IMPROVING CONDITIONS FOR MENTALLY ILL INDIVIDUALS IN THE CRIMINAL JUSTICE SYSTEM

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INTRODUCTION

Deinstitutionalization, the process of moving the mentally ill out of large state-run institutions, was predicated in part on the assumption that individuals would be able to utilize community-based health care to meet their needs.[1] Despite this belief, adequate funding for these resources never materialized, leading to the unprecedented incarceration of the mentally ill. This results from minor offenses that are a frequent product of various mental illnesses.[2] Because of deinstitutionalization, America's prisons and jails have become the default mental-health facilities in the country,[3] with ten times the amount of mentally ill individuals as hospitals.[4] Yet, as Toni Carter, a commissioner in Ramsey County, Minnesota said, "Jail is jail;"[5] prisons and jails were not built to house and care for the country's mentally ill, and when mentally ill prisoners are released, their conditions have worsened.[6] Though a comprehensive solution to this pervasive problem will not be quick or inexpensive, the system needs reform. There are several possible routes for reform. One option is to promote diversion programs that reduce the number of those incarcerated and mentally ill. Another option is to promote programs designed to provide adequate levels of care and continuing support to the mentally ill already in the penal system to reduce recidivism rates. Both options have shown promise in states where they are used. However, until more states establish diversion programs with properly-equipped

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[1] *See* PBS, *Some Frequently Asked Questions*, PBS (May 10, 2005), http://www.pbs.org/wgbh/pages/frontline/shows/asylums/etc/faqs.html.

[2] *See* Michael Ollove, *New Efforts Aim to Keep The Mentally Ill Out Of Jail*, HUFFINGTON POST (May 19, 2015), http://www.huffingtonpost.com/2015/05/19/mentally-ill-jail_n_7316246.html.

[3] *See* David Eagleman, *Our Prison System Is Our De Facto Mental Health Care System*, BIG THINK, http://bigthink.com/in-their-own-words/our-prison-system-is-our-de-facto-mental-health-care-system.

[4] Meredith Clark, *Prisons are the 'New Asylums' of the US: Report*, MSNBC (Apr. 8, 2014), http://www.msnbc.com/msnbc/prisons-are-the-new-asylums-the-us#51523.

[5] Ollove, *supra* note 2.

[6] *See* TREATMENT ADVOCACY CENTER, *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey*, TREATMENT ADVOCACY CENTER (2014), http://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf.

facilities, the most viable option is to make sure those already in the penal system are receiving proper care.

I. DIVERSION PROGRAMS

If the problem with mental health care is that too many mentally ill individuals are funneled into jails and prisons, the most obvious solution is to prevent these individuals from being imprisoned in the first place. Diversion programs channel mentally ill individuals away from the criminal justice system to special mental health oriented tracks where they can get help.[7] Diversionary tactics consist of pre-booking models, in which individuals are diverted before they are even charged with a crime, and post-booking models, which divert individuals once they have been arrested and charged.[8] Common pre-booking strategies include training special police teams to respond to mental health crisis calls, hiring mental health professionals to work with police teams, and forming general partnerships between police officers and mental health service providers.[9] Common post-booking strategies include jail-based pretrial screening programs and mental health courts.[10] These strategies can be used separately or in combination with one another.[11]

Often, police officers arrest mentally ill individuals because there are no other ways for the individuals to get treatment.[12] Joel Dvoskin, chairman of the Nevada Behavioral Health and Wellness Council noted that "[i]f you dramatically increase the number of crisis options, police will be less likely to arrest [the mentally ill]."[13] Diversion strategies give police officers those alternative crisis options. Several cities have instituted plans that comport with this line of thinking.[14] In 2010, San Antonio, Texas opened a private treatment center as an alternative to hospitals and jails. A similar program in Miami, Florida, provides an alternative place to house nonviolent mentally ill offenders.

Although diversion programs are ideal, they necessarily rely on facilities in which the mentally ill can be housed and receive care. While both the San Antonio and Miami programs have saved their respective

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[7] *See* Frank Sirotich, *The Criminal Justice Outcomes of Jail Diversion Programs for Persons with Mental Illness: A Review of the Evidence*, 37 J. AM. ACAD. PSYCHIATRY & L. 461, 461 (2009).
[8] *See id.* at 462.
[9] *See id.* at 462–63.
[10] *See id.* at 463.
[11] *See id.* at 462.
[12] *See id.*
[13] Michael Braga et al., *'Definition of Insanity'*, TAMPA BAY TIMES (Dec. 18, 2015), http://www.tampabay.com/projects/2015/investigations/florida-mental-health-hospitals/competency/.
[14] *See id.*

states money,[15] the facilities required considerable funds to get running initially. The San Antonio program was made possible by funding by private donors.[16] The state-funded Miami program only has sixteen beds (up from ten beds), and the Florida legislature is hesitant to spend money on expanding these kinds of programs.[17] States already low on resources may not be willing to spend time and money developing new programs, when they already have other systems in place—however ineffective they may be.[18]

II. BETTER PRISON PROGRAMS

The incarcerated mentally ill are often mistreated or undertreated.[19] They do not receive adequate medical care, leave in worse condition than when they entered, and have high recidivism rates.[20] This is, in part, because correctional officers are not trained to identify signs of mental illness and deal with mentally ill individuals.[21] Not only is treatment inhumane, but the system is also actively wasteful. Soaring recidivism rates among the mentally ill indicate that mentally ill inmates often cycle through the system repeatedly, costing the system money.[22]

While keeping mentally ill individuals out of prisons and jails is the ultimate goal, correctional officers should still be taught how to recognize the symptoms of mental illness, and how to handle mentally ill individuals. Some states, such as Indiana, North Carolina, and Pennsylvania, already provide this training to corrections officers.[23] In Cook County Jail, by default one of the largest mental-health facilities in

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[15] *See id.* The San Antonio center saves the city ten million dollars per year. The Miami program costs twenty percent less than a mental hospital.
[16] *See id.*
[17] *See id.*
[18] *See* Treatment Advocacy Center, *supra* note 6 (encouraging jails and prisons to conduct cost studies because caring for mentally ill individuals outside of jail or prison may mistakenly appear to be the more cost effective option).
[19] *See* Dustin DeMoss, *The Nightmare of Prison for Individuals with Mental Illness*, HUFFINGTON POST (May 25, 2015), http://www.huffingtonpost.com/dustin-demoss/prison-mental-illness_b_6867988.html.
[20] *See id.*
[21] *See id.*
[22] *See* Treatment Advocacy Center, *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*, TREATMENT ADVOCACY CENTER (2010), http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.
[23] *See* Alisa Roth, *Officer Training for Mental Health in Short Supply*, MARKETPLACE (June 30, 2015), https://www.marketplace.org/2015/06/30/health-care/officer-training-mental-health-short-supply.

the country,[24] corrections officers learn about different mental illnesses and how to talk to mentally ill inmates. The officers then test their knowledge with roleplaying training exercises.[2526] Such training is important because it facilitates communication between prison guards and inmates, which can limit unnecessary use of force,[27] harmful solitary confinement,[28] and lengthier sentences for uncooperative inmates.[29] This in turn would reduce the number of lawsuits brought because of excessive force or death.[30]

It is also important to make sure that, upon release, inmates have the proper follow-up care they need. Aftercare programs for inmates are not always adequate.[31] For example, a survey of seventeen New Jersey jails found that, while twelve of the jails reported that release planning for mentally ill individuals was very or extremely important, ten of those jails only provided aftercare for less than ten percent of their inmates with mental illnesses.[32] In contrast, some states have taken more proactive measures. The Kansas Department of Corrections ("KDOC") has made a substantial commitment to prisoner aftercare with its mental health re-entry services.[33] "For years, we used to think our services stopped at the door and the community took over," said Viola Riggin, director of health care services for KDOC.[34] Now, mentally ill inmates work with parole officers and KDOC discharge planners up to eighteen months in advance of release.[35] The new program follows up with inmates for up to ninety days after release, lengthening their transition time from the previous thirty-day limit.[36] Riggin added, "That [ninety]

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[24] *See* Matt Ford, *America's Largest Mental Hospital is a Jail*, THE ATLANTIC (June 8, 2015), https://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/.
[25] *See* Roth, *supra* note 23.
[26] *Id.*
[27] *See* Jamie Fellner et al., *Callous and Cruel: Use of Force Against Inmates with Mental Disabilities in US Jails and Prisons*, HUMAN RIGHTS WATCH (May 12, 2015), https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and.
[28] *See* FRONTLINE: THE NEW ASYLUMS (PBS 2005).
[29] *See* PBS, *supra* note 1.
[30] *See* Roth, *supra* note 23.
[31] Treatment Advocacy Center, *supra* note 22.
[32] Nancy Wolff et al., *Release Planning for Inmates with Mental Illness Compared With Those Who Have Other Chronic Illnesses*, 53 PSYCHIATRIC SERV. 1469, 1470 (2002).
[33] *See* Meg Wingerter, *Officials Step up Support for Parolees with Mental Health Issues*, THE GARDEN CITY TELEGRAM (Nov. 1, 2016), http://www.gctelegram.com/news/state/officials-step-up-support-for-parolees-with-mental-health-issues/article_09782855-f641-5851-8871-680519e0061d.html.
[34] *Id.*
[35] *See id.*
[36] *See id.*

days, it's just imperative. Every time a patient breaks down [his or her] mental health treatment, it can cause permanent damage."[37] Though it is not clear whether the program has saved money, since it started in 2006, recidivism rates for parolees with mental illnesses has dropped from 75% to 35%.[38]

CONCLUSION

Of the two solutions presented above—diversion programs or equipping jails and prisons to deal with the mentally ill—the latter seems more immediately feasible. Diverting mentally ill individuals requires places ready to divert them to. Until those facilities are built, it makes sense to properly equip the place where they are currently reside.

One impediment to the development of community-based mental-health resources has been the Medicaid Institutes for Mental Disease exclusion ("IMD exclusion").[39] This exclusion prevented the use of federal Medicaid funds for the treatment of patients aged twenty-one to sixty-five in mental health or substance abuse residential treatment facilities with more than sixteen beds.[40] The law remained unchanged for years, until April 2016, when the government issued a final rule that, among other things, softened the IMD exclusion.[41] Now, it allows plans to cover fifteen day inpatient stays for individuals aged twenty-one to sixty-four. Though this change is not as dramatic as the full repeal that some hoped for,[42] it is a step in the right direction. Hopefully it is only the first step of many.

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[37] *Id.*
[38] *Id.*
[39] *See* Brittany La Couture, *The Problems with The IMD Exclusion*, AMERICAN ACTION FORUM (Oct. 15, 2015), https://www.americanactionforum.org/insight/the-problems-with-the-imd-exclusion/#_ednref1.
[40] *See id.*
[41] *See* Alison Knopf, *Medicaid Rule Puts IMD Exclusion in Better Context*, BEHAVIORAL HEALTHCARE EXECUTIVE (June 7, 2016), http://www.behavioral.net/article/medicaid-rule-puts-imd-exclusion-better-context.
[42] *See, e.g.*, NASMHPD, *Position Statement on Repeal of the Medicaid IMD Exclusion*, NASMHPD (June 6, 2000), https://www.nasmhpd.org/content/position-statement-repeal-medicaid-imd-exclusion.