Central East (HHS Region 3)
MHTTC Mental Health Technology Transfer Center Network
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Mental Illness and Involvement with Criminal Justice

This brief is the first in a series intended to familiarize behavioral health professionals with issues and interventions for individuals with serious mental illness at different points of contact with the criminal justice system. A second brief offers a closer look at clinical and programmatic approaches responsive to the needs of justice-involved individuals with serious mental illness.

Overview

Mental health has increasingly become a common concern for public health and public safety stakeholders, spawning innovative collaborations between behavioral health and criminal justice systems.[i] People with serious mental illness (SMI), particularly those who also have drug and alcohol problems, are more likely to become involved with the criminal justice system than the general population. They are also far more vulnerable to the negative consequences that often result. It is estimated that 10 times as many individuals who have a mental illness were confined in jails and prisons in 2014 than in state psychiatric hospitals across the country, putting them at high risk for victimization by other inmates, interruption of beneficial treatments and medications, and death in custody—largely due to suicide.[ii] Yet, people with SMI remain overrepresented at every point across the criminal justice system.

Population	
Police contacts involving individuals with mental illness [iii]	**10-40%**
Annual jail admissions with SMI (males) [iv]	**15%**
Annual jail admissions with SMI (females) [iv]	**30%**
Jail inmates who had ever been told by a mental health professional they had a mental disorder [v]	**44%**
Prison inmates who had ever been told by a mental health professional they had a mental disorder [v]	**37%**
Prison inmates with current SMI symptoms who spent time in solitary confinement [vi]	**29%**
People in jails with symptoms of a psychotic disorder [vii]	**24%**
People with SMI incarcerated in their lifetime [viii]	**40%**
People with SMI plus a co-occurring substance use disorder (SUD) incarcerated in their lifetime [viii]	**60%**

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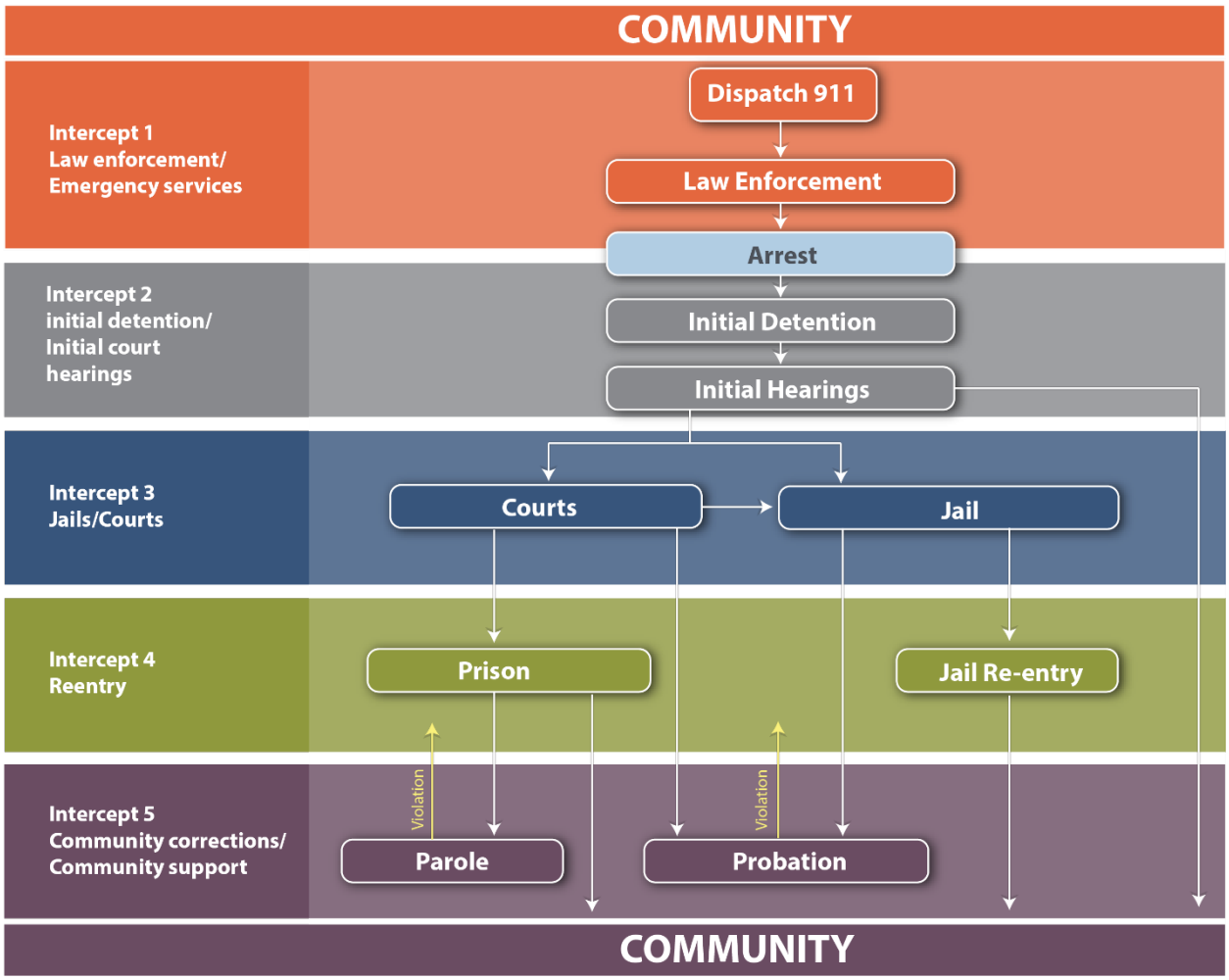
A Framework for Collaboration

In planning collaborative initiatives to reduce the numbers of individuals with SMI who are incarcerated or repeatedly return to custody, criminal justice and behavioral health partnerships in states and local jurisdictions have found the Sequential Intercept Model (SIM) useful. The SIM (depicted in Figure A) identifies each point along the justice system continuum where interventions on behalf of people with mental illness can effectively achieve these reductions. It has been applied to planning across all points of criminal justice contact—from ensuring that fewer law enforcement contacts result in arrest (Intercept 1) to reducing recidivism by increasing access to services and supports essential to success in the community upon release (Intercept 5).

Figure A. Source: GAINS Center—Mapping Intervention Points Across the Criminal Justice System



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Intercept 1: Contact with Law Enforcement/Arrest

Why do police encounters with people with SMI often result in arrest?
• Law enforcement may not be trained to recognize and respond to symptoms of SMI. • Police may perceive mental disorder symptoms as noncompliant or disruptive behavior. • Contact with law enforcement may trigger defensive responses among people with SMI that can escalate quickly. • Those with co-occurring SUDs may be intoxicated or in possession of illegal drugs.

Research suggests the proportion of arrestees with any type of mental illness is more than three times as high as that of arrestees without a mental disorder. Studies show 17–34 percent of arrestees processed in the United States report a recent history of mental health intervention; however, post-arrest mental health screenings identify many more with undiagnosed mental disorders, suggesting the total proportion of arrestees with current symptoms or some past mental disorder history may be as high as 60 percent.[ix]

Law enforcement and behavioral health leadership generally agree that processing individuals with SMI who represent a minimal risk to public safety can create more problems than it solves. An increasing number of jurisdictions have implemented effective collaborative approaches that curtail unnecessary arrests and detention of low-level offenders with SMI.

CIT and LEAD: Effective approaches to reducing arrests of people with mental illness	
Crisis intervention training (CIT) consists of at least 40 hours of hands-on, scenario-based training that prepares officers to recognize symptoms of mental disorders and apply de-escalation techniques and other responsive approaches effective for people with SMI. In smaller jurisdictions, all front-line officers may be trained, while larger jurisdictions may have specialized CIT teams that respond to calls involving people with mental disorders.	**Law enforcement–assisted diversion (LEAD)** directly connects people in crisis who pose minimal threat to public safety with mental health services in lieu of arrest. Police collaborate with mental health agencies to familiarize officers with community resources, giving them the option to transport individuals to services instead of arresting them. LEAD has been implemented in response to overdose events, suicide threats or attempts, and other types of mental health crises.

Intercept 2: Pre-trial Diversion—Booking, Initial Detention, Arraignment

When individuals are arrested, they are charged and then booked into local jails or lockups until they appear before a magistrate. At their first appearance (arraignment), the court determines if they will be released on their own recognizance, if they will remain in custody until their court date (pre-trial detention), or if an amount of cash surety (bail) must be posted to secure their return for trial. Since many individuals with SMI cannot afford to post bail, they are likely to remain in jail until trial.

Interventions that occur after arrest but prior to initial jail detention (pre-booking) offer an opportunity to avoid complications that arise when people with SMI are booked into jails. For example, post-booking diversion programs can reduce the amount of time people with SMI spend in jail awaiting trial or transfer to a mental health facility. Screening for mental disorders

at intake can identify candidates for specialized mental health jail diversion or pre-trial supervision programs. Outreach efforts may also take place in jails prior to arraignment, with a recommendation to the presiding judge to make program participation a condition of release.

Why is it important to divert arrestees with SMI before they are booked into jails?

- People with SMI who have not been convicted of a crime but can't afford bail often await trial in jail for several months.
- Pre-trial detention can result in loss of medical benefits or housing and cause overwhelming difficulties upon release.
- Incarceration disrupts medication and other treatments, cuts off access to recovery support, and destabilizes individuals.
- Suicide is the leading cause of death in jails; risks are particularly high for individuals in custody with SMI.
- Jails are seldom equipped to offer the full range of services available in the community.

Intercept 3: Courts, Jails, or Prisons

Specialty Courts

Many courts have specialized dockets for defendants with SMI and co-occurring SUDs that allow plea agreements to include participation in mental health court programs. Therapeutic jurisprudence or problem-solving courts generally involve partnerships between behavioral health service providers, probation, and the court. Defendants usually enter a guilty plea with the stipulation that the conviction will be expunged upon successful program completion. Some jurisdictions require a conviction but defer or suspend sentences to allow individuals an opportunity to successfully complete the program and avoid jail or prison time. These approaches fall into the category of post-trial diversion.

Probation

Probation is another sentencing option that courts may use for people with SMI. Individuals sentenced to a period of probation remain in the community if they agree to comply with the conditions of release set forth by the judge at sentencing. Probation officers (POs) provide supervision to support the individuals and monitor compliance. Smaller, specialized caseloads assigned to POs with mental health training allow additional time to work with probationers with SMI on accessing supports and adequate levels of ongoing care. Probation often works in conjunction with community mental health providers, using a team approach that can include case managers, peer support specialists, social workers, and clinicians.

Custody

Many individuals in custody with SMI have committed low-level offenses that generally do not call for jail time. They are sentenced to probation but often end up in custody when they fail to meet the conditions of release. Lacking additional community services and supports, they may test positive for substances, fail to report to probation at assigned intervals, or fail to attend programs that are part of the conditions of their release. When repeated violations result in revocation and they are taken into custody, additional difficulties can arise.

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How does incarceration unduly impact people with SMI and co-occurring disorders?

- Individuals with SMI are more vulnerable to sexual or violent victimization by other inmates.
- When symptoms of mental illness and trauma interfere with adherence to rules, people with SMI are sanctioned.
- Punitive sanctions often include administrative segregation (solitary confinement) or, in some cases, restraint.
- These sanctions can increase suicidal ideation and lead to more infractions due to trauma-related symptoms.
- Time may be added to sentences as a disciplinary sanction for repeated rule violations.
- The overall result is that individuals with SMI and co-occurring disorders have significantly longer stays in custody compared to those without either disorder who are sentenced for similar crimes.[x]

Jails, detention centers, and prisons are mandated by law to provide care to inmates for serious medical conditions, including mental disorders, on par with what they would receive in the community.[1] This legal mandate does not apply to treatment for SUDs. An estimated 75 percent of the incarcerated population has a SUD, yet only 1 out of 10 inmates receives treatment in custody. Studies also indicate that 74 percent of people in prisons who use drugs and alcohol also report a mental health issue.[xi] Co-occurring disorders are the rule rather than the exception.Professional standards set by jail and prison associations call for screening, assessment, and appropriate care for inmates and detainees with mental illness (see Figure B). Many—but not all—local jails screen for mental disorders and provide care; however, quality and comprehensiveness of services vary widely. Prison systems are better positioned to provide adequate mental health services, in part due to longer durations in custody and more predictable release dates. Approximately 80 percent of state prison facilities screen for mental disorders at intake.[xii]

Correctional mental health standards of care

Upon intake to a secure facility, National Commission on Correctional Health Care standards call for:

- Mental health screening within 2 hours and assessment follow-up within 14 days
- A mental health examination that includes an evaluation of suicide risk
- Information within 24 hours on mental health services available and how to access them
- Health appraisals within 7 days that include history of mental health issues, suicide attempts, hospitalizations, substance use, and psychiatric medications
- Interventions and stabilization of symptoms for acute psychiatric events or suicide attempts
- Privacy and confidentiality regarding diagnosis and treatment

National Commission on Correctional Health Care. (2016). *New position statement on substance use disorder treatment.* http://www.ncchc.org/substance-use-disorder-treatment-position-statement

Figure B.

Custody environments often trigger symptoms of mental disorders, and withdrawal from substances can exacerbate their severity.[xiii] Repeating assessments once individuals have adjusted to the custody environment can provide a more accurate picture of current symptoms. Minimally, assessments should be repeated prior to release and any time behavior suggests the possibility of a mental disorder.[xiv]

[1] **429 U.S. 97, Estelle v. Gamble (No. 75-929), Argued: October 5, 1976, Decided: November 30, 1976**
This Supreme Court decision established the right to health care for prisoners.

Intercept 4: Reentry

Reentry challenges for people with SMI and co-occurring SUDs

Once released from custody, people with SMI are:

- More likely to be homeless, to become suicidal, and return to substance use
- More likely to be rearrested or returned to custody due to parole violations

Those with co-occurring SUDs:

- Have even higher rates of recidivism
- Are less likely to adhere to treatment [xv]

Reentering individuals with SMI require specialized transitional mental health case management and strong pre-release linkages to community-based care in order to succeed. Effective approaches include transitional case management that allows individuals to begin pre-release meetings with a mental health case manager who will continue to work with them in the community after release. Resources for medication management and other psychiatric services that are essential to ongoing recovery must be in place prior to release. Securing benefits to sustain treatment participation is crucial, along with "warm handoffs"—more than a referral phone number and address—to community providers. People with co-occurring disorders can benefit from mental health peer support as well as addiction recovery peer support, or they may have a decided preference for one or the other. Developing social connectedness and pro-social contacts is as important to reentry success as clinical care.

Intercept 5: Community Supervision and Support

Like individuals diverted from jail and supervised in the community, individuals with SMI who are reentering the community from incarceration benefit from specialized community services and supports. They may be assigned to experienced probation or parole officers responsible for smaller caseloads who have specific mental health and substance abuse training. This allows more time to monitor medication compliance, administer random drug screenings, and ensure access to adequate community-based care. Mental health agencies may work with parole and probation by placing peer recovery specialists, case managers, or social workers in local offices to conduct groups and meet regularly with individual parolees and probationers.

In some cases, individuals serve their entire sentence and are released without probation or parole supervision in the community. Pre-release planning can be a challenge if individuals have significant behavioral health needs. Continuity of care is a priority; many correctional facilities provide supplies of "gap" medications upon release until individuals are under the care of a prescriber in the community. Pre-release planning for individuals with SMI who have served their maximum sentence involves locating mental health programs that offer day treatment, low-intensity residential care, or housing programs combined with intensive outpatient services.

Reentering individuals with SMI may also benefit from Housing First and supported employment programs, a recovery community and other activities to expand their network of social support, and ongoing integrated care for co-occurring disorders.

Ensuring adequate reentry support: The Mentally Ill Offender Community Transition Program

Established by the Washington State Legislature for individuals with SMI who are approaching release, the Mentally Ill Offender Community Transition Program consists of the following:

- Pre-release planning (assessment, treatment planning, and benefit enrollment) to begin at least 90 days prior to release
- Intensive case management, individual and group counseling, and transitional housing available immediately upon release
- A single multidisciplinary support team: case manager, psychiatrist, nurse, addiction counselor, community corrections officer, and residential house manager
- Structured programming, frequent contact, bimonthly home visits, and 24/7 crisis response
- Structured goals for avoiding further criminal activity and abstaining from illicit drug use

Conclusion

At every point across the criminal justice system continuum—from initial contact with law enforcement to reentry into the community after a period in custody—behavioral health and criminal justice partnerships play a crucial role in improving the outlook for people with SMI. The second in this series of briefs will offer a deeper look at promising programs, clinical issues, and best practices.

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