

# A CALL TO ACTION

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Ending an American Tragedy:  
Addressing the Needs of Justice-Involved People  
with Mental Illnesses and Co-Occurring Disorders

National Leadership Forum on  
Behavioral Health/Criminal Justice Services

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In 1841, Dorothea Dix was appalled by the conditions she observed in Massachusetts jails and crusaded for more humane responses to the needs of those inmates with mental illnesses. Within a decade her work was translated into therapeutic state run institutions that traded punishment for care. Over the next century, without sustained commitment to Dix's vision for recovery, these facilities fell into disrepair to the point that today, hundreds of thousands of people with mental illnesses crowd our county jails and state prisons.

In 1946, Life Magazine published an exposé detailing cruel and inhumane conditions in State psychiatric hospitals across the United States.<sup>1</sup> The article described widespread abuse of patients resulting, in part, from “*public neglect and legislative penny pinching*,” and was punctuated by a series of haunting photographs depicting desolate and shameful conditions under which people with mental illnesses were being confined, often for years or even decades on end. The author referenced grand jury reports as well as State and Federal investigations documenting widespread abuses and hazardous living conditions in State institutions. Citing severely inadequate staffing, substandard treatment, inappropriate use of restraints, and provision of little more than custodial care, the institutions were described as, “...*costly monuments to the States' betrayal of the duty they have assumed to their most helpless wards*”

Although the population of State psychiatric hospitals continued to grow over the next decade, the publication of this article, along with similar accounts from other media sources, began to expose a crisis that had existed largely hidden from public view for far too long. As more light was shed on the horrific treatment people received in State psychiatric hospitals, along with the hope offered by the availability of new medications, a flurry of federal lawsuits resulted in court decisions leading to substantial reductions in the numbers of people housed in State psychiatric hospitals.

Unfortunately, while State hospital beds were shut down by the thousands, the types of comprehensive community-based services and supports promised as a condition of their closing were never developed. Combined with changes in sentencing practices,

1 (1946). Bedlam 1946: Most U.S. mental hospitals are a shame and a disgrace.



1940s State hospital

evolution of quality of life ordinances, and restricted definitions of eligibility for public sector behavioral health services, this has resulted in many individuals with mental illnesses and co-occurring substance use disorders repeatedly coming into contact with the criminal justice system. Our Nation is once again in the midst of another shameful and costly mental health crisis that has been allowed to fester and grow, largely out of public sight. It is a secret of stunning proportions; in numbers and in harm.

Everyday, in every community in the United States, our law enforcement officers, courts, and correctional institutions are witness to a parade of misery brought on by an inadequately funded, antiquated, and fragmented community mental health system that is unable to respond to the needs of people with serious mental illnesses. Each year, more than 1.1 million people diagnosed with mental illnesses are arrested and booked into jails in the United States. Roughly three-quarters of these individuals also experience co-occurring substance use disorders, which increase their likelihood of becoming involved in the justice system. On any given day, between 300,000 and 400,000 people with mental illnesses are incarcerated in jails and prisons across the United States, and more than 500,000 people with mental illnesses are under correctional control in the community.

Over the past 50 years we have gone from institutionalizing people with mental illnesses, often in subhuman conditions, to incarcerating them at unprecedented and appalling rates—putting recovery out of reach for millions of Americans.

These people are not all the same. They are a heterogeneous group.

- A small subgroup does resemble the State hospital patients of yesteryear, and their presence in our jails/prisons is one of the most egregious and disturbing images related to our failed systems of care. The availability of intensive care models, including hospital care for some, is critical.
- Many other citizens with mental illnesses in our jails have less disabling conditions and with access to appropriate community treatment and support, will do quite well.
- A third subgroup includes people with mental illnesses who have traits that are associated with high arrest and recidivism rates. These individuals would be best served with good treatment and supports, which include interventions targeted to their dynamic risk factors for arrest.

As we attempt to respond to the needs of these people and respect the legitimate public safety concerns of all community members, conditions in these correctional settings, which are designed for detention and not therapeutic purposes, are often far worse than conditions described in the State hospitals of the 1940s. Moreover, when justice-involved persons with co-occurring disorders leave correctional institutions, they repeatedly are left adrift only to recycle through the criminal justice system. Furthermore, individuals who become involved in the justice system often must contend with the additional stigma of criminal records, which make access to basic needs in the community, such as housing, education, and employment, even more difficult to obtain.

*This national disgrace, kept hidden for too long, represents one area in civil rights where we have actually lost ground. This failed policy has resulted in a terrible misuse of law enforcement, court, and jail resources, reduced public safety, and compromised public health.*

These conditions have recently resulted in investigations into the treatment of people with mental illnesses in institutional settings, only this time the institutions are correctional facilities that were never intended to serve as de facto psychiatric hospitals. Over the past decade alone, the U.S. Department of Justice has issued findings from investigations of mental health conditions in more

than 20 jail and prison systems across the United States, with additional investigations currently ongoing. Equally reminiscent of the past, among the more pervasive findings from these investigations are severely inadequate staffing, substandard treatment, inappropriate use of restraints, and provision of little more than custodial care.

The following excerpts are taken from recent grand jury and Department of Justice reports:

- “During our tour, we observed inmate JM hitting her head on the window of her cell and talking with slurred speech. She was housed in a hospital cell under suicide watch. She spoke of seeing angels and said that she was afraid of her cellmate (who was in the advanced stages of pregnancy) was trying to harm her. She had been at [the jail] for approximately one month prior to our visit. JM stated on her intake



Courtesy WFOR-TV Miami

2009 county jail psychiatric unit

form that she had previously been treated at a mental hospital in Little Rock and that she had been seen at a local hospital in January 2005 for seeing ‘spiritual things.’ Shortly after her admission to [the jail], she was placed on suicide watch for making statements about going to sleep and not getting up and ‘not caring if she was alive or not.’ Her medical record notes numerous instances of ‘talking wildly’ and ‘talking to herself.’ She told us that she had a history of hypothyroidism and told us the names of various psychiatric medications that she had been taking before being admitted to [the jail]. Throughout our tour, we could hear JM moaning and crying and at times

screaming. In spite of all this, this inmate was never evaluated by a mental health care provider. We were told that she was not started on any psychiatric medications or sent to the local hospital because she did not have the ability to pay.”

- “Inmate M.K. hung herself on January 5, 2003 after having been admitted on December 4, 2002. Her record contained the following inmate request form dated two days before her death on January 3, 2003. The note indicated the following:

*‘I need to see the doctor to get my medicine straightened out. I am not getting my meds that my doctor faxed prior orders for me, and I brought in the medication myself and paid for it. I cannot afford to be treated this way! Please help me! I need my medicine.’*

There is no indication that M.K. received her medication before her death.”

There are no comparable Department of Justice investigations into a lack of community services, because there is no constitutional right to community-based services as there is for persons who are incarcerated. However, by contrast, there are success stories in the community. A recent report by the Health Foundation of Greater Cincinnati offers a number of compelling personal stories from four Forensic Assertive Community Treatment (FACT) Teams they fund.



1940s State hospital

Courtesy State Archives of Florida

- “My housing is a lot better. My Social Security just got approved today, so I start receiving that again. They cut it off while I was in prison. I did 18 months in prison. I got [Social Security] back with the help of [the FACT team]. And they’ve been helping me with my housing. And that’s a lot better ‘cause now I can get adjusted to a certain environment. And I don’t have to worry about where I’m going to live, one week to the next for whatever reason.”
- “Well, I was really in bad shape. I didn’t know how to go about getting help. The only thing that I really knew that I had to do was try to care for myself and my habit. And that’s what leads to criminal behavior, which limited me on jobs. I felt like I couldn’t work because of my record. So, I had to keep being a criminal to support myself and my habit. I didn’t know where to go for help. I didn’t know who to talk to. I was suicidal all the time. And I really hated myself for all the feelings and things that I was doing. I had an apartment but I was evicted because I couldn’t pay the rent. And then, I was just, like, going from place to place and sometimes in homeless shelters and sometimes with friends or just wherever. I was in jail all the time. I just spent two years in the penitentiary. I’ve been in the penitentiary 3 times and I’ve been in jail probably 30 to 40 times.” The same consumer, when asked about life after receiving FACT services, reported: “Yeah, I haven’t had any problems. I work at McDonalds full-time.”

Clearly, jails and prisons were never intended as a community’s primary setting to provide acute care services to individuals experiencing serious mental illnesses. In most cases they are ill equipped to do so.

When we look at community-based services, we find current policies governing the funding and organization of community mental health care have resulted in people with more intensive and chronic treatment needs being underserved or unserved in typical community-based settings. This is due in large part to rules and regulations that limit flexibility in designing service and reimbursement strategies targeting the specific needs of people with serious mental illnesses. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and

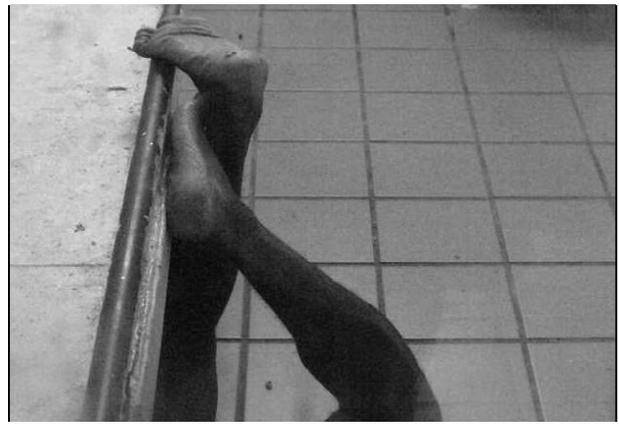
Medicaid Services (CMS) are two agencies housed within the U.S. Department of Health and Human Services (DHHS). SAMHSA has identified intensive case management, psychosocial rehabilitation, supported employment, and supported housing as evidence-based interventions, consistently yielding positive outcomes for persons with serious mental illnesses.

However there are several obstacles to using Medicaid to pay for these effective services. These include categorical restrictions on eligibility, which exclude many people with serious mental illnesses and co-occurring substance use disorders who have been involved in the criminal justice system, as well as fragmentation in coverage for treatment of medical, mental health, and substance abuse problems. Narrow criteria for "medical necessity" and definitions of covered services that are often not aligned with what we know about evidence-based practices create barriers to more effective service delivery and recovery outcomes. As a result, there is an increased demand for services provided in hospitals, emergency settings, and the justice system, contributing to extraordinarily high costs for local communities, states, and the Federal government.

Furthermore, new practices have been slow to be made available to justice-involved persons with co-occurring disorders. For example, it has now become widely accepted that all services for people with serious mental illnesses, particularly those with criminal justice involvement, be trauma-informed. Among both women and men with criminal justice involvement, histories of trauma are nearly universal. Ninety-three percent of 2,000 women and men in federally funded jail diversion programs between 2002 and 2008 reported at least one incident of physical or sexual abuse in their lifetime. Sixty-one percent reported physical or sexual abuse in the last 12 months. Yet few programs, institutional or community-based, offer environments that are trauma informed or trauma specific.

Moreover, a recent study found 31 percent of women being booked into local jails with current symptoms of serious mental illness.<sup>2</sup> This compares with 14 percent of men. These rates exacerbate the issues of providing

2 Steadman HJ, Osher F, Clark Robbins P, Case, BA, & Samuels S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60: 761-765.



Courtesy WFOR-TV Miami

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adequate services for women in predominantly male facilities whose physical plants and staffing are geared to men. Gender-specific services that reflect a trauma-informed culture must be developed in all institutional and community settings to respond to the frighteningly high rates of mental illness among women in contact with the criminal justice system.

In addition, we know that individuals using mental health services—often referred to as “consumers”—have a significant impact on creating recovery-oriented mental health and substance abuse services. For people involved in the criminal justice system, forensic peer specialists—those with histories of mental illness and criminal justice system involvement—can help pave the way for a successful return to the community.

The ability to effectively design, implement, and reimburse treatment providers for delivering high quality services targeting specialized treatment needs is critical to establishing an effective community-based system of care for people who experience serious mental illnesses. In the absence of what are now seen as essential services for people with mental illnesses living in the community, people will continue to be forced into more costly, deep-end services in hospitals, crisis centers, emergency rooms, and the justice system.

The result is a recycling of individuals between jails, prisons, shelters, short-term hospitalizations, and homelessness—with public health, public safety, and public administration implications that are staggering. Now more than ever, as we strive to provide health care to our most vulnerable citizens, *we must address this serious public health and public safety crisis. It is*

*high time to be open and honest about the deplorable conditions that exist and take steps to address them. We offer four recommendations for immediate action.*

### Recommendations for Immediate Action

✓ **The President should appoint a Special Advisor for Mental Health/Criminal Justice Collaboration.**

Currently, there is no fixed responsibility within the Federal government to promote effective mental health/criminal justice activities and ensure accountability for the use of public dollars. The Special Advisor will serve as an advocate and ombudsman across the wide array of Federal agencies that serve the multiple needs of justice-involved people with mental and substance use disorders. One of his or her tasks will be to implement an immediate review of all CMS and SAMHSA regulations to identify conflicts and inconsistencies for people with mental illnesses and co-occurring substance use disorders—particularly those involved in the justice system.

✓ **Federal Medicaid policies that limit or discourage access to more effective and cost-efficient health care services for individuals with serious mental illnesses and co-occurring substance use disorders should be reviewed and action taken to create more efficient programs.**

Congress is encouraged to review Medicaid policies and take action that will enable states to create more effective and appropriate programs targeting eligible beneficiaries most likely to experience avoidable admissions to acute care settings. Such programs should allow states flexibility in designing and implementing targeted outreach and engagement services, coordinated care management, and community support services that are likely to reduce expenditures on deep-end services, and engage people in prevention, early intervention, and wellness care in the community. Services provided should reflect evidence-based and promising practices and should be designed around principles of recovery, person-centered planning, and consumer choice. Because of the high rates of co-morbid health care needs among people with serious mental illnesses and co-occurring substance use disorders, programs should seek to

establish more effective integration of primary and behavioral health care service delivery system as well.

✓ **All States should create cross-system agencies, commissions, or positions charged with removing barriers and creating incentives for cross-agency activity at the State and local level.**

No one system can solve this problem alone. These cross-system groups or individuals will play a key role in spanning the different administrative structures, funding mechanisms, and treatment philosophies of the mental health, substance abuse, and criminal justice systems. States must make clear that collaboration is not only possible but expected. In Montana, for example, the State Department of Corrections and Department of Public Health and Human Services jointly fund a boundary spanner position that facilitates shared planning, communication, resources, and treatment methods between the mental health and criminal justice systems.

✓ **Localities must develop and implement core services that comprise an Essential System of Care:**

Recognizing the limited resources often available and the complexities of the cross-system collaborations required, the eight components of an Essential System of Care are best approached in two phases. Phase 1 includes less expensive, easier to mount services. Phase 2 includes essential evidence-based practices that are more expensive and more challenging to implement, but are critical to actually increasing positive public safety and public health outcomes.

#### Phase 1

- **Forensic Intensive Case Management**
- **Supportive Housing**
- **Peer Support, and**
- **Accessible and Appropriate Medication**

These four services are the ones we believe are minimally necessary to break the cycle of illness, arrest and incarceration, and recidivism. We believe these services—described in brief below—can be

implemented quickly, cost-effectively, and with positive results. However, these services can only be effective if the programs that provide them are structured and staffed by people who understand and are prepared to address trauma as a risk factor for both mental health problems and criminal justice involvement. A trauma-informed system that features trauma-specific interventions can help ensure public health and public safety and transform individuals' lives.

**Forensic Intensive Case Management (FICM)** is designed for justice-involved people with multiple and complex needs and features services provided when and where they are needed. FICM focuses on brokering rather than providing services directly, making it less expensive than ACT. For a brokered service model to be effective, communities must have adequate and accessible services to which individuals can be linked. What makes these services "forensic" is "criminal justice savvy,"<sup>3</sup> that is, providers understand the criminal justice system and the predicaments of their clients involvement in it.

**Supportive Housing** is permanent, affordable housing linked to a broad range of supportive services, including treatment for mental and substance use disorders. Supportive housing can significantly decrease the chance of recidivism to jails and prisons and is less costly on a daily basis than jail or prison. Unfortunately, affordable housing is in short supply in many communities, and ex-offenders with drug-related offenses often have trouble securing public housing assistance. Housing for ex-offenders must balance the needs for supervision and the provision of social services.

**Peer Support** services can expand the continuum of services available to people with mental and substance use disorders and may help them engage in treatment. Forensic peer specialists bring real-world experience with multiple service systems and an ability to relate one-on-one to people struggling to reclaim their lives. The practice of consumer-driven care—as exemplified by the involvement of mental health consumers in service design, delivery, and evaluation—is at the heart of a transformed mental health system.

3 Morrissey J, Meyer P, & Cuddeback G. (2007). Extending Assertive Community Treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal*, 43(5).



Courtesy Sharon Wise

### Youth support family members with mental health and substance abuse issues, 2008

**Accessible and Appropriate Medication** supports continuity of care for individuals with mental illnesses whose treatment often is disrupted when they become involved in the criminal justice system. They may not receive appropriate medication in jail or prison or adequate follow-up when they return to the community. It is imperative that people with mental illnesses and co-occurring substance use disorders have access to the right medication at the right dosage for their condition, as determined by the individual together with his or her clinician.

### Phase 2

Clearly, the Phase 1 services are necessary, but not sufficient. Services that support the Essential System of Care include several evidence-based practices for people with serious mental illnesses. These services may be more expensive or difficult to implement than the four listed above, but we encourage States and communities to move toward development of these services by codifying them in policy, supporting them in practice, and rewarding their implementation. Phase 2 services include:

- **Integrated Dual Diagnosis Treatment**, which provides treatment for mental and substance use disorders simultaneously and in the same setting
- **Supported Employment**, which is an evidence-based practice that helps individuals with mental illnesses find, get, and keep competitive work
- **Assertive Community Treatment (ACT)/ Forensic Assertive Community Treatment**

(FACT), which is a service delivery model in which treatment is provided by a team of professionals, with services determined by an individual's needs for as long as required, and

- **Cognitive Behavioral Interventions Targeted to Risk Factors** specific to offending, are a set of interventions, well researched within both institutional settings and community settings, that have a utility when extended to community treatment programs.

This list of evidence-based and promising practices is illustrative but not exhaustive. Clearly, however, there is much that can be done to help people with mental and substance use disorders avoid arrest and incarceration and return successfully to their communities after jail or prison. We acknowledge that in difficult financial times, new dollars may not be available. However, though new money is not always required for systems change, new ways of thinking are.

To meet the public health and public safety needs of our communities demands a fully collaborative campaign involving both the behavioral health and criminal justice systems. Neither system can continue business as usual. The criminal justice system needs to do an adequate job of screening, assessing, and individualizing responses to detainees and inmates identified with mental illness. The behavioral health system needs to refine and deliver evidence-based practices with an awareness of its responsibility to not only improve the quality of life of its clients, but to address interventions to factors associated with criminal recidivism in these clients and to more directly involve clients as partners in a recovery process that recognizes the community's public safety concerns.

Prime examples of this Essential System of Care have been developed within the CMHS TCE Jail Diversion program since 2002. San Antonio, TX, has become a national model with a highly integrated system of care that reflects strong behavioral health and criminal justice partnerships that have resulted in a centralized police drop-off that directly links persons to case management, medications, housing, and peer support. A medium-size city that has built a comprehensive, integrated system around an existing community mental health center is Lincoln, NB. These are but two examples of successfully moving entire

communities forward via a jail diversion program to achieve Phase 1 services and move towards Phase 2 implementation. These goals are achievable even in today's economic tough times.

We must move toward a day when people with mental and substance use disorders receive the effective community-based interventions they need and deserve, and jails and prisons no longer are forced to serve as primary, de facto treatment facilities. We know what works to address successfully the needs of people with mental and substance use disorders who come in contact with the criminal justice system; now we have to *DO* what works. *The time for action is now!*

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### *National Leadership Forum Members*

**Thomas Berger**

*Vietnam Veterans of America*

**Sandra Cannon**

*Ohio Department of Mental Health*

**Neal Cash**

*Community Partnership of Southern Arizona*

**David Fuller**

*Manhattan Outreach Consortium*

**Robert Glover**

*National Association of State Mental Health Program Directors*

**Gilbert Gonzales**

*Bexar County Mental Health Authority Center for Health Care Services*

**Richard Gowdy**

*Missouri Department of Mental Health*

**Jennifer Johnson**

*San Francisco Office of the Public Defender*

**Hon. Steve Leifman**

*Special Advisor on Criminal Justice and Mental Health to Florida Supreme Court*

**Stephanie LeMelle**

*New York State Psychiatric Institute, Columbia University Department of Psychiatry*

**Ginger Martin**

*Oregon Department of Corrections Transitional Services Division*

**John Morris**

*The Technical Assistance Collaborative*

**Fred Osher**

*Council of State Governments Justice Center*

**Linda Rosenberg\***

*National Council for Community Behavioral Healthcare*

**David Shern**

*Mental Health America*

**Henry J. Steadman\***

*Policy Research Associates, CMHS National GAINS Center*

**Carol Wilkins**

*Corporation for Supportive Housing*

**B. Diane Williams**

*Safer Foundation*

**Dee Wilson**

*Texas Department of Criminal Justice*

**Sharon Wise**

*The Gregory Project of Washington D.C.*

\*Co-chair of National Leadership Forum