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Criminal justice and the mentally ill: New remedies for a vexing problem

By Ted Gest

The Challenge

Responding to individuals with mental illness is one of the criminal justice system's most difficult dilemmas. Someone who is acting oddly may prove to be a grave danger to others or merely a harmless person in need of routine treatment. Public concern is greatest about potentially life-threatening incidents, rare as they are. Last month, two sheriff's deputies in Prince George's County, Md., were shot to death after they were called to the home of a 24-year-old man who had been behaving erratically and, three days earlier, had been diagnosed with paranoid schizophrenia. That episode remains under investigation, but overall, many police, judicial and correctional officers are not well trained to deal with people who exhibit mental illness. Even those with adequate preparation frequently have trouble convincing mental health treatment providers to accept referrals promptly and to provide effective services.

Background

Since the 1950s, the emphasis in American mental health treatment has shifted from institutionalization to community-based care. This means that hundreds of thousands of people who once might have been hospitalized now receive treatment on an out-patient basis, if at all. This involves a small proportion of U.S. residents: about five percent of the population suffers from serious mental illnesses, and only a small fraction of them commit violent crimes. Yet from a justice system standpoint, the problem looms larger. About 16 percent of prison and jail inmates report a mental illness or having stayed overnight in a mental hospital, says the U.S. Bureau of Justice Statistics. Over the course of a year, about 700,000 inmates with serious mental illnesses are booked into local jails, the majority for non-violent offenses; three fourths of them also have co-occurring substance abuse problems. Among the mentally ill inmates sentenced to state prisons, about 53% committed a violent offense compared with 46% of other inmates. This does not mean that most people with mental illness are prone to violence, but distinguishing among the dangerous and the harmless during a tense situation may be impossible.

One of the first places to address the issue with a major initiative was Memphis, where in 1987 police responded to a call and found a young man with a history of mental problems threatening to commit suicide with a knife. Officers told him to drop the weapon; when he ran, they shot him to death. The police department had already included 4½ hours of training for officers who intervened with persons with mental illness. Consultation with the National Alliance for the Mentally Ill and others convinced officials that they needed more (more training and better linkages with the mental health system). So they devised a Crisis Intervention Team (CIT)

approach for such cases. The Memphis model since has been adopted by other jurisdictions, including Montgomery County, Md.

Highlighting Innovation

Until recently, no systematic effort had addressed the problem nationally. In 1999, the Council of State Governments set up a partnership with six organizations to form a Criminal Justice/Mental Health Consensus Project, whose report was issued in June 2002. After hearing from more than 100 policymakers, clinicians, and consumers, the project made 46 policy statements, including a call for localities to do “community audits” that bring criminal justice agencies and health service providers together to assess each other’s needs, available services and limitations. The report recommends changes across the justice system, starting with police response to service calls, and continuing through jail intake of suspects, prosecutors’ review of cases, decisions on pretrial releases, sentences, and releases from incarceration. It covers ways to improve training and lists elements of an effective mental health system that responds quickly and effectively to serious cases. No single change can cover all potential ramifications, but among the most visible innovations are teams that try to de-escalate incidents before they turn deadly, send subjects to treatment when appropriate, and carefully screen incoming jail inmates for signs of suicide.

How do crisis intervention teams and screening programs work?

Localities use different approaches, but the essential idea of crisis intervention is for highly trained police officers and healthcare providers to respond promptly to calls for help. Memphis, for example, requires instruction for nearly 10 times as long as previously (40 hours). The sessions include scenarios based on actual incidents and interactions with family members. To make sure teams are available at all hours, more than 15 percent of patrol officers need to take part. Trainers stress ways that officers can affect the behavior of the person being sought without using force. Montgomery County, Md., also requires 40 hours of training for officers who volunteer to take it. Among case types discussed are disoriented people who yell at passing motorists, calls from families reporting mentally ill relatives, and severely depressed people who do not exhibit suicidal tendencies. Officers do part of their training with voices screaming into a headset, to simulate what some mental patients experience.

Montgomery County also operates a “pre-booking diversion” program that attempts to keep mentally ill people who commit minor, non-violent offenses out of the justice system. On recommendation from a Crisis Intervention Team officer, “mobile crisis” teams assess whether subjects are suitable for mental treatment—typically, people with “mood” or “thought” disorders; if so, the mobile crisis team takes over the case. Still, many ill people end up in jails, which Montgomery County corrections director Arthur Wallenstein says have “increasingly become a human service provider of last resort.” In Montgomery County, detained inmates are screened at three separate points of intake for suicidal tendencies. The jail includes a “clinical assessment and triage services” unit that assesses inmates for possible diversion into community facilities. The county also provides a list of detainees to local mental health providers, who then can engage the inmate and frequently obtain consent to release of information useful to correctional authorities. Maryland operates a Community Criminal Justice Treatment Program that provides shelter and treatment to mentally ill offenders. In 2000, only about 6 percent of participants returned to detention centers, hospitals or the streets.

The state of play

The Criminal Justice/Mental Health Consensus lists dozens of jurisdictions and private agencies that have started programs to deal with some aspect of the crime-mental illness problem. Several places have instituted variations on the crisis intervention team model. The Long Beach, Ca., Police Department, for example, created Mental Evaluation Team units with a police officer and a clinician who respond to calls. Others concentrate more on the judicial process. A Community Support Program in Milwaukee operates a small clinic that provides community-based services to defendants or offenders with mental illness for whom detention or incarceration is deemed unnecessary. Broward County, Fla., and a number of other jurisdictions have set up Mental Health Courts that may offer defendants the opportunity for community-based treatment under court supervision. At the other end of the justice system, New York State started a Parole Support and Treatment Program that works with parolees to ensure that they receive help in housing arrangements that come with varying levels of staff support. No jurisdiction has yet set up a system that the Consensus Project would deem comprehensive.

Do criminal justice-mental health reforms make a difference?

While there is no one model suitable for all localities, places with crisis intervention teams do report improvements on a number of fronts. Memphis says its teams have responded quickly to calls, most within five minutes. Use of crisis-intervention units has reduced the need for more elaborate and costly units like Special Weapons and Tactics (SWAT) teams. After Albuquerque adopted a CIT model in 1999, the use of SWAT resources dropped 58 percent. Albuquerque found that in nearly half of CIT calls, subjects were taken to mental health facilities; fewer than 10 percent of calls resulted in jailings. The number of Memphis officers injured in calls that involve mental illness has declined by nearly 40 percent. In addition, officers now must spend an average of only 15 minutes waiting for subjects to be admitted to mental health care, compared with 4 to 6 hour waits in the past. Florence, Ala., started a fast track system to do medical assessments at a hospital emergency room within 30 minutes of arrival.

What is the federal government's role?

The Criminal Justice/Mental Health Consensus Project was highlighted in a Senate Judiciary Committee hearing on June 11, 2002. As a follow-up, legislation is being drafted that would create a federal grant program to be administered by the Justice Department and HHS. Details are being worked out, but the measure would help localities set up programs that aid people in contact with the criminal justice system who need mental health care, substance abuse treatment, and other services. The Bureau of Justice Assistance, a Justice Department agency, already has a program to help states and localities set up "mental health courts" that would assign experienced judges and staff members to deal with cases that involve mental illness. SAMHSA, a division of HHS, awards grants for jail diversion involving mental health issues. The criminal-justice mental health nexus also is one of the subjects being considered by a Freedom Commission on Mental Health that was created by President George W. Bush in April.

Concerns and future directions

Because there is no simple organizational structure that will fit every jurisdiction, communities must recognize that extraordinary cooperation across government and private agency lines is required for reforms to succeed. Even if criminal justice agencies reorganize to handle calls with mental health implications efficiently, treatment providers must also agree to take referrals more

seriously. Another problem is that even if governmental and private systems operate properly, there may be no way to force some subjects into treatment. As is true of other criminal justice reforms, many jurisdictions need to be convinced that crisis intervention teams and other improvements will be cost-effective before they make the necessary investments to beef up law enforcement training and mental health systems. The Consensus Project argues that funding reforms on the front end will save costs down the line. It notes that a study in King County, Washington found that the repeated jailing, hospitalization, release, and re-admission of just 20 individuals over one year cost taxpayers \$1.1 million. The county started a mental health court that provided defendants more treatment and incurred fewer justice system costs.

The Consensus Project plans to start an area on its web site (www.consensusproject.org) for those interested in exchanging information about plans in their regions to address the problem. The project also will provide technical assistance to interested agencies.

To Learn More: Available Resources

- Criminal Justice/Mental Health Consensus Project report accessible at www.consensusproject.org, or from the Council of State Governments, 233 Broadway, 22nd Floor, New York, N.Y. 10279, 212-912-0128.
- Collaborating organizations on the Consensus Project: Association of State Correctional Administrators, Middletown, Ct.; Bazelon Center for Mental Health Law, Washington, D.C.; Center for Behavioral Health, Justice & Public Policy, Baltimore, Md.; National Association of State Mental Health Program Directors, Alexandria, Va.; Police Executive Research Forum, Washington, D.C.; Pretrial Services Resource Center, Washington, D.C.
- “Mental Health and Treatment of Inmates and Probationers,” U.S. Bureau of Justice Statistics, Special Report, July 1999, NCJ 174463 (accessible through www.ojp.usdoj.gov/bjs).
- “Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage.” U.S. Justice Department, Bureau of Justice Assistance, April 2000, NCJ 182504. Accessible from the National Criminal Justice Reference Service, www.ncjrs.org.
- “Police Response to Mental Health Emergencies—Barriers to Change,” Randolph Dupont and Sam Cochran, *The Journal of the American Academy of Psychiatry and the Law*, Vol. 28, No. 3, 2000.

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