma services.<sup>261</sup> The courts have been shown to improve service provision to offenders and victims, and increase level of supervision of participants, but have not shown to reduce recidivism.<sup>262</sup>

#### VIII. RECOMMENDATIONS FOR SYSTEM REFORM

The criminal justice system was not designed to be a treatment center for individuals who have mental illnesses and addictions. Not only are these individuals at increased likelihood of arrest, when compared to the general population, but they are at increased risk of victimization in correctional settings, more vulnerable to adverse events as a result of incarceration.<sup>263</sup> When incarcerated, they cost tax-payers a lot of money, and when released they have difficulty avoiding rearrest and reincarceration.<sup>264</sup> Changing this can be achieved, however, through combined and coordinated efforts of the criminal justice and mental health systems.

The most effective way that the U.S. can achieve reform is to invest resources in diversion, with a strong emphasis on prebooking diversion. A study of diversion strategies found that these programs greatly reduced the amount of time that mentally ill offenders spent behind bars.<sup>265</sup> Diversion strategies cut down dramatically on inappropriate housing of the mentally ill in correctional settings,<sup>266</sup> and reduce criminal justice costs incurred by individuals with mental illness.<sup>267</sup> One study concluded that prebooking diversion of individuals with severe mental illness saved tax-payers over \$2800 per individual diverted during the subsequent two years, mostly due to reduced criminal justice costs.<sup>268</sup> Involvement of a probation officer to monitor compliance

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<sup>261</sup> See *id.*

<sup>262</sup> See Winick et al., *supra* note 257, at 429.

<sup>263</sup> See E. Lea Johnston, *Conditions of Confinement at Sentencing: the Case of Seriously Disordered Offenders*, 63 CATH. U. L. REV. 625, 626–27 (2014).

<sup>264</sup> CHRISTIAN HENRICHSON & RUTH DELANEY, CTR. ON SENTENCING & CORR., *THE PRICE OF PRISONS: WHAT INCARCERATION COSTS TAXPAYERS* (2012) (explaining the cost of prisons to taxpayers); Bernard S. Arons, Director, SAMHSA CTR. FOR MENTAL HEALTH SERVS., *Testimony on Mental Health and Criminal Justice* (Sept. 21, 2000), available at <http://www.hhs.gov/asl/testify/t000921a.html> (discussing the recidivism rates of the mentally ill in jails).

<sup>265</sup> See Sirocich, *supra* note 220, at 469.

<sup>266</sup> See Steadman et al., *supra* note 232, at 645–49.

<sup>267</sup> See Cowell et al., *supra* note 98, at 302–03.

<sup>268</sup> See Cowell et al., *The Impact on Taxpayer Costs of a Jail Diversion*

with treatment can lower attrition rates.<sup>269</sup> Additionally, if mental health treatment programs included programming aimed at addressing and changing criminal thinking patterns and behavior, recidivism could be lowered as well.<sup>270</sup>

When individuals with mental illness are arrested and charged with crimes, postbooking diversion should be done to steer them towards treatment and rehabilitation services. Drug Courts have proven effective in improving outcomes for drug-abusing offenders,<sup>271</sup> and other types of specialty courts have emerged and show promise for helping the individuals that they serve.

The community mental health system needs to adapt in order to provide treatment for individuals diverted by the criminal justice system. As noted, changing of civil commitment statutes to strict dangerousness standards has decreased availability of inpatient psychiatric services for many who require them, and many authors call for shifting of civil commitment statutes back to need for treatment standards so that individuals in need of psychiatric hospitalization will have better access to hospitalization.<sup>272</sup> Strengthening of the community mental health system with implementation of evidence-based practices for our patients with criminal justice involvement is also necessary. Specifically, those of us in the community mental health system need to learn to address criminogenic factors and provide cognitive behavioral interventions in order to help our patients avoid arrest and imprisonment. Addiction must be treated and use principles of effective correctional treatment in our patients with criminal justice involvement. Finally, those of us working in community mental health need to develop programs to engage the unengageable—the “multi-problem patients” with severe mental illness, personality disorder, and addictions. All psychiatrists should have violence risk assessment and violence management skills so that patients with violent histories experience less

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*Program for People with Serious Mental Illness*, 41 EVALUATION AND PROGRAM PLAN. 31, 34 (2013).

<sup>269</sup> Annette S. Crisanti et al., *Understanding Study Attrition in the Evaluation of Jail Diversion Programs for Persons with Serious Mental Illness or Co-Occurring Substance Use Disorders*, 41 CRIM. JUST. & BEHAV. 772, 786 (2014).

<sup>270</sup> See GAYLE BICKLE, OHIO DEP'T REHAB. & CORR., BUREAU OF RESEARCH & EVALUATION, AN INTERMEDIATE OUTCOME EVALUATION OF THE THINKING FOR A CHANGE PROGRAM i (2013).

<sup>271</sup> See *What are Drug Courts?*, NADCP, <http://www.nadcp.org/learn/what-are-drug-courts> (last visited Mar. 3, 2015).

<sup>272</sup> See, e.g., Quanbeck et al., *supra* note 6, at 1249.

marginalization and expulsion from community mental health agencies.

When individuals are incarcerated, they must receive effective treatment. Treating mental disorders and addictions in prison can not only help relieve suffering and improve functioning, it can also decrease reoffending.<sup>273</sup> Provision of mental health treatment in jail has been shown to reduce the reincarceration rate, with those who completed more “treatment sessions” deriving greater benefit.<sup>274</sup> Therapeutic community interventions have been shown to decrease repeat offending among those with addictions, if coupled with aftercare.<sup>275</sup> Methadone maintenance decreases relapse if started in prison and continued in the community.<sup>276</sup>

Although diversion will narrow the stream of people coming in to jail and prison, resources will still need to increase to improve screening and enable individuals identified by screening to be referred to an adequate base of treatment providers to meet their needs. Screening influences housing and security designation processes among other important decisions made in regard to inmates, and it must be done effectively using evidenced-based screening instruments.<sup>277</sup> Provider resources must be adequate to ensure that psychiatric evaluations are comprehensive and can lead to individualized treatment plans.<sup>278</sup> Effort should be made by correctional mental health providers to understand the environment that their patients live in and work around correctional barriers to compliance to improve outcomes for their patients. Where addiction is concerned, screening, identification and detoxification must continue. Additionally, correctional institutions must let go of stigma against harm reduction and medication-assisted treatment and provide evidence-based services to patients with addictions.

Finally, reentry planning must start early, and it must be thoughtful and thorough to provide linkage to community mental health treatment for individuals with mental illness and addictions who are released to the community. Reoffending rates among individuals with mental illness are known to be high, at

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<sup>273</sup> See Fazel & Baillargeon, *supra* note 61, at 962–63.

<sup>274</sup> See Abdalla-Filho et al., *supra* note 101, at 464.

<sup>275</sup> See Fazel & Baillargeon, *supra* note 61, at 957.

<sup>276</sup> See *id.*

<sup>277</sup> See Hinton, *supra* note 154, at 214.

<sup>278</sup> See *id.*

approximately 50%.<sup>279</sup> Therefore, when individuals do fail, creative solutions should be employed, such as remanding individuals to treatment centers rather than sending them back to prison. If individuals in diversion programs pick up new legal charges, they should be made eligible for rediversion, or reenrollment in the same diversion program, as it has been shown by a small study that rediverting once can cut the rate for subsequent rediversions down, thus improving recidivism rates and keeping individuals out of the criminal justice system.<sup>280</sup>

### CONCLUSION

As a society, the U.S. has shown a tendency to marginalize people with mental illness. Individuals with severe mental illness have gone from correctional institutions to state-run psychiatric institutions, then back to correctional institutions over the past 200 years.<sup>281</sup> At this time the criminal justice and mental health systems face a mandate from U.S. society to shift people with mental illness away from correctional institutions and into the community mental health system. Diversion presents a unique opportunity for the systems to collaborate, respond to society's mandate, and improve the lives of individuals with mental illness who find themselves caught up in the criminal justice detention system.

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<sup>279</sup> See *Criminal Justice: Study Finds Higher Rates of Jail Recidivism Among People with Co-Occurring Severe Mental Illness and Substance Use Disorders*, CENT. FOR EVIDENCE-BASED PRAC. (Feb. 1, 2012), <http://www.centerforebp.case.edu/stories/study-finds-higher-rates-of-jail-recidivism-among-people-with-co-occurring-severe-mental-illness-and-substance-use-disorders>.

<sup>280</sup> See Boccaccini et al., *supra* note 218, at 835.

<sup>281</sup> See E. FULLER TORREY ET AL., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 1 (2010).