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Mental Health On Trial: An In-Depth Look At The Criminalization of Mental Illness In The United States Criminal Justice System

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Mental Health On Trial: An In-Depth Look At The Criminalization of Mental Illness In The
United States Criminal Justice System

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by

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ABSTRACT

The criminal justice system was created to identify, incarcerate, and rehabilitate men and women that have broken the law. However, over two million people with mental illnesses are placed into jails every year. The lack of proper psychological evaluation and diagnosis coupled with misunderstood evidence and economic hardship has produced a system that treats these men and women as criminals rather than someone suffering from an illness. When an individual with mental health issues comes into contact with the criminal justice system they are often improperly evaluated by first responders, wrongfully convicted, and inappropriately sentenced. The lack of proper psychological evaluation and diagnosis, coupled with misunderstood evidence and economic hardship, has produced a system that treats these men and women as criminals rather than individuals suffering from illness. The criminal justice systems, and its designated officials, are typically undereducated in the implications and cognitive processes of someone who has a mental illness. They are not trained to understand that, due to a medical condition, the "criminal" may have an altered perception of rules and social norms that does not fit within the typical guidelines of the system. This study explores the impact of this system on mentally ill offenders, the interpretation by both the defendant and the prosecution of the crimes committed, and the decisions behind sentencing the individual. It will look at how, if convicted, the penal system treats the mentally ill population and how/why recidivism rates are so high for these offenders. Due to gaps in knowledge on the part of those involved in the prosecution and possible conviction of said offenders, they frequently do not receive proper representation and treatment. If convicted, many of these individuals are seldom provided mental health care evaluations and are isolated from both staff and other prisoners, which causes them to become more distressed and symptomatic within the system.

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1. INTRODUCTION

The criminal justice system was designed to bring the guilty to justice through punishment and incarceration. The process attempts to identify, incarcerate, and rehabilitate men and women who have broken the law. Many of the methods used by the criminal justice system can be effective in helping offenders recreate their life, build skills, and function in society. However, some individuals actually become more unhealthy within the system and find it difficult or impossible to abide by the strict regimen. People with mental illness who come into contact with the criminal justice system are frequently misunderstood by first responders, wrongfully convicted, and inappropriately sentenced. Men and women with mental illness are often categorized and punished as criminals, rather than being treated as individuals suffering from an illness. Often times the person with mental illness does not understand the social standards or the implications of the act or crime that they committed, and many times don't even realize that they have broken the law.

There are many problematic issues with regards to using the criminal justice system as the primary place to manage the mentally ill population. First, is the conviction itself. According to Steven Leifman, Associate Administrative Judge for the Eleventh Judicial Circuit of Florida, "Most members of the Judiciary are inadequately trained or unqualified to respond to the unique needs of people with serious mental illness involved in the criminal justice system… they [people with mental illness] receive 'uneven justice'" (Committee on Psychiatry and the Community, 2016, xii). Justice is considered uneven when retribution is unequal to the original crime or when the crime of a population being convicted is not understood by the person sentencing them. Mentally ill offenders are usually arrested on non-violent misdemeanor charges. When a mentally ill person is arrested, they are less likely to make bail, more likely to

spend longer periods of time in jail awaiting their trial and tend to suffer from higher recidivism rates upon release. "A 2012 analysis by the council of state governments found that in New York City, people with mental illness stayed in jail on average almost twice as long as people without mental illness (112 days versus 69 days). Part of that is bail: only about 12 percent of defendants with mental illness were able to make bail compared with about 21 percent of those without mental illness" (Roth, 2018, 262). Typically, while awaiting trial, the person has to go off of medication, which further disturbs their behavior and disrupts the trial process.

If bail is made, during their release, coordinating time and dates is a difficult task for most people with mental illness. Because of this, they tend to miss many court dates and appointments, leading to further legal issues. Without follow up care and support, maintaining daily responsibilities and staying on medication becomes a difficult, and sometimes impossible, task. When they do not show up in court or follow up in community clinics, the person is marked as "lost to follow up" (Committee on Psychiatry and the Community, 2016). The mentally ill population needs additional support to prevent this from happening. Their mind frame can shift often and become fragile at the slightest trigger and without people there to support, encourage, and keep them on track, they quickly become lost. When they finally do reappear, they seem noncompliant and have backslid several steps from where they were before their release. "We failed to put two and two together: that they had spent the intervening months or years behind bars, that they had been victimized in correctional faculties, that their mental health treatment had been grossly inadequate, and that their deteriorated condition had something to do with that life trajectory" (Committee on Psychiatry and the Community, 2016, xiv).

Even people in the psychiatric community are reluctant to treat those with mental illness that are involved with the criminal justice system. Treating someone with mental illness is

extremely unpredictable and complex and most practitioners don't want to get involved with the additional task of dealing with people who have criminal charges. "As a result, they [mental health professionals] may themselves inadvertently criminalize individuals who engage in unsafe behavior as a consequence of their behavior. And all the while, our clients and families…find themselves tossed in between systems and practitioners that are commonly unprepared, and sometimes unwilling, to respond to their needs" (Committee on Psychiatry and the Community, 2016, 3). This makes an already vulnerable population of people even more susceptible to high rates of recidivism, compromised public health and safety, homelessness, and disparate use of expensive and inefficient acute care services (Committee on Psychiatry and the Community, 2016).

The criminal justice system is not the place for an ill population of people. If a person with a physical injury or illness was locked away without treatment it would be considered counterproductive, dangerous, and unhealthy. However, since psychological illness is not viewed in the same way as physical illness, individuals with mental illness are frequently locked away without treatment. Bandy X. Lee, a psychiatrist at Yale, stated, "The chief problem is that mental health care and criminal justice start with different philosophies… so the ethos itself of the criminal justice approach is incompatible with therapeutic means and methods… Can institutions designed with radically different priorities than maintain psychic well-being under any circumstances be adapted to offer appropriate care and should they?" (Roth, 2016, 106). The criminal justice system was designed to punish and rehabilitate criminals. It was not designed for those with illnesses who require a nurturing and supportive environment. The different philosophies that were established to implement the healthcare and justice systems do not intertwine and do not adequately address alternative populations.

1.1 History

Throughout history societies have employed some form of a justice system to command order and establish law. These practices have included publicly flogging and torturing individuals, shunning them from their social groups, locking them away in jail cells, and publicly executing them with crowds of observers. The historical record further indicates the presence of a powerful and still ongoing debate- what to do with people who society considered "mad" or "insane". Distress surrounding these individuals and the danger that they might bring to themselves or others has filled people with fear and avoidance. In the 1700's and 1800's those with serious mental illness were isolated, locked away in jails and hospitals. In the 1800's, state hospitals and asylums were created to further manage populations of the mentally ill. In this setting, they received little to no treatment and the conditions were abhorrent and inhumane (Committee on Psychiatry and the Community, 2016). Now, in the 2000's, we have come a full circle and once again put people with mental illness into jails to get them off the streets and away from the rest of society.

With the Judiciary Act of 1789, the first courts were established, and a more civil way of punishing people was implemented. However, this new system did not change the treatment of the mentally ill, or insane, persons. To this day, there are debates centered on how to manage people with mental illness which include questions such as; how do you inflict punishment on a person who does not understand what justice is? How does one decide if a person was competent when committing a crime? And how do you make sure that society is safe from people who are deemed crazy by the same social system that they live in?

In the 1850s Dorothea Dix, a mental health advocate and reformer, investigated mental asylums and found that conditions were repulsive; patients lived like they were prisoners, they

were isolated from one another, frequently over medicated, and living in their own waste with little or no help from medical professionals. The innovative idea of moving the mentally ill into institutions to provide food, shelter, and safety had turned into a program overwhelmed by neglect and lack of resources. Dix played an instrumental role in asylum reform and founding or expanding more than 30 hospitals for the treatment of the mentally ill. She was a lead figure in national and international movements that challenged the idea that people with mental illness could not be helped or cured (Parry, 2006). Dix was an advocate for moral treatment and showing others the appalling conditions in existing institutions and promoted the inherent value of compassionate care (Parry, 2006). She was able to expose the negative conditions that the mentally ill were enduring in institutions and to bring awareness to the issues and suffering that they were experiencing in institutions. The attention that Dix brought to the horrifying conditions was one of the factors that started the movement for deinstitutionalization, the process of replacing long-stay psychiatric hospitals with less isolated community mental health services for those diagnosed with mental disorders and disabilities.

Another factor that brought attention to individuals with mental illness was the manufacturing of psychotropic medications, such as Thorazine, during the 1950s. These new drugs helped reduce symptoms in severely ill patients and they were declared safe to live within, or at least closer, to society. These drugs made community-based care a more feasible and cost-effective solution in comparison to psychiatric hospitals.

Soon after, President John F. Kennedy signed the Community Mental Health Act (also known as the Mental Retardation and Community Mental Health Centers Construction Act of 1963) in 1963. The goal of the Community Mental Health Act was to create a new era of mental health care that abolished institutions and focused on "behavioral health care" that helped

manage mental health care and substance abuse disorders in the community (National Council for Behavioral Health, 2019). Community-based behavioral health care, still used today, is delivered by a combination of government and county-run organizations that operate as both profit and non-profit centers. These behavioral health programs are designed to provide acute care and outpatient resources for those with mental illness and reduce the need for long-term institutional treatment. During the same time, the Civil Rights Movement continued to bring awareness and advocate for the horrifying conditions that people with mental illness were experiencing. With these new policies in place to shift care to the community, the exposure of the devastating conditions in institutions, and the creation of new drugs to aid in the care of the mentally ill, the process of deinstitutionalization took off as a promising method of providing better care and alternatives for a mentally ill population of people.

1.2 Consequences of deinstitutionalization

Beginning in the 1960s, deinstitutionalization was initiated, and patients were removed from asylums and released into the community. Although most of the leaders who began the movement of deinstitutionalization had good intentions, the crusade did not bring about the positive change people had hoped for. When the process began, the patients that had been previously living in institutions were released and the majority of these patients were left with even fewer resources than they had in the asylums. They were now jobless, homeless, and without support. Without basic necessities, medication, therapy, or a place to stay, the mentally ill were left on the streets to remain isolated from society and scavenge for resources. According to the Bureau of Justice Statistics (2006), state prisoners and local jail inmates who had mental health problems were twice as likely as inmates without a mental health problem to have been homeless in the year before their incarceration. With the negative stigma attached to both mental

illness and homelessness, the amount of 911 calls that police officers received left a burden on the criminal justice system to try to manage the mentally ill population. "Beginning in the late 1900's we transferred responsibility of people with SMI [serious mental illness] from the psychiatric hospitals to our jails and prisons, ironically placing our most vulnerable in far worse conditions than the psychiatric hospitals they left… only adding to the damaging stigma already brought on by the illness itself" (Committee on Psychiatry and the Community, 2016, xi-xii).

The majority of individuals with mental illness that come into contact with the criminal justice system are categorized with a serious mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, or a brief psychotic disorder). The National Institute of Mental Illness (2017) defines serious mental illness (SMI) as "A mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities" (para. 4). It is estimated that as many as one in two Americans with serious mental illness will be arrested at some point in their lives (Roth, 2016; Draine et al., 2002). According to the Treatment Advocacy Center (2016), approximately 20 percent of inmates in jails and 15 percent of inmates in state prisons have a serious mental illness. In 2014 there were 744,600 inmates in county and city jails and 1,561,500 inmates in state prisons, with numbers still growing. "Combining the estimated populations of jail and state prison inmates with serious mental illness produces an estimated population of 383, 200 inmates with mental illness. Since there are only approximately 38,000 individuals with serious mental illness remaining in state mental hospitals, this means 10 times more individuals with serious mental illness are in jails and state prisons than in the remaining state mental hospitals" (Torrey, 2014, 2). Individuals with a history of mental health problems and symptoms are frequently seen

cycling through local jails, State prisons, and Federal prisons at higher rates than those without mental illness history and symptoms (see Figure 1).

Table 1: Prevalence of Mental Health Problems Among Prison and Jail Inmates

Mental Health Problem	State Prison Inmates		Federal Prison Inmates		Local Jail Inmates	
	Number	Percent	Number	Percent	Number	Percent
Any Mental Health Problem	705,600	56.2%	70,200	44.8%	479,900	64.2%
History and Symptoms	219,700	17.5%	13,900	8.9	127,800	17.1
History Only	85,400	6.8	7,500	4.8	26,200	3.5
Symptoms Only	396,700	31.6	48,100	30.7	322,900	43.2
No Mental Health Problem	549,900	43.8%	86,500	55.2%	287,600	35.8%

Note: Number of inmates was estimated based on the June 30, 2005 custody population in State prisons (1,255,514), Federal prisons (156, 643, excluding 19,311 inmates held in private facilities), and local jails (747,529).
*Details do not add to totals due to round, includes State prisoners, Federal prisoners, and local jail inmates who reported an impairment due to a mental problem.

Additionally, the Bureau of Justice Statistic (2006) found that Jail inmates had high rates of mental health disorders (60%), followed by State prisoners (49%), and Federal prisoners (40%). The rates of illness were collected from diagnosing based on DSM-IV criterial using questions that addressed behaviors and symptoms related to major depression, mania, or psychotic disorders within a 12-month period before the interview (James & Glaze, 2006, 3). Figure 2 shows the significant number of inmates with mental illness that were symptomatic at the time of the interview or had shown symptoms of mental health issues in the past. Although researchers found significant results in Federal and State prisons, the inmates in the local jail population was the highest, suggesting that at the time of arrest, people with mental illness are typically the most vulnerable due to symptoms of their mental illness and lack of supportive

resources. Since local jails only hold inmates for a short amount of time until sentencing decisions have been made, the amount of people with mental illness that they arrest are typically experiencing acute symptoms and have not received treatment in a significant period of time.

While living in their local community, most mentally ill persons are not provided with the resources to succeed. Rather than given access to services and support, instead they are expected to find a way to maintain on their own. The majority of people with mental illness fall through the cracks without ever receiving help and, as shown in Figure 2, when they are picked up by police they are typically already in a deteriorating state of psychosis. Mental health services should be available to all, according to their needs and regardless of their ability to pay (Committee on Psychiatry and the Community, 2016). However, this is typically not the case.

Only people with support system and financial stability are able to pay for services. It is important to recognize that the mentally ill are consumers in need of different types of services and that they deserve respect and adequate continuous psychiatric interventions the entire way as they move back and forth between the community and correctional facilities (Committee on Psychiatry and the Community, 2016).

Table 2: Recent History and Symptoms of Mental Health Problems Among Prison and Jail Inmates

	Percent of inmates in		
	Local	State	Federal
Mental Health Problem			
Any Mental Health Problem	56.2%	44.8%	64.2%
Recent history of mental health problem	24.3%	13.8%	20.6%
Told had disorder by mental health professional	9.4	5.4	10.9
Had overnight hospital stay	5.4	2.1	4.9
Used prescribed medications	18.0	10.3	14.4
Had professional mental health the	15.1	8.3	10.3
Symptoms of mental health disorders	49.2%	39.8%	60.5%
Major depressive disorder	23.5	16.0	29.7
Mania disorder	43.2	35.1	54.5
Psychotic disorder	15.4	10.2	23.9

Note: Includes inmates who reported an impairment due to a mental problem. Data are based on the Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of inmates Local Jail, 2002.

1.3 Substance abuse

Substance abuse is another complicating factor when considering ways to provide treatment and diversion for the mentally ill population. The majority of people with mental illness also have comorbidity, the presence of two chronic diseases or conditions, with another disorder. Substance abuse is significantly elevated in the mentally ill population due to the large amount of attempts at self-medication with street drugs and alcohol. It is estimated that three-fourths of prisoners who have mental illness also have a substance use problem, which can become dangerous in the prison population because of the severity of withdrawal symptoms. About 80 percent of people with mental illness in the criminal justice system also have a cooccurring substance use disorder (Roth, 2018). Additionally, before arrest, it is often difficult to tell if symptoms are stemming from mental illness or a substance. This adds to the danger and further blurs the lines of intervention for first responders. Since effective intervention requires substance treatment in addition to mental health treatment, it is difficult to find places that will

take people with substance abuse issues. This, once again, leaves an already vulnerable population without support and help. People with mental illness and substance abuse disorders don't belong in jail, it doesn't make the community any safer or help to rehabilitate them (Committee on Psychiatry and the Community, 2016).

1.4 Arrests

People with mental illness are often arrested for robbery, disrupting others, using drugs, loitering, etc. Because of this, there are over 10 million adults booked into jails every year and over 700,000 with active mental illness symptoms (Slate & Johnson, 2008). Despite the large population of mentally ill individuals that are arrested, statistics show that the majority of crimes that they are arrested for are mild and nonviolent. The percentage of major crimes only represent 2% of the population with mental illness out of approximately 8.2 million individuals in the United States with mental illness (Treatment Advocacy Center, 2018). Because of the amount of arrests and lack of alternative resources, the mentally ill population still make up the majority of the jail and prison population. Most of society fears that a mentally ill person will harm them, and yet people with mental illness are actually 11 times more likely to be victims of a serious crime, 8 times more likely to be robbed, 140 times more likely to be stolen from, and 15 times more likely to be victims of assault (Slate & Johnson, 2008). The very people that are considered violent typically suffer at the hand of offenders rather than commit crimes themselves.

If it's true that people with mental illness are less likely to commit a serious crime or become violent, why do they make up such a large portion of jails, prisons, and courtrooms? Research has found that when first responders (typically police officers), prosecutors, judges, juries, etc. are presented with a person with mental illness, they do not have the proper training or resources to comprehend what that person is experiencing. As result, people with untreated

mental illness are sixteen times more likely to be killed by a law enforcement officer (Treatment Advocacy Center, 2018). Trying to differentiate between people who are mentally ill or malingering (exaggerating or faking illness), is difficult for trained practitioners, and it is nearly impossible for untrained law enforcement officers. The negative stigma against mental illness also comes into play as people are less likely to believe that someone who committed a crime was not in their right mind. As a result, people with mental illness are typically convicted because they are considered a threat to society and are placed in jails or prisons to be removed from those that consider them dangerous. Confining these people to the criminal justice system is typically seen to be the logical option since they are deemed unfit to live in society and no long-term care options are available.

1.5 Stigma

"In biblical times and still today in some cultures, seeing visions or hearing voices is an indication of holiness, not madness…others might consider it a sign of mental illness to hear Jesus saying anything, good or bad" (Roth, 2018, 4). In Western society mental health issues are not looked at in a positive light. Visions and hearing voices are considered signs of psychosis and the person experiencing them is considered dangerous and insane. In Western culture, mental illnesses are not regarded as "true" illness. If someone has a physiological diagnosis, they are encouraged to seek medical attention, take medications, build a strong support system, and practice self-care. If someone is suffering from a psychological diagnosis, they are told to get over it, stop being dramatic, and manage it on their own. The amount of resources available is significantly larger for physical illness as well. Hospitals, walk-in clinics, and private practice offices are ubiquitous. It is usually easy to arrive at the clinic and get assistance with or without an appointment. For mental health issues, resources are limited, harder to locate, and difficult to

pay for through most insurance companies. "You are far better off in this country having cancer than mental illness. At least with cancer you have a shot at getting well" (Committee on Psychiatry and the Community, 2016, 41-42). Even if a person's mental illness is managed, they still continue to suffer due to the negative stigma and blame that society puts on them. Western society tends to accuse individuals with mental illness of being responsible for their sickness, whereas they would not blame someone with a physical ailment for causing their own medical issues.

2. THE SEQUENTIAL INTERCEPT MODEL

Munetz and Griffin (2006) present the Sequential Intercept Model as a strategy for managing mental illness within the criminal justice system. The sequential intercept model is organized according to the "flow" of contact for individuals in the criminal justice system. People move through the system step by step in a linear and predictable way (Committee on Psychiatry and the Community, 2016). Each point represents a "point of interception" or opportunity for intervention to prevent individuals with mental illness from entering or penetrating deeper into the criminal justice system (Munetz & Griffin, 2006). The Sequential Intercept model introduces a way to intervene before the problem happens or worsens. This model provides mental health practitioners and criminal justice officers a way to identify areas that they can help and avoid further conflict. "By addressing the problem at the level of each sequential intercept, a community can develop targeted strategies to enhance effectiveness that can evolve over time. Different communities can choose to begin at different intercept levels, although the model suggests more 'bang for the buck' with interventions that are earlier in the sequence" (Munetz & Griffin, 2006). Unfortunately, few people are intercepted early and many people with mental illness pass through points of interception without receiving help. The goal of

the Sequential Intercept Model is to develop collaboration to create a more finely meshed system with earlier intervention, reducing the number of people that move past each intercept point (Munetz & Griffin, 2006).

The Sequential Intercept Model address five main areas that intervention can be provided to help a person with mental illness. The first, law enforcement and emergency services, address prearrest situations when first responders initially become involved. Munetz and Griffin (2006) suggest community interventions such as "mobile crisis teams of mental health professionals, mental health workers employed by the police to provide on-site and telephone consultation to officers in the field, teaming of specialty trained police officers with mental health workers from the public mental health system to address crises in the field, and creation of a team of police officers who have received specialized mental health training and who then respond to calls that to involve people with mental disorders" (Munetz & Griffin, 2006, 546; Lamb et al., 2002).

The second point, initial hearings and detention, occurs post-arrest, when the person has already been detained. During this time, specialized resources include mental health assessment after arrest that can advise the court about mental illness and options for treatment. Many of these can lead to diversion alternatives or treatment as a condition of probation (Munetz & Griffin, 2006).

The third intercept, jails and courts, is an area that is currently receiving much focus. Special-jurisdiction courts called mental health courts are becoming more popular to help manage people with mental illness that make it to the court system. These courts have a separate docket and specialty court programs that address the needs of individuals with mental illness who come before the criminal court. Mental health courts limit punishment and instead focus on problem-solving strategies and linkage to community treatment to avoid further involvement in

the criminal justice system of the defendants who come before them (Munetz & Griffin, 2006). Unfortunately, not all areas have adopted the use of mental health courts and many areas still only see people with mental illness in a criminal court setting.

Munetz and Griffin (2006) use reentry planning from jails, prisons, and hospitals as the fourth level of intercept. Many times, people who are released from jails and prisons are not provided with a plan or follow-up resources after their release. Transitional planning includes communication between both the mental health system and the criminal justice system. Together the systems can alert the public mental health system when a client has been incarcerated and allows additional support and transitional planning to be made. The fifth and final intercept identified is community corrections and community support services. The majority of people that have mental illness struggle to comply with probation or parole and will fail to attend treatment appointments, ending in revocation of parole and return to incarceration (Munetz & Griffin, 2006). Similar to mental health courts, some jurisdictions are adopting designated probation or parole officers who specialize in working with caseloads of mentally ill individuals (Munetz & Griffin, 2006). These help to provide long-term support and stability so that people who have cycled through the criminal justice system once do not return through the process again.
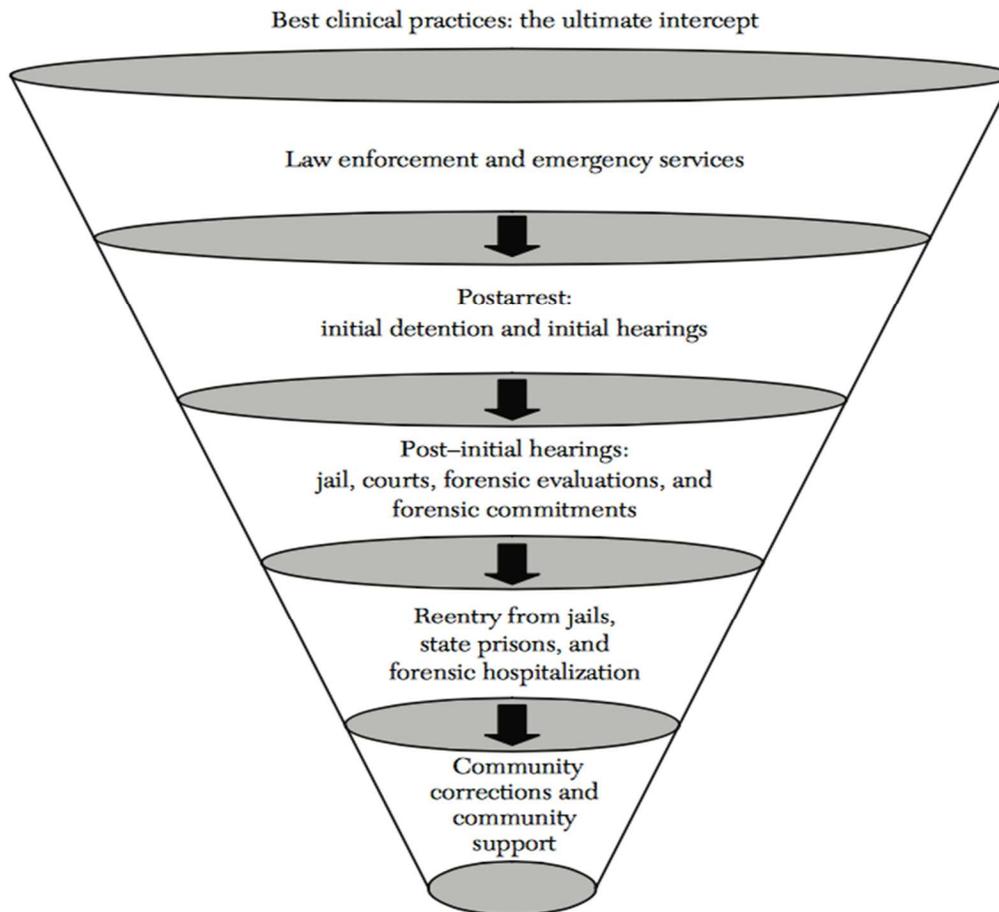
Best clinical practices: the ultimate intercept

Law enforcement and emergency services

Postarrest:
initial detention and initial hearings

Post–initial hearings:
jail, courts, forensic evaluations, and
forensic commitments

Reentry from jails,
state prisons, and
forensic hospitalization

Community
corrections and
community
support

Figure 1: Sequential Intercept Model

3. TRAUMA AND MENTAL ILLNESS

Trauma can have a negative impact on those with SMI. Mental illness takes many different, unpredictable forms. Situations that appear normal to the average person might seem overwhelming and frightening to someone with mental health issues. In emotionally stimulating situations, all rationale gets put aside, especially to someone who is already having difficulty tolerating reality. To avoid further traumatizing or agitation many techniques can be used to support and deescalate the situation. When mental health professionals partner with law enforcement and criminal justice personnel, a great deal of the fear and misunderstanding can be removed from the situation. The Committee on Psychiatry and the Community (2016), provides

a model for working with the family, criminal justice personnel, and law enforcement. It begins with forming a relationship with the family and the patient before there is a problem. Building rapport with a patient and allowing them to trust the practitioner and feel safe within the system can make an enormous impact in a situation. Next, rather than waiting for a crisis, actions can be taken to help keep that patient on track, provide support, and monitor closely before there is a problem. "An ounce of prevention is worth a pound of a cure: teaching the family how to work with the team as a 'support extender' is well worth the time and effort to avoid a situation deteriorating because no one is able to provide enough structure and support on their own… The key is to provide continuous intervention to prevent the patient from slipping and work as a team to pull them back on track before the situation escalates" (Committee on Psychiatry and the Community, 2016, 47).

It is important to understand that people with mental illness are human and, just like everyone else, they get aggravated and discouraged. Constantly cycling through the criminal justice system and periods of instability is difficult and creates feelings of helplessness and hopelessness. One of the goals should be to shift them from being a "target" to becoming an ally that works with the person, validates their self-worth, and treats them as a human being (Committee on Psychiatry and the Community, 2016). For example, rather than telling someone what is best for them, ask what their personal goals are and offer to help achieve those goals. "We have to engage her around *her* hopeful goals, not try to force her to fit into our framework. Within a relationship built on mutual respect and partnership it is much more likely that she will make more good decisions and fewer bad ones" (Committee on Psychiatry and the Community, 2016, 28).

Crisis situations are traumatic for the patient, the family, and even the officer in charge. Being trauma-informed can help reduce stress and misunderstanding significantly. First responders need to be trained in trauma and how to recognize and be sensitive to the needs of a mentally ill person. "Traumatic events may contribute to trauma response involving force, coercion, and abuse of authority directed at individuals who are vulnerable and can't escape" (Committee on Psychiatry and the Community, 2016, 22). Trauma-informed models focus on core principles of safety, trust, collaboration, choices, and empowerment. People trained in trauma-informed care are able to promote safety and reduce the risk for all involved by providing trauma-specific interventions. This method reduces the need to use force, restraint, and other traumatic actions.

4.   INVOLUNTARY COMMITMENT

In the nineteenth century, while people were advocating for the rights of the mentally ill, a question arose about whether a mentally ill person should be able to be committed to a facility without their permission. At this time, the stipulations on committing someone were low, and rights could be taken away and people without a diagnosed illness could be locked away. To resolve this issue and increase the rights of the patient, policies were changed that made it a difficult process to involuntarily commit someone. "The result was dramatic legal changes that have since made it much harder to have a person with mental illness hospitalized against his will. Today a person needs to be considered either an immediate risk to self or others, or 'gravely disabled,' to be committed. Even if a patient meets these criteria, hospitals may hold him for only seventy-two hours without a hearing" (Roth, 2018, 220). Although it is important to maintain patient rights, the majority of the mentally ill don't understand that they are a danger to themselves or others when they are going through a difficult episode. Most families don't know

where to turn during these times and without preventative measures, the only recommended source is that they call the police when they believe the situation has become escalated enough that they can't handle it. This usually leads to the police having to make an arrest. After the arrest the person will appear before a judge that will determine their competency and stability. "Even when successful, this procedure suggests how confused our system has become: it's one more way that the legal system makes what are effectively *medical* decisions, ones that judges aren't necessarily qualified to make" (Roth, 2018, 221). Although maintaining patient and citizen rights is important, law enforcement has to be involved just to get loved ones help, which usually backfires due to the criminal charges that they will likely receive.

5. FIRST RESPONDERS

5.1 The role of the police

The deinstitutionalization movement raised a variety of concerns involving whether persons with mental illness should be criminalized for their behavior (Green, 1997). There are always police on duty, making them the first responders to 911 calls. "In 2015 the New York City Police Department estimated that it responded to more than four hundred mental health calls per day, more than twelve thousand per month" (Roth, 2018, 234; Rodriguez, 2015). Officers respond quickly and use their discretion to address the situation and, when they are unable to deescalate things, they are expected to make an arrest so that justice can be served and peace returned. The police are required to protect both the safety and needs of the society and the needs of the person with mental illness, providing everyone with the safest and most peaceful options possible. Most police officers believe that people who appear strange or violent need to be quickly restrained and sent to jail so that they do not become a harm to others (Committee on Psychiatry and the Community, 2016). Many times, this leads to the police having to make

arrests when a mentally ill person is too confused or psychotic to be calmed down and might become violent. "If the suspect doesn't obey or doesn't obey quickly enough, the police are trained to move in closer and shout louder, effectively escalating the situation until the suspect responds. It's meant to be scary, but for a person with mental illness, particularly one who is psychotic or paranoid, it can be downright terrifying. And sometimes it produces the opposite of the intended response, driving the person to lash out rather than obey" (Roth, 2018, 236-237). Officers must look at the way that situations need to be handled from both a legal and a medical perspective when it comes to mentally ill offenders (Green, 1997).

One of the difficult aspects of this method is when a person can't be involuntarily committed, and the police are called, the control of the situation is shifted to the officer rather than the family. Even if the family does not want to press charges, it is out of their control and it is up to the officer and the State if they want to press charges. Also, the actions of the mentally ill person can be translated by the officer based on their assessment of the situation. Touching a police officer, even when the person is in a confused, unstable frame of mind, can be classified as assaulting an officer if they feel threatened during the incident.

Another contributing factor is if the officers and family are able to involuntarily commit the person without arresting them first. "Two standards are at work, the first standard relates to an officer's authority, and, in the officer's eyes, duty, to take someone who is mentally ill to the hospital. The second standard is applied by the hospital staff in determining whether the individual meets the criteria to be held against his or her will for an evaluation" (Green, 1997, 482). Once a person who is mentally ill is arrested or picked up by police officers they are typically taken to a hospital for assessment. Difficulty arises here for the officers because of the lengthy wait times at the hospital that takes them away from their job. Often, if the patient is not

deemed an immediate threat to themselves or others then they are released, placing them back into the care of the officer and forcing them to make an official arrest or release the person. This is one of the many reasons that dealing with calls involving the mentally ill are frustrating for a police officer. "The whole situation is frustrating for the deputies, none of whom ever imagined they were going into mental health work" (Roth, 2018, 63). Another reason is because they spend an extended amount of time trying to keep peace and deescalate situations rather than focus on criminal calls and activities. Districts all differ on the policies and protocols that officers are expected to follow when dealing with mentally ill offenders. No matter what the policy though, police officers are not formally trained to recognize, assess, or treat mental illness and do not have the experience to deescalate many of the situations that they respond to. Unfortunately, this leads to many misunderstandings and wrongful assessment of situations, which can end up with either the mentally ill person or the officer injured (Green, 1997).

6. COURT PROCESS

Once a person with mental illness reaches the court, the process becomes even more difficult. Judges and juries are left with difficult choices to make and mental illness tends to make the decision-making process less clear cut in regard to intent, threat, and sentencing decisions. There is no set policy for how a judge should manage a situation involving a mentally ill person, so they are tasked with the responsibility of ordering involuntary confinement of people who are dangerously mentally ill and often rely on carefully considered, but inherently limited, options about one's future danger behavior (Stone, 2018). How to assess an individual based on their level of future dangerousness is a difficult, near impossible, task. To be ordered into involuntary commitment there must be clear and convincing evidence that the person is a danger to self or others. Unfortunately, there is no clear-cut way to measure future dangerousness

and assessment is left in the hands of psychiatric diagnosis and impressions, past behavior or episodes, and threats made to self or others.

6.1 Decision-making process

Another main factor for the judge to consider is the social support that the mentally ill person has if they do return to society. This proves to be an important area because people with a mental illness that have social support and people to help them typically do better when released than people who do not have support. However, many people with mental illness do not have family or friends that can help them regulate and stay on track. Without support, the judge typically decides that it is safer for the defendant to be kept in jail because they are seen as an elevated potential threat to self, others, or a flight risk from the court if they are released.

Next, it has to be decided what constitutes as a potentially dangerous act and what "dangerous" means. Does a person have to be an imminent threat to be considered dangerous? Usually, the court makes this decision based on "impending" threat, a threat that is likely to occur at any moment or in the immediate future (Stone, 2018). Courts also assess failed attempts at committing an act in the past and patterns of the behavior the individual has shown over time. Classifying danger tends to be even more difficult. It is typically assumed to mean that the person will cause bodily harm to self or others but other possible alternatives of the word "dangerous" must be considered as well.

6.2 Sentencing decisions

After it is decided that the person is an immediate threat and should be involuntarily committed, the next step is sentencing the individual. This decision usually falls on judges who, similar to the police officers previously discussed, are tasked at deciding what is the right course of help or treatment for a person that is mentally ill. Also, like officers, this is based on the

discretion of the court that has little training experience dealing with the mentally ill. "[The] judge's determination is a single straightforward question: is the person, if released today, a danger to self or others in the community at large?" (Stone, 2018, 64). Although it's a straightforward question, it is extremely difficult to answer based on all of the factors involved with decision-making. It is important for judges and juries to make a decision that protects society, provides an individual with the help that they need, and all the while upholds the rights and liberties of the defendant.

Whatever decision the judge makes regarding sentencing the individual, the judge customarily orders the person to take medication to decrease psychotic behavior and chances of another incident occurring. Through the use of regimented medication, the judge can try and prevent future dangerousness and the chance of recidivism. However, medications are unaffordable and unavailable to many of the mentally ill population. Because a doctor is needed to prescribe the medication, and the drug itself can be costly, the person might not have the ability to get the needed medication. Also, as mentioned before, making and keeping appointments with doctors and courts can be extremely difficult for some people with mental illness, further preventing them from being able to follow the judge's instructions. Unfortunately, there are few resources to help the mentally ill afford psychiatric medications and to follow up to make sure that they are able to receive the recommended medication.

7. THE INSANITY DEFENSE

Although the insanity defense is frequently used in television shows and books, it is extremely rare in actual court cases. Estimates suggest that attorneys ask for the insanity defense in somewhere between 0.1 and 0.5 percent of felony cases and, of those, only 10-60 percent are considered successful in the cases that it is used in (Roth, 2018) "Whether somebody can be

found not guilty by reason of insanity hinges on whether he was sane enough to understand what he was doing when he committed the crime" (Roth, 2018, 177). The insanity defense seems like a solution because it demonstrates that the defendant was not in sound mind at the time of the crime. However, a person who is found guilty by reason of insanity can spend far greater amount of time in a hospital than they would have served in a prison. If they use an insanity plea the implications of the criminal charges are equally as problematic as they would have been with a criminal conviction.

8. JAILS AND PRISONS

8.1 Pre-trail procedure

After the arrest, the mentally ill person is locked in jail to await their trial. During this time, they are usually prevented from taking the medication that they need due to the lack of availability in jails. The family is not allowed to bring medication to the inmate and there are not enough resources at the jail to locate the patient's psychiatrist (if they have one) for an emergency refill or consult. As the Committee on Psychiatry and the Community (2016) points out, most of the time jails say that inmates receive the medication that they need but in reality, medications are scarce in jails and, even if the person does receive medication, there is no guarantee that it will be the right type or dose that they are prescribed.

8.2 Post-trial procedure

After the court makes the sentencing decision, the defendant is either entered into a regimen of legally mandated meetings, appointments, and hearings, to try to treat and rehabilitate them or they are placed in jail/prison. Most mentally ill offenders in jail endure a long and difficult stay. They are more likely to face longer court sentences and less likely to make bail and

parole. While incarcerated, they are more likely to end up in solitary confinement and suicide is far more common than it is with non-mentally ill inmates. The outbursts, hallucinations, delusions, and abnormal behaviors make them seem dangerous to most of the correctional officers and other prisoners. The strict rules and routine are difficult for most mentally ill inmates to follow. Activities that seem routine (e.g. being put in handcuffs) can be terrifying for a person who is psychotic or paranoid. Many experience re-traumatization depending on past experiences and the condition that they were in during their arrest. Because of their seemingly threatening behavior, inmates are "doubled down" on for punishment and given an even more strict set of rules. When they do not abide by these they are put in solitary confinement, which makes even the mentally stable prisoners lose their sanity.

Another factor is the degradation that occurs to the inmates in these institutions. "Jails and prisons are dehumanizing places: the uniforms' that strip people of their individuality, the endless rules, the gruff way that many, though certainly not all, officers address prisoners. The sense of us and them, that divide between the prisoners and the officers or really the prisoners and the rest of use, is especially pronounced on mental health units… even the very legitimate caution with which the deputies approach the cells adds to the sense that these people are something other than human, creatures to be feared" (Roth, 2018, 40). The feeling of dehumanization and lack of empathy might not be a negative thing for mentally stable criminals, but to a person who is mentally ill it can be horrifying.

The majority of jails and prisons strictly adhere to the Health Insurance Portability and Accountability Act (HIPAA), rules regarding the protection of inmate's personal information. Therefore, "Crucial medical information, which could have direct bearing on how a prisoner is treated, is not disclosed to the officers who are responsible for their safety" (Roth, 2018; 56).

While HIPAA is important and protects confidential information, even the people working at criminal institutions are not allowed information about the prisoners. This would be analogous to asking a nurse to take care of a patient but not providing information, it is both dangerous and counterproductive for the caretaker and the patient.

9. RATIONING RESOURCES

9.1 Medical professionals

Providing care for the mentally ill requires a number of mental health providers employed at the jails and prisons. Unfortunately, because of the low salary, dangerous work conditions, and remote location of the facilities, there are very few mental health practitioners actually employed at most correction facilities. In a study looking at the inmate population in Arizona, between April and December of 2015 there was a backlog of 377 appointments for mental health care and the waiting list for a psychiatric appointment was 1,385 patients due to shortage of staff (Roth, 2018). In 2016 there was a ratio of 1 psychiatric health care provider to 1,861 prisoners in need of mental health care (Roth, 2018). With the low number of practitioners against the growing number of prisoners with mental health issues, there is no way to provide adequate care for all of the people in need. Because of this, practitioners have to rely on the correctional staff to provide information about the inmate's condition. "Psychiatrists and clinicians rely on the officers to be their eyes and ears, alerting them to people whose behavior has suddenly changed or appears to be abnormal" (Roth, 2018, 120). However, as discussed previously, most of the staff is not trained on signs and symptoms of mental health issues and might think that the patient is being difficult or malingering to get attention. When psychiatrists are able to see patients, they have such a large caseload that they are only able to spend a few minutes with a patient, typically in a nonconfidential space such as a cell door, tray slot, or

hallway. The turnover rate for correctional staff and practitioners is high due to the stress of the

job which creates financial strain for the institution and lowers the criteria for the screening

process because of the amount of people that the institution is having to train and retrain for the

job. Due to the lack of screening and training, neglect and abuse are startlingly common.

Twenty-four of the states fully contract out their prisoner health care to private contractors,

another twelve contracts out some of their care, and only fourteen operate their own prison health

care systems (Roth, 2018; Galik, et al., 2014).

9.2 Medication

Due to the lack of medical professionals that work in jails and prisons, it can take weeks

to get a medication adjustment or be seen by a doctor or therapist. The lack of resources usually

mean that facilities have to resort to the least-labor-intensive treatment available, medication

(Roth, 2018). Unfortunately, this means that the majority of patients do not have their medication

handled properly and their side effects and dosage are not monitored consistently, if at all. When

inmates are seen the time is limited and only scratches the surface of underlying issues. Intensive

treatment is reserved for patients that are the sickest of the sick and it is the doctor or therapist's

job, after only a short evaluation of hundreds of patients, to determine who is the most desperate

for basic care (Roth, 2018). Other issues relating to the treatment of the mentally ill in a jail is

the rationing of important resources. For example, second hand medications that are cheaper for

the institution to receive are usually given to inmates. Although these typically work the same,

the generic forms might not work as well for the more sensitive individuals. The amount of

medication that a person is receiving also might have to be lessened due a reduced supply. All of

these factors create a perfect storm for the deterioration of a mentally ill individual.

9.3 Isolation

Isolation is one of the main ways that correctional officers are able to maintain the inmate population and inflict punishment when rules are not followed. It is left up to the discretion of correctional officials to decide who is breaking the rules and if it is deemed extreme enough to isolate them from the rest of the population. In the United States, there are at least 80,000 people in solitary confinement. This number does not include juvenile or immigration facilities or local jails. Of the people in solitary, between a third and a half are believed to have some form of mental illness (Roth, 2018, 136). Even for healthy inmates who have never struggled with mental illness, isolation can be a brutal form of torture that confuses and agitates the person experiencing it. "This slow and daily tampering with the mysteries of the brain [is] immeasurably worse than any torture of the body and because its ghastly signs and tokens are not so palpable to the eye and sense of touch as scars upon the flesh; because its wounds are not upon the surface, and it extorts few cries that human ears can hear; therefore I the more denounce it, as a secret punishment which slumbering humanity is not roused up to stay" (Roth, 2018, 138-139). Some people can be kept in solitary for weeks and can accumulate new charges while in confinement based on their "uncooperative" behavior. More than half of all prison suicides occur in solitary confinement due to the effects on the mind.

9.4 Suicide

Suicide is extremely common among mentally ill prisoners. "Suicide is the leading cause of death in correctional facilities, and multiple studies indicate as many as half of all inmate suicides are committed by the estimated 15% to 20% of inmates with serious mental illness" (Treatment Advocacy Center, 2016, 4). When a prisoner says that they want to harm or kill themselves they are put on a suicide watch with precautions. Depending on the facility's protocol

this often means checking on the patient more regularly. However, a person can significantly harm or kill him or herself in a short amount of time. If a prisoner causes self-harm, they are often times given disciplinary action, including solitary confinement, which can make the despair and the underlying issues worsen. Incarceration can be extremely lonely for most, especially when in isolation and the majority of prisoners self-harming are looking for someone to care or give them attention.

10. THE DEATH PENALTY

As discussed, many factors are involved in the criminal justice system when dealing with a mentally ill offender. The processes from the 911 calls to the imprisonment of the individual are all extremely controversial and complex. One of the highly debated areas within the criminal justice system is whether or not a person found mentally ill can be sentenced to capital punishment. Many people are supportive of the death penalty because they believe that retribution is the answer to preventing a person from killing again and deterring future criminals. The question that surrounds both sides of this debate include how to define competence, how to maintain competency, and the ethics of using death penalty when the person who committed the crime might not have been in their right mind at the time of the incident. The death penalty was designed for the "worst" 2% of the population, serial killers, rapists, dictators, etc. However, since the death penalty began, those that have been put to death have been almost entirely unpredictable and influenced more by class and race than by the severity of the crime they committed (Slate & Johnson, 2008). Even though people that support the death penalty believe that the person will be put to death, the majority of the time these criminals sit on death row and are never executed.

10.1 Supreme court rulings

In their book, *Executing the Mentally Ill*, Miller and Radelet (1993) analyze one of the of the most influential cases regarding mental illness and the death penalty. The case of Alvin Ford, a mentally ill person who was convicted of the murder of a police officer, went through 16 years of competency assessment, sentencing, and appeals to determine if he was competent at the time of the crime that he committed. During Ford's trial (*Ford v. Wainwright*) the Supreme Court determined that "Execution of the insane violates both contemporary standards of decency and the basic dignity of man" (Miller & Radelet, 1993; 137) and that execution is forbidden if the defendant is unaware of the punishment they are about to suffer and why they will suffer it. All factors should be considered on individual basis. By using individualization, the jury can assess what the offender did, who he is, and why he did it. The jury is also expected to consider if the defendant will be a continuing threat and will try to harm or kill others again in the future. For consideration to be a capital punishment case, competent, reliable mental health evaluations must include a medical and social history, historical data from patient and individual sources, thorough medical exam with neurological exam, and all appropriate diagnostic studies considered (Miller & Radelet, 1993).

10.2 Defining competency

Defining competence has many complex components in criminal cases, especially with a defendant that has mental illness. "A criminal case cannot proceed if the defendant is deemed incompetent. It's one of only two points in the criminal justice system where, legally speaking, the defendant's sanity matters. The other point in the criminal justice system when sanity is relevant is at the time that the crime was (allegedly) committed" (Roth, 2018, 176). One of the areas that is difficult to determine is if a person who is symptomatic is competent to stand trial

and to receive a fair trial. The Supreme Court ruled that, "[N]o man shall be called upon to make his defense, at a time when his mind is in that situation, as not to appear capable of so doing; for, however guilty he may be, the enquiring into his guilt, must be postponed to that season, when, by collecting together his intellects, and having them entire; he shall be able so to model his defense, as to ward off the punishment of the law" (Roth, 2018, 181; Old Baily Proceedings Online, 2017).

Several other issues arise when considering a death row case. First, does understanding the death penalty need to be a cognitive or an affective understanding? For example, does the defendant need to understand what the death penalty is or be able to comprehend the meaning of being put to death? When capital punishment is inflicted does the offender need to understand the complex process that is being inflicted on them and that they, as a person, will cease to live? This is up to the judge and jury's discretion, there is no set guideline or case to refer to.

Some states question *mens rea*, the intent of wrongdoing, in their consideration of the crime and the intent to commit the crime. For example, what does it mean to commit a heinous, atrocious, or cruel crime? Many people believe that retribution is necessary if a person murdered someone and had malicious intent. However, if there is no vicious intent behind the crime, and a mentally ill offender kills someone during a psychotic episode, should they still be sentenced to death? The majority of time when a mentally ill person commits a murder or seriously injures someone it is during a state of confusion and lack of mind-body control. They are suffering from an illness and unable to control or understand their actions. Since there is no intent behind the crime and the injury that the person inflicted was unintentional, there is debate as to whether the person that committed crime can or should be sentenced to death.

Death row inmates are in the custody of the state and do not have the right to refuse medication. This leads to the third, and possibly the most important question is, if a person who is mentally ill is not competent enough to stand trial, in and out of wavering competent stages, or if they experience chemically induced competence, is that equal to natural competence? Defendants that are considered not competent enough to stand trial are sent to a state hospital or a facility that works with them on regaining enough competence to make it through the court processes. "In what is often called legal education, classes that emphasize the intensive repetition of basic facts about the court system- including what the difference is between a misdemeanor and a felony or what the jury does" (Roth, 2018, 185). These facilities work through rehearsing situations a person might experience in the courtroom, being put on strong medication, and repetitive training on how to answer questions. Patients are put in an environment that promotes memorization or court-involved terms and how to parrot back answers. Some of these facilities have been observed using "competency" methods such as watching shows like *Law and Order*, *Criminal Minds*, and other crime shows to exhibit how the justice process works and how to respond to questions that the prosecution could ask. The average length of stay for competency-related issues is around 6 months. "Twenty states define *reasonable* [period of time] as a year or less because research has shown that most people will be restored in six months to a year and that trying to treat beyond that is pointless" (Roth, 2018, 187). If a person is considered un-restorable, they are either civilly committed to a hospital or the case is dismissed, either way leaving the person with little hope or help. In summary, are these programs restoring competency and teaching what the court process consists of or just trying to get the person proficient enough so that they can parrot back responses? This is a difficult area to determine and is as objective as the rest of the criminal justice process when it comes to mentally ill offenders. When medication

and treatment are given to avoid mental decline, is that truly competency and sanity? Since there are no clear guidelines, these are also questions the judge or jury is left to decide.

11. PREVENTION

Many preventative measures can be taken to divert mentally ill persons from jails and prisons and instead provide them with vital treatment to help rehabilitate them. First, as shown by the Sequential Intercept Model, preventing arrest takes intervention before a crisis occurs. People tend to react with emotion rather than logic during tense situations. Providing interventions to help deescalate the crisis rather than arresting people with mental illness makes a huge difference. In the case that someone is arrested, intervening early is critical to ensure that they receive appropriate treatment while incarcerated. Therapists and behavioral health services need to partner with the criminal justice system to provide services. This is where specialty court systems and specialty programs can help significantly. Mental health systems and criminal justice systems developing partnerships is vital to this process. "More successful collaborations permit utilization of specific best practice approaches that integrate attention to both behavioral health issues and criminal risk issues and use positive structure and support, more than negative contingencies and punishment, to support progress" (Committee on Psychiatry and the Community, 2016, 14). Practitioners and law enforcement partnering together creates a more consistent, stabilized way of helping the individual in crisis rather than the situation escalating and becoming dangerous. "Nearly 1 in 10 police encounters involve individuals with mental disorder, yet, until recently, few law enforcement agencies had a systematic approach to addressing "mental disturbance" calls, and few patrol officers were prepared to resolve such crises safely and effectively. Until recently, few communities had developed effective partnerships between law enforcement and behavioral health providers" (Committee on

Psychiatry and the Community, 2016, 57). Practitioners can help by putting law enforcement officers on alert if they have a patient who they think might become violent. By making that phone call and talking to the people who are likely to respond to an incident, the chances that the situation will escalate and the person having to be arrested significantly decreases.

Helping in smaller steps can make a huge impact. Rewarding and encouraging people in a community and individual basis helps the person in crisis manage the daily, internal crisis that they are struggling from and feel better about seeking help when needed. Many times, the mentally ill person does not feel safe and comfortable seeking help because of the negative stigma and consequences they experience due to their mental illness. Promoting an environment of encouragement and support goes a long way to helping them feel safe and turning to their treatment team when they need help.

As a community, the misconceptions about mental illness need to be addressed to decrease stigmatization, barriers to services, decrease the risk of violence, and help a population in need instead of isolating them from the rest of society. "Minimizing violence involves a culture shift: the safety of client and staff is considered a high priority. Welcoming, respect, and collaboration are built into every encounter within an environment that has safe spaces and safe procedures to defuse potentially risky situations, recognizing that violent encounters are most likely to be triggered when individuals who have previous trauma perceive themselves to be in danger and out of control" (Committee on Psychiatry and the Community, 2016, 32). Risk can be exacerbated by the lack of sensitivity and overreacting to potential violence by creating prion-like atmospheres in community-based settings (Committee on Psychiatry and the Community, 2016). Therefore, people need to feel safe and understood by the community that they live in. If a

mentally ill person, or any person, feels safe in a situation they are less likely to act irrationally and, therefore, bad outcomes are significantly reduced.

Increasing community resources that are available 24-7 to immediately evaluate people that need help can also positively impact the mentally ill. Most of the time the person does not need to be hospitalized but needs help, guidance, medication adjustment, etc. If the person has a place to turn (such as emergency walk-in clinics that are currently available for physically ill persons) there will be a safe structure to help the individual calm down and consider alternative options. Unfortunately, very few resources exist for immediate evaluation and emergency care.

When an inmate is released from a jail or prison they are placed back in society without any guidance, resources, or support to help them manage their time and choices after incarceration. This is especially difficult when the person has been detained for a long amount of time. While this is a tough situation for all prisoners, it can be extremely damaging and counterproductive for the mentally ill population. Placing them in a situation without resources, medication management or refills, social support, etc. puts them directly back in the circumstances they were in before arrest and increases their chances of recidivism. If the individual has a felony conviction, it is even more difficult to find housing and jobs than for others that have been in prison. "Repeated hospitalizations and incarcerations have made it hard for him to hold a job for very long. Each time he gets out, he has to start over again. Both mental illness and a criminal history carry stigmas that make it hard to explain gaps in employment or housing history when applying for a job or a new lease" (Roth, 2018, 216)**.** Helping plan reentry into the community can reduce the chances of the person being a repeat offender and having to be detained again and providing resources to support and monitor them after they are released and provide support to get, and keep, their life on track. Many people with mental illness stop

taking medication when they start to feel better and falsely believe that the medication is no longer necessary. Monitoring the individual could help prevent them from relapsing and also help adjust the medication to reduce uncomfortable side effects.

12. RESULTS

Current research has provided evidence that jails and prisons are not improving the mental health crisis, even though they hold one of the largest populations of mentally ill. Incarceration is based on punishment rather than medical care and those with mental illness that are being placed in these institutions are getting worse. While it may keep the mentally ill off the streets and out of the community, incarceration of these individuals does not benefit anyone, and it in no way assists the mentally ill individual in improving their life or managing their illness (Committee on Psychiatry and the Community, 2016). Placing a mentally ill person in jail at times may place their illness "on hold", but more often exacerbates the condition and in no way improves their health or their situation within their community.

Police officers are now being expected to manage situations more like social workers rather than the career for which they were trained and employed. Their lack of training in how to manage situations with people with mental illness is dangerous and frustrating for all involved. Researchers have shown that treating the mentally ill as patients rather than prisoners frequently creates positive results, however with the lack of long-term resources available outside of jails and prisons, those with mental illness often find themselves in a revolving cycle of arrest, incarceration, release, and relapse.

It is imperative that society implements a system filled with resources, training, competency, compassion and understanding. Those that suffer from mental illness are us, our families, and our friends. Just like a physical illness there is no way to determine who will get

sick and to what extreme they will have to suffer. "At the core, however, is the clear understanding that our system fails on almost every level to achieve the promise of justice, public safety, rehabilitation, and recovery" (Committee on Psychiatry and the Community, 2016, 3). A system needs to be implemented to repair and rehabilitate and provide growth and healing, not inflict punishment and suffering on the mentally ill and those around them. A new system and a new culture of understanding. One that, rather than stigmatizing and isolating those with mental illness, at its very core realizes that "the majority of people suffering from mental illness are being punished for a disease that they did nothing to deserve" (Committee on Psychiatry and the Community, 2016, 19).

13. SOLUTIONS AND FUTURE DIRECTIONS

All of this being said, the process behind the "justice system" now revealed, what do we do to change it? Many advocates believe that the mental health system owes it to both those suffering from mental illness and the criminal justice system to familiarize criminal justice officials on the roles and responsibilities of mental health workers. A new system based on collaboration and a process that benefits everyone, that puts mental health care workers in the forefront of crisis to deescalate situations rather than using untrained officers. Better long-term support resources need to be established so that the incarcerated population decreases, which in the end saves time, money, and resources. By lowering officer stress, providing better options for the mentally ill, and having trained mental health care workers and criminal justice officers to work together, and have a common goal, the need for jailing mentally ill offenders will reduce.

Earlier intervention to stabilize patients would reduce the need to get first responders involved. Acute care and outpatient facilities are more effective for medication management and stabilization than the trauma of arresting a mentally ill person and making them endure the court

process. Also, if there were more community-based treatment programs that focus on behavioral interventions and basic needs of the mentally ill- housing support, drug treatment, cognitive behavioral treatment, etc. arrests would decrease (Stone, 2018). Donald Stone (2018) noted "Focus on targeting identifiable subpopulations at elevated risk of violence, identifying effective treatments, and determining where policy interventions could reduce barriers to these treatments…the press should cease perpetuating the myth that people with mental illness are more prone to violence, the stigma and resulting social isolation of the mentally ill does nothing to improve society's sense of safety and security" (79). Rather than looking at how society is affected by the mentally ill, the perspective needs to shift to how to satisfy and help them through social interactions. People with mental illness are simply that, a person with an illness. They are still capable of reason, emotion, and living full and productive lives. Yet society's fear of mental illness often causes labels of those that suffer from it as different and deserving. "It could happen to us. It could happen to me… and that is such a frightening thought that we quietly search for explanations to prove that the mentally ill really aren't like us and they somehow deserve the torment they suffer" (Earley, 2006, 122).

For those that are arrested, mental health courts are becoming a new trend in the United States and have been shown to help reduce recidivism and prevent the mentally ill from having to be placed in jails and prisons. These courts are designed to work with clients and have different rules than other courts. They focus on patient treatment, finding resources and shelter for the mentally ill, and helping them regain and maintain their health. Mental health courts, and the officers that are trained to work with them, focus on both pre-booking and post-booking, diverting the mentally ill both before and after booking to prevent them from incurring a criminal record and helping them find rehabilitation. These systems typically consist of a crisis

intervention team (a first response team consisting of mental health workers and trained police officers), court supervision in the community, and a team of probation officers, mental health court staff, and mental health workers all working together to provide medical care, rather than incarcerating mentally ill offenders. These systems are efficient and have shown successful results. Unfortunately, only some states have established mental health courts and more often than not, the mentally ill are being processed by criminal courts and placed in jail. There needs to be community-wide partnership and a shift in the stigmatization of mentally ill persons. A community that is educated and compassionate about those with mental illness, not one that fears its victims but one that has shifted to understanding of it, making its management and health a priority with full knowledge of available resources for those individuals.

"It should be considered fundamentally unacceptable in our legal and behavioral health system that something like this happens to even *one* person, let alone thousands of people… we have become numb and unmotivated to facilitate change" (Committee on Psychiatry and the Community, 2016, 8). It should also be unacceptable to isolate and fear an entire group of people that need the help and support the community they live in. Instead of being set apart from community they need to be assimilated and included in the different aspects of life and be given the opportunity to live a "normal" life with a job, friends, and family. According to Steven Leifman, Associate Administrative Judge for the Eleventh Judicial Circuit of Florida, "We all must be part of the solution. However, if we do nothing it is clear that we will only perpetuate the recycling of individuals with mental illnesses through our criminal and correctional systems at great human and fiscal costs" (The Committee of Psychiatry and the Community, 2016, xiii)

14. CONCLUSION

The criminal justice system is a complex process for all of those that enter it. How to manage people within the system that suffer from mental illness is an even more difficult, and highly debated process. The historical record shows that there has always been a stigma attached to mental illness and disability. The stigma began with the first recorded incidents of mental illness and continues today in 2019. "The severe neglect of community mental health care in the United States has certainly contributed to the extraordinary number of people with mental illness behind bars… we have re-created much of the same dysfunction that pervaded the asylums of the nineteenth and twentieth centuries and the very abuses we sought to end by shutting them down" (Roth, 2018; 8). Despite all of the developments focusing on the nature, causes, and treatment of physical and mental illness, society seems to be stuck when it comes to improving conditions, providing adequate treatment, and socially accepting people with mental illnesses. Instead of growing, researchers have found that the stereotype of dangerousness of the mentally ill has actually increased due to media coverage of recent mass shootings, public policy, and false news reports about violent mentally ill offenders. "Yet in so many other ways, we continue to treat people with mental illness almost exactly as we did before electricity was invented, before women had the right to vote, and before the abolition of slavery. We still lock sick people away from the rest of society…its wrong because it doesn't cure mental illness or prevent people with mental illness from committing crimes when they get out. And it's wrong because locking up vulnerable people in inhumane conditions is fundamentally immoral" (Roth, 2018; 11). Additionally, "we want to believe they did something that caused their insanity. That is why we can justify housing them in inhumane conditions and punishing rather than treating them" (Earley, 2006, 122).

Mental illness always has been and always will be part of society. Just like physical illness, mental illness does not go away overnight and typically needs proper treatment to improve. Although the rehabilitation system might be adequate for some, the United States is drastically failing the mentally ill population. People with mental issues are being re-institutionalized in jails rather than treated and rehabilitated. In all of the situations discussed in this paper, the solutions are only temporary because the source of the problem, the subject's mental illness, has not been addressed (Green, 1997). We need to stop and decide what we are doing to better the lives of the mentally ill and question how our lives are really being bettered with a sick population of people being locked away. "If, as it is sometimes said, the definition of insanity is doing the same thing over and over again and expecting a different outcome, then there is little doubt that it is we, who continue to expect the nearly impossible from those least-equipped to handle it, are the crazy ones" (Roth, 2018, 268). The treatment of mental health is a crisis that is currently growing in the United States population and the methods that are being used over and over and are just delivering the same, noneffective outcomes. Methods of treatment have been inadequate to slow down or fix the problem. However, is not too late for change. As Slate and Johnson wrote in their book *Criminalization of Mental Illness* "Indeed, in any crisis there is danger, but there is also, often unrealized, the opportunity for positive change" (2008, 9). A crisis that is identified and improved can result in positive change rather than tragedy. With attention brought to the issues within the criminal justice system, stigmas reduced among the mentally ill, and true rehabilitation, the system can still be changed for the better and the lives of many people improved.

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