

## Examining Prevailing Beliefs About People with Serious Mental Illness in the Criminal Justice System

*Arthur J. Lurigio*  
*Loyola University Chicago*

**THIS ARTICLE EXAMINES** many of the prevailing beliefs about the presence of the mentally ill in the criminal justice system. I begin by providing a backdrop for the longstanding problem of people with serious mental illness (PSMI) being processed through the criminal justice instead of the mental health system. I explore the notion of criminalization and what that term means with respect to current practices related to PSMI in the criminal justice system. I argue that true criminalization is a relic of past police practices and is no longer the primary conduit that brings PSMI into courts, jails, or prisons. I then discuss the policy of deinstitutionalization, which is associated historically with the growing number of PSMI in jails and prisons across the United States. I contend that the disproportionate representation of PSMI in the criminal justice system is largely the result of punitive crime control policies and the war on drugs.

I briefly describe programs that have been implemented to serve PSMI under the authority of law enforcement, courts, and corrections. I note that the criminal justice system has made serious attempts to care for PSMI. Further, I explore the special problems that complicate the lives of PSMI and contribute to the challenges of working with them at every step in the criminal justice process. I indicate that mental illness is only one of a host of problems that plague criminally involved PSMI.

### **The Prevailing Beliefs About PSMI in the Criminal Justice System**

#### **Belief 1: People with Serious Mental Illnesses Have Been Criminalized**

##### *The Notion of Criminalization*

Nearly 40 years ago, scholars first observed that PSMI were becoming criminalized (i.e., they were being processed through the criminal justice system instead of the mental health system) (Abramson, 1972). Criminalization occurs when people with no criminal intent are placed under arrest and detained for minor crimes or ordinance violations. These behaviors, known as public disorder or nuisance offenses, can be unnerving, threatening, or even frightening to bystanders. If someone's behavior disturbs customers in a restaurant, store, or mall, or interferes with the flow of traffic on a major thoroughfare, the police are frequently called to the scene to restore order.

In the 1980s, several studies found that PSMI were being arrested when a mental health

alternative would have been preferable but was unavailable (Lurigio, Snowden, & Watson, 2006). A ground-breaking observational study suggested that, *ceteris paribus*, PSMI suspected of minor crimes were more likely to be taken into police custody after a street encounter than were people who showed no signs of mental illness but were suspected of the same crimes (Teplin, 1983). The early literature on criminalization is replete with cases in which PSMI were arrested for expressing symptoms of mental illness. Such incidents often escalated into more serious acts of law-breaking (e.g., assaulting a police officer) (Teplin, 2000). No evidence gained from these studies ever indicated that the police were biased against PSMI or deliberately treated them inhumanely or abusively.

To the contrary, the police sometimes resorted to arrest in order to obtain services for PSMI (Teplin, 1983). So-called “mercy bookings” were undertaken to ensure that arrestees would obtain “three hots and a cot” (i.e., warm meals and a place to sleep, particularly in extreme weather conditions) (Teplin & Pruett, 1992). In many jurisdictions, PSMI were arrested so that they would be in a safe environment while they waited for a treatment bed to become available (Torrey, et al., 1992). This type of action constitutes thoughtful police service, not the criminalization of PSMI.

A significant proportion of police contacts with PSMI (who are not suffering from co-occurring substance use disorders) involve no criminal activity (although if improperly managed, such contacts can devolve into situations that do result in an arrest) (Council of State Governments, 2002). Most PSMI who are arrested, charged, and convicted of felonies are handled through the criminal justice system, not because they are being criminalized, but because they have behaved criminally. General discussions about the criminalization of the mentally ill rarely acknowledge that degrees of criminality and mental illness co-exist in the same individuals (Fichtner & Cavanaugh, 2006). Such discussions often homogenize the mentally ill in terms of their disease and their criminality. Similarly, PSMI commit crimes for a variety of reasons, at different rates and different times, as do people without serious mental illness.

### *The Notion of Homogeneity*

One study found that PSMI could be grouped into three categories according to their criminal histories (Lurigio & Lewis, 1987). The first group was arrested largely for public order violations and fit the characterization of the criminalized mentally ill; they were arrested for simply displaying the signs and symptoms of mental illness in public. The second group was arrested for committing petty or survival crimes, such as prostitution, shoplifting, and minor drug sales, or for committing crimes to supplement the meager income that they received from panhandling or entitlement programs. The third group was indistinguishable from offenders with no mental illness. Their criminal histories contained an assortment of street crimes, including robbery, burglary, and battery.

Other researchers have suggested additional typologies of criminal behavior among PSMI. For example, a study of the recidivistic patterns of parolees with mental illness found that the vast majority of those who committed crimes (90 percent) did so because of problems with anger and impulsivity; 5 percent committed crimes that were attributable to their symptoms, and 2 percent committed crimes to survive on the streets (Peterson, Skeem, Hart, & Vidal, 2009). Another set of groupings includes PSMI who commit low-level (non-violent) crimes to survive; those with co-occurring substance use and Axis II diagnoses (character disorders) who commit serious crimes; and those who commit violent crimes as a consequence of their symptoms and thus fit the pernicious stereotype of the violent mentally ill (Hiday, 1997). Based on these characterizations, researchers and practitioners should investigate more vigorously the parallel and intersecting trajectories of mental illness and criminality among PSMI in order to understand the relationship between symptoms and crimes as well as to identify the particular service needs of PSMI at each step in the criminal justice process.

The presumed homogeneity of criminally involved PSMI coincides with a belief in mutual exclusivity—someone is either “mentally ill” or a “criminal,” but not both. This belief is perhaps related to the legal principle of intent and explicitly linked to the insanity defense, which is an

affirmative defense that requires proof that those accused were unable to control their behavior or distinguish between “right and wrong” at the time the crime was committed. The public’s conflation or confusion of insanity and mental illness perpetuates the distinction between “mad and bad” (Erickson & Erickson, 2008).

In practice, forensic cases are tried using different procedural guidelines, housed in different facilities, and subjected to different release mechanisms; they have been appropriately excluded from the debate about criminalization. Hence, PSMI convicted of felonies have been deemed “criminal”; they are thus held responsible by the law and in court, and therefore, cannot be “criminalized.” In such instances, the term “criminalization” is a misnomer. Fewer than 1 percent of criminal defendants proffer the insanity defense, and only a small percentage are successful—found “not guilty” by reason of insanity—and then placed in special facilities (Fersch, 2005). Thus, most PSMI in prisons and jails have been judged by the courts as legally culpable.

In the context of the above considerations, the traditional notion of “criminalization” is antiquated and should be replaced with a more comprehensive view of the factors that relate to the processing of PSMI through the criminal justice system (Fisher, Silver, & Wolff, 2006; Lurigio, 2004; Lurigio & Rodriguez, 2004; Rotter, et al., 1999). Whether police are called to defuse a psychiatric crisis, respond to a relatively minor “public order” offense, or arrest a suspect with mental illness on a felony charge, the essential question remains the same: How can the mental health and criminal justice systems respond effectively to the complicated needs of criminally involved PSMI?

### *Research on Criminalization*

Using evidence stemming from three primary sources (police reports, incarcerations, and the relative arrest rates of the mentally ill), a review of the literature on the criminalization of PSMI concludes that studies of police contacts and arrests at best present only inconclusive support for the criminalization of PSMI (Teplin, 1991). Investigations of the topic have employed mostly post-hoc strategies of data collection that are fraught with interpretation problems – for example, asking police officers after the fact to explain their decisions about handling PSMI. Such approaches produce biased data. Further, small samples, the lack of baseline comparisons, and invalid, inconsistent, and nonstandard assessment procedures also limit the usefulness of data on the prevalence of PSMI in jails and prisons.

The absence of longitudinal research precludes definitive conclusions about the causal relationship between policy changes and the criminalization of PSMI (Lamb & Weinberger, 1998, 2005; Teplin, 1991; Teplin & Voit, 1996). PSMI who have been granted due process and are found guilty and sentenced for crimes are not being criminalized in the strict sense of the term. If properly administered, police-, court-, and jail-operated diversionary strategies are designed to minimize the criminalization of PSMI. For more than 20 years, jails and prisons have been overcrowded and underfunded. Hence, people charged with low-level crimes, especially public-order offenses, are today unlikely to be detained, much less incarcerated.

### **Belief 2: Deinstitutionalization Is the Cause of Criminalization**

According to the prevailing wisdom, a sea change in mental health policy, known as deinstitutionalization, shifted the focus of care for PSMI in psychiatric hospitals to local community mental health centers and became the single largest contributing factor to the criminalization of the mentally ill (Borzecki & Wormith, 1985; Grob, 1991; Lurigio & Swartz, 2000; Whitmer, 1980). The deinstitutionalization movement was fueled by journalistic exposés of patient abuse, effective new medications to treat severe mental illness, federal entitlement programs that paid for community-based mental health services and the availability of insurance coverage for inpatient psychiatric care in general hospitals (Sharfstein, 2000). Despite its lofty intentions, the policy of deinstitutionalization was never properly implemented. Although it achieved its goal of reducing the use of state hospitals, it never succeeded in providing adequate, appropriate, or well-coordinated outpatient treatment for large percentages of PSMI, above all

those with the most severe and chronic mental disorders (Shadish, 1989).

Tragically, this unsuccessful transition to community mental health care took its greatest toll on those patients who were least capable of handling the basic tasks of independent daily living. Many became unwanted charges of the criminal justice system because of the dearth of treatment and social services (Grob, 1991; Torrey, Steiber, Ezekiel, Wolfe, Sharfstein, Noble, Flynn, 1992). Although purported innumerable times and in diverse literatures, the causal link between deinstitutionalization and criminalization has never been rigorously tested.

### *The Hydraulic Hypothesis*

The increase of PSMI in the nation's jail and prison populations supposedly occurred in part because of the decline in the size of the state mental hospital population, supporting Penrose's (1939) theory that a relatively stable population in industrialized societies is permanently confined (i.e., as the census of one institution of social control—the mental hospital—goes down, the census of another—the prison—goes up). Also known as the “hydraulic hypothesis,” Penrose's theory posits that a constant number of people with psychiatric disorders in industrialized or Western societies will always require institutional care.

If psychiatric hospitals are unavailable or unwilling to treat PSMI, then these patients will have to be housed elsewhere (e.g., prisons and jails). Part of the increase in the number and proportion of incarcerated PSMI is thus certainly attributable to deinstitutionalization and its corollaries. For example, if PSMI are arrested for public order offenses and accumulate a criminal history, they might be more likely in the long run to be sentenced to jail or prison. Nevertheless, deinstitutionalization only partially explains the large number of PSMI now in prisons (Jemelka, Trupin, & Chiles, 1989). For example, the 2 percent increase in the proportion of men with previous psychiatric hospitalizations sentenced to prison between 1968 and 1978 is much too small to account for all of the men who were released from psychiatric hospitals and who later committed crimes during that same time period (Jemelka et al., 1989). In addition, the census in state psychiatric facilities has remained relatively flat, while the prison population has been increasing since 1990 at a rate of 6 percent annually (Frank & Gilard, 2006).

One study examined evidence for the inverse correlation between the number of PSMI in jails and prisons and those in psychiatric hospitals, using census data collected from those three institution types between 1904 and 1987 (Palermo, Smith, & Liska, 1991). The data supported the conclusion that jails and prisons have become convenient repositories for PSMI. Another study that measured the aggregate institutionalization rate in the United States (state hospitals and prisons) found that the rate was essentially unchanged from 1955 (when the hospitalized psychiatric population was at its highest) to 2002 (when the prison population was at its highest to date). These findings suggest evidence that the population under the umbrella of social control simply shifted from patients to inmates (who would have been patients 50 years earlier) (Harcourt, 2006).

A review of several studies on the imprisonment of PSMI, however, found no conclusive support for the hydraulic hypothesis (Teplin & Voit, 1996). Similarly, an examination of imprisonment data in six states, which compared the number of prisoners with prior psychiatric hospitalizations in 1968 and 1978, failed to show a purported shift of PSMI from state hospitals to prisons (Steadman, Monahan, Duffee, Hartstone, & Robbins, 1984). What, then, does explain the continually large numbers of PSMI entering jails and prisons?

The belief that deinstitutionalization caused an influx of PSMI into the criminal justice system is based in part on the correlational fallacy and rests on untenable assumptions. The emptying of state hospitals began a decade before the precipitous increase of crime and the politicization of the crime problem in the 1960s, and 25 years before the implementation of the policy of mass incarceration. Nevertheless, major policy changes in mental health care and crime control have run parallel for several decades, suggesting concomitance but not causality. If the population of the hospital simply shifted to the prison, then the populations of “patients” and “criminals” would have to overlap substantially in their composition.

Indeed, research suggests that the population of state hospitals changed in the 1970s, resulting in an increase in the rate of arrests for released patients because of the “changing clientele of state hospital[s],” that is, the growing number of patients with previous offense histories (Cocozza, Steadman, & Melick, 1978). This intersection between the two populations is attributable to shared demographic characteristics and not to the increased risk of criminality among former patients attributable to mental illness. A review of 200 studies on the relationship between crime and mental disorders concluded that [the association] “can be accounted for largely by demographic and historical characteristics that the two groups share. When appropriate statistical controls are applied for factors, such as age, gender, race, social class, and previous institutionalization, whatever relations between crime and mental disorder are reported, tend to disappear” (Monahan & Steadman, 1983, p. 152). A much more recent investigation found that the rise in the percentage of incarcerated PSMI from 1950 to 2000 has been modest and is predictable in light of the overall increase in the number of people incarcerated during that time period. Specifically, while the proportion of PSMI in psychiatric institutions fell by 23 percent, the percentage of incarcerated PSMI increased only 4 percent in the last half of the last century (Frank & Glied, 2006).

### *Poverty and Mental Illness*

PSMI often reside in highly criminogenic and impoverished environments that exert pressures on them to become engaged in criminal behavior. The factors that characterize these environments also affect poor people with no serious mental illness (e.g., joblessness, gang influences, failed educational systems, and residential instability) (Silver, Mulvey, & Swanson, 2002). PSMI have many types of problems because of the poor and disadvantaged communities in which they typically live (Draine, Salzer, Culhane, & Hadley, 2002). Homelessness, crime, under-education, and unemployment are endemic to these neighborhoods. A large percentage of poor people experience these difficulties—whether they have mental illness or not—rendering them more susceptible to criminal activity and victimization (Lamberti, 2007). The risk factors that predict crime among PSMI are the same factors that predict crime among people with no serious mental illness (Bonta, Law, & Hanson, 1998; Skeem, Eno Loudon, Manchak, Vidal, & Haddad, 2008).

Since the earliest epidemiological studies of mental illness, researchers have found a correlation between poverty and serious mental illness; people of lower socioeconomic status are more likely than those of higher socioeconomic status to be diagnosed with a serious mental disorder (U.S. Surgeon General, 1999). The unrelenting stress of poverty increases the risk of mental illness (Eaton & Muntaner, 1999). Mental illness can also pull a person downwards into poverty because the symptoms of mental illness can interfere with going to school and finding and maintaining employment. In addition, most poor people have no or limited insurance coverage for primary mental health care. Therefore, their symptoms go untreated, producing irreversible clinical deterioration and recurrence of more severe episodes of psychiatric disease.

Poor communities with high levels of social disorganization and weak informal social control mechanisms also have a higher tolerance for deviant behaviors and are more welcoming to PSMI who can find affordable places to live in communities where crime is rampant and police presence is elevated. A large-scale, seven-year study of the relationship between socioeconomic status and mental illness suggested that poverty, acting through economic stressors, such as unemployment and lack of affordable housing, is more likely to be a precursor to, than a sequela of, serious mental illness (Hudson, 2005). Thus, the correlates of crime are also the correlates of serious mental illness (Fischer, Silver, & Wolff, 2006).

### *The Prison Explosion and the War on Drugs*

The prison population in the United States quadrupled from 1980 to 2000 and has exceeded the 1 million mark every year since 1995. The rate of incarceration per 100,000 Americans climbed from 139 in 1980 to 478 in 2000—a 243 percent increase (Bureau of Justice Statistics, 2002a). By mid-year 2009, the number of incarcerated adults had grown to 2.3 million (Bureau of Justice Statistics, 2010). The United States now has the highest documented incarceration rate in the world (714 per 100,000 persons) and the highest documented prison and jail populations in

the world, followed by Russia and South Africa (Walmsley, 2006, 2009).

Since the 1980s, an overwhelming emphasis on law enforcement strategies to combat illegal drug use and sales has resulted in dramatic increases in the nation's arrest and incarceration rates. Rates of arrest and incarceration for drug offenses have continued at a record pace into the 21st century, although general population surveys did report declines in illegal drug use in the United States during the 1990s (Tonry, 1995, 1999). Drug offenses have been among the largest categories of arrests since the 1980s. From 1980 to 2000, for example, arrests for drug offenses more than doubled. In 2000 alone, more than 1.5 million persons were arrested for drug offenses—more than four-fifths for drug possession (Bureau of Justice Statistics, 2002b). PSMI who live in poor neighborhoods have easy access to illicit substances, which are more likely to be sold on the street in those communities, and they are likely to be arrested for possession because of the increased police presence in underclass areas.

Offenders convicted of drug possession and sales (and who also have high rates of drug use) have been incarcerated with greater frequency and for longer prison terms than previously and have constituted one of the fastest-rising subgroups in the nation's prison and probation populations since the onset of the current imprisonment binge (Beck, 2000). A fairly large proportion of these individuals have co-occurring psychiatric disorders, thus adding to the number of mentally ill offenders in the nation's criminal justice system (Lurigio, 2004; Swartz & Lurigio, 1999). Like dolphins among tuna, many mentally ill, drug-using persons are caught in the net of rigorous drug enforcement policies (Lurigio & Swartz, 2000).

PSMI who use illicit drugs are more prone to violence and thus more likely to be arrested and incarcerated than those who do not use illicit drugs (Clear, Byrne, & Dvoskin, 1993; Swanson, Estroff, Swartz, Borum, Lachicotte, Zimmer, & Wagner, 1997; Swartz, Swanson, Hiday, Borum, Wagner, & Burns, 1998). One study of a sample of PSMI in jail found that substance use disorders have a greater effect on criminal behavior than mental illness does (Junginger, Claypoole, Laygo, & Crisanti, 2006). Numerous studies have also demonstrated that people with comorbid psychiatric and substance use disorders are more likely than people with mental illness alone to engage in violent behavior (Harris & Lurigio, 2007).

The current war on drugs and the high rate of comorbidity between drug use and psychiatric disorders accounts partially for the large numbers of PSMI in our nation's jails and prisons. Fragmented drug and psychiatric treatment systems fail to afford fully integrated care for persons with such co-occurring disorders, compounding their problems in both areas of concern and elevating their risk for arrest and incarceration (Lurigio & Swartz, 2000). PSMI share many of the socioeconomic and other characteristics of criminally involved people (youth, unemployment, poverty, lack of education, substance use) and live in the same criminogenic neighborhoods where the presence of police and the likelihood of arrest are high, presenting an expansive gateway for PSMI to enter the criminal justice system.

### **Belief 3: The Number of PSMI Continues to Grow**

The percentage of PSMI in correctional populations has presumably grown and will continue to grow. Evidence suggests that rates of serious mental illness in the prison population rose substantially during the 1990s. For example, in a 2001 national survey, 25 of the 29 state prison systems with longitudinal healthcare data reported that the proportion of inmates with PSMI increased measurably between 1990 and 2000 (Thigpen, Hunter, & Ortiz, 2001). These estimates were based on self-reported perceptions of growth and beg the question of whether the actual rates of inmates with mental illness have actually risen, or if sensitivity to the problem among prison administrators has simply increased, and similarly (and more likely), whether more and better screening procedures for mental illness were implemented in the 1990s, thereby uncovering more cases of incarcerated PSMI than earlier.

Various studies have measured the prevalence of mental illness in jails and prisons for more than three decades. Except for a handful of investigations (e.g., Teplin, 1990), the prevalence of psychiatric disorders has been established using weak methodologies and

epidemiological imprecision (e.g., Ditton, 1999). Moreover, psychiatric prevalence rates in correctional institutions are difficult to capture because they fluctuate with changes in law enforcement and sentencing practices, rates of psychiatric morbidity in the community, and the structure and financing of the community mental health system. In addition, many crime control policies that have fueled the exponential growth in the incarceration rate—for example, intensive street-level drug enforcement and crackdowns on “quality of life” or public order offenses—have disproportionately affected PSMI. Therefore, prevalence estimates that rely on studies from the 1980s or the early 1990s have little usefulness in the planning and delivery of mental health services to current jail detainees and prison inmates (Harris & Lurigio, 2007).

The calculation of comparable prevalence rates among different settings or studies has been hampered by variations in sampling techniques, data collection procedures, and operational definitions of mental illness. Varying definitions of what constitutes a “mental disorder” can significantly affect the results of psychiatric prevalence studies in correctional settings (Pinta, 1999). Specifically, a “narrow” definition of mental disorders that encompasses only serious mental illness, such as bipolar disorder, major depression, and schizophrenia, would lead to a much lower prevalence of serious mental illness than would a “broad” definition of mental disorders that encompasses a wide range of other diagnoses, such as paraphilias, substance use disorders, and Axis II (personality) disorders (Pinta, 1999).

Most studies of PSMI in jails and prisons have been performed in single jurisdictions because large-scale, epidemiological research has been precluded by limitations in investigator resources and restrictions in their access to multiple correctional facilities (Lamb & Weinberger, 2005; Pinta, 1999; Veysey & Bichler-Robertson, 2002). However, recent attention to the increasing number of PSMI in prisons has prompted the implementation of cross-jurisdictional, epidemiological studies of incarcerated populations, such as the National Commission on Correctional Health Care Study, and a meta-analysis of more than 60 prevalence studies of prisoners with mental illness (Fazel & Danesh, 2002). The bottom line from this research is that “we know little about the true prevalence of mental illness among offenders throughout all stages of the criminal justice system, or about the extent to which the needs of mentally ill offenders are going unmet” (Mears, 2004, pp. 257-258). More prevalence research must be conducted to specify the need for treatment and to generate precise baseline indicators of the nature and severity of mental illness, which can be used in studies to determine program effectiveness.

#### **Belief 4: Treating PSMI Will Lower Recidivism**

The prevention of recidivism is a practical motivation for providing services to PSMI in jails and prisons and also to those on probation and parole supervision. However, no pathogenesis between mental illness and crime has ever been established. The untreated symptoms of the three most serious mental illnesses (schizophrenia, bipolar disorder, and major depression) suggest either no or a weak causal pathway. No theoretical model explains or predicts a precise relationship between serious mental illness and criminal behavior (Mears, 2004). Hence, major mental illness, in and of itself, would seem to present no added risk of criminal activity.

No studies have shown that the alleviation of psychiatric symptoms alone affects recidivism among criminally involved PSMI (Skeem, Manchak, Vidal, & Hart, 2009; Steadman, Dupius, & Morris, 2009). In fact, treating only mental illness among those who are criminally involved, without implementing any other interventions aimed at criminogenic factors, could arguably increase, not decrease, the risk of crime. For example, treated depression enhances vitality and energy among criminals and noncriminals alike, which is not to suggest that PSMI in the criminal justice system be deprived of treatment. Instead, it is important to recognize that psychiatric treatment might have no effect on reducing crime. In contrast, research suggests overwhelmingly that the co-occurrence of substance use disorders and other Axis I diagnoses accelerate criminal activities, especially among people with criminal intent and inclinations. Evidence for the relationship between violence and alcohol misuse, abuse, or dependence is also abundant and unequivocal (Lurigio & Swartz, 2000).

Treating mental illness could have an indirect effect on recidivism. In other words, relieving symptoms could help PSMI become sober and employed, find and retain stable housing, develop better self-control, return to school, mend relationships with family, and follow the designated rules of supervision, thereby avoiding probation and parole violations. Further, relieving the symptoms of major mental illness can make PSMI more amenable to interventions that will have a positive effect on crime, such as cognitive behavioral therapy that can change criminal thinking (Bonta et al., 1998). Even with no effect of treatment on criminality, jails and prisons still have a moral, ethical, and legal obligation to handle PSMI with compassion and to provide them with empirically supported services and interventions.

Serious mental illness alone rarely leads people to commit crimes and, therefore, the treatment of mental illness alone is unlikely to prevent or reduce crime or recidivism. PSMI can benefit from the same evidence-based cognitive behavioral therapies that affect criminal thinking among people with no mental illness. Most important, integrated treatment for co-occurring psychiatric and substance use disorders is critical in helping PSMI manage their symptoms and change their potential criminal trajectories (Lurigio, 2009).

### **Belief 5: The Criminal Justice System Is Ill Equipped to Handle PSMI**

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

Jails and prisons have become the largest de facto treatment settings for the mentally ill, and correctional mental health care providers often contend with inadequate services and impossibly heavy caseloads. Specialized programs for PSMI, such as mental health courts, hold great promise for diverting PSMI from the criminal justice system and ensuring that they receive proper interventions (Bernstein & Seltzer, 2004; Watson, Hanrahan, Luchins, & Lurigio, 2001). Nonetheless, current resources for psychiatric treatment and other services rarely meet the demand for such care. However, criminal justice agencies are continually striving to do so (Council of State Governments, 2002).

With respect to programs and services, the criminal justice system has created interventions at each point of interception with PSMI. The literature abounds in instances of such initiatives (Council of State Governments, 2002). For example, to bridge both the mental health and criminal justice systems, in 1988, the Memphis Police Department created and implemented the first Crisis Intervention Team program in the United States (Compton, Bahora, Watson, & Oliva, 2008; Memphis Crisis Intervention Team., n.d.).

Operating at both the pre-and post-adjudication levels, specialized mental health courts hold great promise for diverting PSMI from the criminal justice system and ensuring that they receive psychiatric treatment and other services (Bazelon Center for Mental Health Law, 2004). Pioneering MHC initiatives were thus implemented in response to three critical problems: the perceived public health risk posed by offenders with serious mental illness, the challenges and costs of housing PSMI in crowded jails, and the pervasive inability of the criminal justice system to respond effectively and humanely to PSMI (Goldkamp & Irons-Guynn, 2000). The first jurisdictions to establish MHCs were Broward County, Florida; King County, Washington; and Anchorage, Alaska. More than 300 mental health courts now operate across the country (Justice Center, Council of State Governments, 2011).

Jail diversion initiatives are another major strategy for reducing the presence of PSMI in the criminal justice system. Such programs offer treatment-based alternatives to criminal justice processing for PSMI who have come into contact with law enforcement agencies or the courts (Lattimore, Broner, Sherman, Frisman, & Shafer, 2003). Several types of diversion models are



operating in the United States, and they vary in their structures and procedures and function at different points in the criminal justice process (Boccaccini, Christy, Poythress, & Kershaw, 2005). Nevertheless, most serve PSMI at early stages in the process (at or following arrest, booking, or initial court appearance), and all are premised on the notion that PSMI should be handled through the mental health system, not the criminal justice system (Schneider, Bloom, & Heerema, 2007).

Post-booking jail diversion programs are intended to benefit both targeted participants and the systems they enter. Individuals who are so diverted are expected to gain greater access to immediate treatment and other interventions, leading to putative reductions in arrests, hospitalizations, and the ongoing need for services from the criminal justice and emergency mental health systems (Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2003; Naples & Steadman, 2003). Other community-based programs for PSMI include specialty probation and parole units as well as jail and prison re-entry programs (Sacks, Sacks, McKendrick, Banks, & Stommel, 2004; Skeem, et al., 2009).

Jails process nearly one million newly admitted detainees with serious mental illness each year (Naples & Steadman, 2003). In many cases, jails and prisons are the final stop on the “institutional circuit” that includes homeless shelters, psychiatric institutions, and substance abuse residences (Bernstein & Seltzer, 2004). Following initial screening and assessment, jails and prisons are mostly well-equipped to implement crisis intervention and suicide prevention—especially crucial services in jail settings—as well as psychiatric interventions at different levels of care: acute (in suicide prevention cells), in-patient (in specialized psychiatric units), and outpatient (in the general population). Although practice standards have been developed for these areas, the quality and level of mental health services still varies considerably in the nation’s jails and prisons (Human Rights Watch, 2003). Many correctional institutions modified their mental health care services only after litigation compelled them to do so (Lurigio & Snowden, 2008).

Major national efforts, such as the federally funded GAINS Center, the Criminal Justice/Mental Health Consensus Project, and the Council of State Government’s Justice Center have launched an ambitious research and service agenda and facilitated the sharing of evidence-based practices among different jurisdictions at the federal, state, and local levels. In addition, important federal legislation (e.g., the Law Enforcement Mental Health Project Act 2000 and the Mentally Ill Treatment and Crime Reduction Act of 2004) has created an impetus for more and better collaboration between the criminal and mental health systems and brought much-needed attention to PSMI in the criminal justice system.

The criminal justice system has competently managed to meet the challenge of handling PSMI at every stage in the process. The criminal justice and the mental health system are built on different foundations. They adhere to different philosophies, possess different capabilities, and satisfy different institutional imperatives. Even so, the former has done much of the work that was exclusively placed in the hands of the latter: providing mental health care for poor PSMI, who have a passel of other problems, such substance use disorders, homelessness, and unemployment.

### *Conclusions*

Serious mental illness is a disease that should be treated like any other disease in correctional institutions, which are compelled to deliver mental health care on legal (e.g., *Ruiz v. Estelle*) and moral grounds (Mears, 2004). Sophisticated technologies that visualize the living brain have revealed aberrations in brain structure and processing among PSMI; the differences establish the biological, and possibly the genetic, underpinnings of serious mental illness and might suggest effective breakthroughs in medical interventions (Kramer, 2009). For the reasons I discussed throughout this article, a disproportionate percentage of PSMI are processed through the criminal justice system and will continue to be as long as punitive crime and drug control policies remain in place.

The effective provision of mental health care is obligatory and should be the expectation of

care for PSMI in jails, prisons, and community corrections programs. In institutional settings, psychiatric medications should be prescribed along with other types of care in a safe, specialized environment to alleviate symptoms, not for the purpose of controlling the population with sedating drugs (Human Rights Watch, 2003). Budgets for psychiatric services and staffing should be increased to meet clinical needs, which will be consistently greater than those in the general population because of the shared demographic and illicit drug use profiles of PSMI and criminally involved people. Many studies suggest that mental health care is woefully underfunded in correctional institutions and fails to meet inmates' psychiatric needs (Human Rights Watch, 2003; James & Glaze, 2006). Such inadequacies leave in their wake much needless suffering among the most vulnerable members of the community.

[back to top](#)

## [References](#)

---

The articles and reviews that appear in *Federal Probation* express the points of view of the persons who wrote them and not necessarily the points of view of the agencies and organizations with which these persons are affiliated. Moreover, *Federal Probation's* publication of the articles and review is not to be taken as an endorsement of the material by the editors, the Administrative Office of the U.S. Courts, or the Federal Probation and Pretrial Services System.

Published by the Administrative Office of the United States Courts [www.uscourts.gov](http://www.uscourts.gov)  
[Publishing Information](#)

- Oser, C.B., Staton-Tindall, M., & Leukfeld, C.G. (2007). HIV testing in correctional agencies and community treatment programs: The impact of internal organizational structure. *Journal of Substance Abuse Treatment*, 32(3), 301-310.
- Pew Foundation. (2009). *One in 31: The Long Reach of American Corrections*. Philadelphia, PA: Pew Foundation. Retrieved from the Pew Foundation Web Site:  
[http://www.pewcenteronthestates.org/report\\_detail.aspx?id=49382](http://www.pewcenteronthestates.org/report_detail.aspx?id=49382)
- Rogers, E. M. (2003). *Diffusion of Innovations* (5th ed.). New York: Free Press.
- Schein, E.H. (2004). *Organizational Culture & Leadership* (3rd ed.), San Francisco: Jossey-Bass.
- Scott, S. G., & Bruce, R. A. (1994). Determinants of innovative behavior: A path model of individual innovation in the workplace. *The Academy of Management Journal*, 37, 580-607.
- Sholomskas, D.E., Syracuse-Siewert, G., Rounsaville, B.J., Ball, S.A., Nuro, K.F., & Carroll, K.M. (2005). Don't Train in Vain: A Dissemination Trial of Three Strategies of Training Clinicians in Cognitive-Behavioral Therapy. *Journal of Consulting and Clinical Psychology*, 73(1), 106-115.
- Taxman, F.S. (2008). "No Illusion, Offender and Organizational Change in Maryland's Proactive Community Supervision Model," *Criminology and Public Policy*, 7(2), 275-302.
- Taxman, F.S., Young, D.W., Tesluk, P., Mitchell, S., Rhodes, A.G., DeCelles, K., & Perdoni, M. (2007). National Criminal Justice Treatment Practices Survey: Organizational Measures Manual. Unpublished Manual.
- Tesluk, P. E., Farr, J. L., Mathieu, J. E., & Vance, R. J. (1995). Generalization of employee involvement training to the job setting: Individual and situational effects. *Personnel Psychology*, 48, 607-632.
- Young, D.W. (2009). Juvenile Assessment, Referral, Placement, and Treatment Planning Survey Items. Unpublished Manual.
- Zeffane, R. (1996). Dynamics of strategic change: critical issues in fostering positive organizational change. *Leadership & Organization Development Journal*, 17(7), 36-43.

### **Examining Prevailing Beliefs About People with Serious Mental Illness in the Criminal Justice System**

- Abramson, M.F. (1972). The criminalization of mentally disordered behavior: Possible side-effect of a new mental health law. *Hospital and Community Psychiatry*, 23, 101-107.
- Bazon Center for Mental Health Law. (2004). *The role of specialty mental health courts in meeting the needs of juvenile offenders*. Washington, DC: Judge David L. Bazon Center for Mental Health Law.
- Beck, A.J. (2000). *Prisoners in 1999*. Washington, DC: Bureau of Statistics.
- Bernstein, R., & Seltzer, T. (2004). *The role of mental health court in system reform*. Washington, DC: Bazon Center for Mental Health Law.
- Boccaccini, M.T., Christy, A., Poythress, N., & Kershaw, D. (2005). Recidivism in two post-booking jail

- diversion programs in Florida. *Psychiatric Services* 56, 835–839.
- Bonta, J., Law, M., & Hanson, C. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin*, 123, 123–142.
- Borzecki, M., & Wormith, J. (1985). The criminalization of psychiatrically ill people: A review with a Canadian perspective. *Psychiatric Journal of the University of Ottawa*, 10, 241-247.
- Bureau of Justice Statistics. (2002a). *Incarceration rate, 1980-2000*. Washington, DC: U.S. Department of Justice.
- Bureau of Justice Statistics. (2002b). *U.S. correctional population reaches 6.6 million*. (Advanced Press Release). Washington, DC: U.S. Department of Justice.
- Bureau of Justice Statistics. (2010). *U.S. correctional population: Midyear 2009*. (Advanced Press Release). Washington, DC: U.S. Department of Justice.
- Clear, T., Byrne, J., & Dvoskin, J. (1993). The transition from being an inmate: Discharge planning, parole and community-based services for offenders with mental illness. In H. J. Steadman & J.J. Cocozza (Eds.) *Mental Illness in America's prisons* (pp. 47-63). Seattle, Washington: National Coalition for the Mentally Ill in the Criminal Justice System.
- Cocozza, J.J., H.J. Steadman, & Melick, M.E. (1978). Trends in violent crime among ex-mental patients. *Criminology* 16:317–334.
- Compton, M.T., Bahora, M., Watson, A.C., & Oliva, J.R. (2008). A comprehensive review of extant research on Crisis Intervention Team (CIT) programs. *Journal of the American Academy of Psychiatry and the Law* 36: 47-58.
- Cosden, M., Ellens, J., Schnell, J., Yamini-Diouf, Y., & Wolfe, M. (2003). Evaluation of a mental health treatment court with assertive community treatment. *Behavioral Sciences and the Law*, 21, 415–427.
- Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project*. New York: Author.
- Ditton, P. (1999). *Mental health and treatment of inmates and probationers*. Bureau of Justice Statistics: *Special report*. Retrieved January 21, 2011 from <http://www.ojp.usdoj.gov/bjs/abstract/mhtip.htm>.
- Draine, J., Salzer, M.S., Culhane, D.P., & Hadley, T.R. (2002). Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services*, 53, 565-573.
- Eaton, W., & Muntaner C. (1999). Socioeconomic stratification and mental disorder. In: Horwitz A.V. & Scheid, T.L. (Eds.), *A handbook for the study of mental health: social contexts, theories and systems* (pp. 259–283). New York, NY: Cambridge University Press:

- Erickson, P.E., & Erickson, S. K. (2008). *Crime, punishment, and mental illness*. New Brunswick, New Jersey: Rutgers University Press.
- Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys. *Lancet*, 359, 545-550.
- Fersch, E.L. (2005). *Thinking about the insanity defense*. Lincoln, NE: iUniverse.
- Fichtner, C. G., & Cavanaugh, J. L. (2006). Malignant criminalization: From hypothesis to theory. *Psychiatric Services*, 57, 1511-1512.
- Fisher, W. H., Silver, E., & Wolff, N. (2006). Beyond criminalization: Toward a criminologically informed mental health policy and services research. *Administration and Policy in Mental Health and Mental Health Services Research*, 33, 544-557.
- Frank, R., & Glied, S. (2006). *Mental health policy in the United States since 1950: Better but not well*. Baltimore, MD: The Johns Hopkins University Press.
- Goldkamp, J., & Irons-Guynn, C. (2000). *Emerging judicial strategies for the mentally ill in the criminal caseload: Mental health courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage: A Report on community justice initiatives*. Philadelphia, PA: Crime and Justice Research Institute.
- Grob, G.N. (1991). *From asylum to community: Mental health policy in modern America*. Princeton, New Jersey: Princeton University Press.
- Harcourt, B.E. (2006). From the asylum to the prison: Rethinking the incarceration revolution. *Texas Law Review*, 84, 1751-1786.
- Harris, A., & Lurigio, A.J. (2007). The mentally ill as perpetrators of violence: A brief review of research and assessment strategies. *Aggression and Violent Behavior*, 12, 542-551.
- Hiday, V.A. (1997). Understanding the connection between mental illness and violence. *International Journal of Law & Psychiatry*, 20 (40); 399-417.
- Hudson, C.G. (2005). Socioeconomic status and mental illness: Tests of the social causation and selection hypotheses. *American Journal of Orthopsychiatry*, 75, 3-18.
- Human Rights Watch. (2003). *Ill equipped: U.S. prisons and offenders with mental illness*. New York: Author.
- James, D.J., & Glaze, L. E. (2006). *Mental health problems of prison and jail*. Washington DC: U.S. Department of Justice, Government Printing Office.
- Jemelka, R., Trupin, E.W., & Chiles J.A. (1989). The mentally ill in prisons: A review. *Hospital and Community Psychiatry* 40, 481-490.
- Junginger, J., Claypoole, K., Laygo, R., & Crisanti, A. (2006). Effects of serious mental illness and substance abuse on criminal offenses. *Psychiatric Services*, 57, 879-882.
- Justice Center, Council of State Governments. (2011). *Mental Health Courts*. Available at [consensusproject.org/issue\\_areas/mental-health-courts](http://consensusproject.org/issue_areas/mental-health-courts). Date accessed 5 February 2011.
- Kramer, P.D. (2009). *Against depression*. New York: Viking.

- Lamb, H.R., & Weinberger, L.E. (1998). Persons with severe mental illness in jails and prisons: A review. *Psychiatric Services* 49, 483-492.
- Lamb, H.R., & Weinberger, L.E. (2005). The shift of psychiatric inpatient care from hospitals to jails and prisons. *Journal of the American Academy of Psychiatry and the Law*, 33, 529-534.
- Lamberti, J.S. (2007). Understating and preventing criminal recidivism among adults with psychotic disorders. *Psychiatric Services*, 58, 773-781.
- Lattimore, P.K., Broner, N., Sherman, R., Frisman, L., & Shafer, M. (2003). A comparison of prebooking and postbooking diversion programs for mentally ill substance-using individuals with justice involvement. *Journal of Contemporary Criminal Justice*, 19, 30-64.
- Lurigio, A. J. (2004). *Transinstitutionalization and the mentally ill in the criminal justice system*. Lecture presented at the Corrections and Public Health Task Force Steering Committee Meeting. Cook County Department of Corrections, Chicago, IL.
- Lurigio, A. J., & Lewis, D. A. (1987, October). *Toward a taxonomy of criminal mental patients*. Evanston, IL: Center for Urban Affairs and Policy Research, Northwestern University.
- Lurigio, A. J., & Rodriguez, P. (2004, April). *A court system's approach to responding to the mentally ill*. Paper presented at the annual Mental Health in Corrections Consortium, Kansas City, MO.
- Lurigio, A. J., & Snowden, J. (2008). The impact of prison culture on the treatment and control of mentally ill offenders. In J. Byrne, Hummer, D., & Taxman, F.S. (Eds.), *Prison violence, prison culture, and offender change* (pp. 164-179). Upper Saddle River, NJ: Allyn and Bacon.
- Lurigio, A.J., Snowden, J., & Watson, A. (2006). Police handling of the mentally ill: Historical and research perspectives. *Law Enforcement Executive Forum*, 6, 87-110.
- Lurigio, A. J., & Swartz, J. A. (2000). Changing the contours of the criminal justice system to meet the needs of persons with serious mental illness. In J. Horney (Ed.), *NIJ 2000 Series: Policies, processes, and decisions of the criminal justice system* (Volume 3) (pp. 45-108). Washington, DC: National Institute of Justice.
- Mears, D.P. (2004). Mental health needs and services in the criminal justice system. *Journal of Health Law and Policy*, 4, 255-284.
- Memphis Crisis Intervention Team. n.d. *Crisis Intervention Team*. Available at <http://cit.memphis.edu> (date accessed 18 January 2011).
- Monahan, J., & Steadman, H. (1983). Crime and mental disorder: An epidemiological approach. In N. Morris and M. Tonry (Eds.), *Crime and justice: An annual review of research* (pp.145-190). Chicago: University of Chicago Press.
- Naples M., & Steadman H.J. (2003). Can persons with co-occurring disorders and violent charges be successfully diverted? *International Journal of Forensic Mental Health Services* 2, 137-143.

- Palermo, G.B., Smith, M.B. & Liska, F.J. (1991). Jail versus mental hospitals: A social dilemma. *International Journal of Offender Therapy and Comparative Criminology* 35, 97–106.
- Penrose, L. (1939). Mental disease and crime: Outline of a comparative study of European statistics. *British Journal of Medical Psychology*, 18, 1–15.
- Peterson, J., Skeem, J., Hart, E., & Vidal, S. (2009). *Analyzing offense patterns as a function of mental illness to test the criminalization hypothesis*. Unpublished manuscript under review.
- Pinta, E. (1999). The prevalence of serious mental disorders among U.S. prisoners. *Correctional Mental Health Report* 1, 44-47.
- Rotter, M., Larkin S., Schare M., et al. (1999). *The clinical impact of doing time: Mental illness and incarceration*. Albany, NY: Research Foundation for Mental Hygiene.
- Sacks, S., Sacks, J., McKendrick, K., Banks, S., & Stommel, J. (2004). Modified therapeutic community for MICA offenders: Crime outcomes. *Behavioral Sciences and the Law*, 22, 477–501.
- Schneider R..D., Bloom, H., Heerema, M. (2007). *Mental health courts: Decriminalizing the mentally ill*. Toronto: Irwin Law.
- Shadish, W.R. (1989). Private sector care for chronically mentally ill individuals: The more things change, the more they stay the same. *American Psychologist* 44, 1142–1147.
- Sharfstein, S. (2000). Whatever happened to community mental health? *Psychiatric Services*, 51, 616-620.
- Silver E., Mulvey E.P., & Swanson J.W. (2001). Neighborhood structural characteristics and mental disorder: Faris and Dunham revisited. *Social Science and Medicine*, 55, 1457-70.
- Skeem, J., Eno Loudon, J., Manchak, S., Vidal, S., & Haddad, E. (2008). Social networks and social control of probationers with co-occurring mental and substance abuse problems. *Law and Human Behavior*, 33, 122–135.
- Skeem, J., Manchak, S., Vidal, S., & Hart, E. (2009, March). *Probationers with mental disorder: What (really) works?* Paper presented at the American Psychology and Law Society (AP-LS) Annual Conference, San Antonio, TX.
- Steadman, H., Dupuis, S., & Morris, L. (2009, March). *For whom does jail diversion work? Results of a multi-site longitudinal study*. Paper presented at the annual conference of the American Psychology-Law Society, San Antonio, TX.
- Steadman, H.J., Monahan J., Duffee B., Hartstone E., & Robbins P.C. (1984). The impact of State mental hospital deinstitutionalization on United States prison populations, 1968–1978. *Journal of Criminal Law and Criminology*, 75, 474–490.
- Swanson, J., Estroff, S., Swartz, M., Borum, R., Lachicotte, W., Zimmer, C., & Wagner, R. (1997). Violence and severe mental disorder in clinical and community populations: The effects of psychotic symptoms, comorbidity, and lack of treatment. *Psychiatry*, 60, 1-22.
- Swartz, J. A., & Lurigio, A. J. (1999). Psychiatric illness and comorbidity among adult male jail detainees in drug treatment. *Psychiatric Services*, 50, 1628-1630.

- Swartz, M. S., Swanson, J. W., Hiday, V. A., Borum, R., Wagner, R., & Burns, B. J. (1998). Violence and severe mental illness: The effects of substance abuse and nonadherence to medication. *American Journal of Psychiatry*, *155*, 226-231.
- Teplin, L. (1983). The criminalization of the mentally ill: Speculation in search of data. *Psychological Bulletin*, *94*, 54-67.
- Teplin, L. A. (1990). Detecting disorder: The treatment of mental illness among jail detainees. *Journal of Consulting and Clinical Psychology*, *58*, 233-236.
- Teplin, L. A. (1991). The criminalization hypothesis: Myth, misnomer or management strategy. In S. Shah & B. Sales (Eds.), *Law and mental health: Major developments and research needs* (pp. 151-183). Washington, DC: U.S. Government Printing Office.
- Teplin, L. (2000). Keeping the peace: Police discretion and mentally ill persons. *National Institute of Justice Journal*, July, 8-15.
- Teplin, L., & Pruett, N. (1992) Police as street corner psychiatrist: managing the mentally ill. *International Journal of Law and Psychiatry*, *15*, 139-156.
- Teplin, L.A., & Voit, E.S. (1996). Criminalizing the seriously mentally ill: Putting the problem in perspective. In B.D. Sales and S.A. Shah (Eds,) *Mental health and law: Research, policy, and services* (pp. 283-310). Durham, North Carolina: Carolina Academic Press.
- Thigpen, M.L., Hunter, S.M., Ortiz, M. (2001). *Provision of mental health care in prisons*. Washington, DC: National Institute of Corrections.
- Tonry, M. (1995). *Malign neglect: Race, crime, and punishment in America*. New York: Oxford University Press.
- Tonry, M. (1999). Why are incarceration rates so high? *Overcrowded Times*, *10*, 3-6.
- Torrey, E. F., Stieber, J., Ezekiel, J., Wolfe, S. M., Sharfstein, J., Noble, J. H., Flynn, L.M. (1992). *Criminalizing the seriously mentally ill*. Washington, DC: National Alliance for the Mentally Ill and Public Citizen Health Research.
- U.S. Surgeon General. (1999) *Mental health: A report of the Surgeon General*. Washington, DC: U.S. Department of Health and Human Services.
- Veysey, B., & Bichler-Robertson, G. (2002). Prevalence estimates of psychiatric disorders in correctional settings. In *Health status of soon-to-be-released inmates: A Report to Congress*, *2*, 57-80. Chicago: National Commission on Correctional Health Care.
- Walmsley, Roy (2006/2009). *World prison population list (5th/8th edition)*. London: School of Law, King's College International Centre for Prison Studies.
- Watson, A., Hanrahan, P., Luchins, D., & Lurigio, A.J. (2001). Paths to jail among mentally ill persons: Service needs and service characteristics. *Psychiatric Annals*, *31*, 421-429.
- Whitmer, C. (1980). From hospitals to jails: The fate of California's deinstitutionalized mentally ill. *American Journal of Ortho-psychiatry*, *50*, 65-75.