BY DONNA LYONS

Fifty-year-old Eddie has spent much of his life in and out of prison for crimes that included drug possession, larceny and burglary. Often homeless, he recalls his stints in jail as a respite from the overwhelming task of taking care of himself. Last fall, Eddie, a grandfather, reached an important turning point in his life. He became the first client discharged from a mental health court in Santa Fe, N.M. Similar to drug courts, the specialized courts are designed to help people like Eddie get mental health treatment, manage their lives and stay out of jail.

“It’s amazing to see the changes in someone over a year with the services and supervision of this court,” says Lupe Sanchez, program manager for the court in the First Judicial District in Santa Fe. Most clients are probation violators. A tough customer, Eddie spent as much as 20 years behind bars, Sanchez said. “Mental health services and case management can help a guy like him go from having no structure and responsibility to being able to live self-sufficiently. No doubt he otherwise would be in jail.”

THE NUMBERS ARE STAGGERING

A recent report by the federal Bureau of Justice Statistics said that more than half of all prison and jail inmates have a mental health problem. That works out to be 705,600 offenders in state prisons and 479,900 in local jails. Mental disorders are increasingly common in the United States, but their prevalence in criminal justice systems is estimated at three times the rate of the general population. Convicts also are more likely to suffer from more than one illness, in particular schizophrenia, bipolar disorder, major depression or acute psychosis “co-occurring” with substance abuse.

The deinstitutionalization of the mentally ill in the 1960s was designed to care for those with acute mental health needs in the community instead of in state-run asylums. But the movement to be more compassionate and cost-effective in treating those with mental illness has had a down side. In the generation since many state mental hospitals closed and treatment approaches shifted to the com-

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munity, many people with serious mental illnesses have failed to get the treatment they need. For some, that means homelessness and crime, and advocates now decry what they call the “criminalization of the mentally ill.”

It is estimated that as many as 40 percent of people in this country with mental illness are not receiving treatment. Some are prone to substance abuse and nuisance or “quality of life” crimes such as trespassing, disorderly conduct and public intoxication. Some drift into property crimes or prostitution, while others may become serious and even dangerous offenders.

Only about one third of offenders with mental health needs receive treatment, according to the Bureau of Justice Statistics survey. Released without care, many such offenders remain in a cycle of crime and incarceration that often starts with juvenile arrests and persists into adulthood.

TRAINING POLICE

Police encounters with the mentally ill are frequent and unpredictable. On a routine basis, police deal with cases of vagrancy and nuisance crimes. They also respond to incidents in which people with mental illness are victims of crime. Officers must make quick determinations of a person’s danger to themselves or others, and try to defuse situations that endanger them or escalate into “suicide by cop” or other tragic scenarios.

Training and experience help police officers recognize signs of mental illness and adapt their response. Symptoms like hallucinations and incoherence may be fairly recognizable; other disoriented, delusional and depressed behaviors may be less conclusive. Many people that police deal with are high on drugs or alcohol, which can contribute to erratic behavior and be confused with signs that a person is suffering from a mental illness.

Police departments around the country have developed “incident management” response and training to deal with individuals exhibiting symptoms of mental illness. Some include training a specialized group of officers to respond to mental health crisis calls and partnerships with the health community to provide emergency psychiatric intervention and follow through services.

A MOVE TO TREATMENT

A growing number of jurisdictions are diverting suitable offenders with mental illness from jails to treatment services. The district court mental health program in Santa Fe that Eddie took part in is just one of many around the country using court supervision to divert and treat mentally ill offenders.

The exploding interest in mental health courts is seen in numbers compiled by the Bureau of Justice Assistance (BJA). In 1997 there were four known mental health courts in the country. By 2004 the number was 70 in 29 states; and by 2006 there were 120 mental health courts in 35 states. BJA administers grants to 37 of these courts around the country.

One, in Reno, Nev., began in 2001 with no additional money but with judges willing to give up their lunch hour to try to connect mentally ill defendants with the minimal services available in the community, according to Sheila Leslie, the Assembly’s majority whip and chair of the Health and Human Services Committee. Leslie also is the specialty courts coordinator for the District Court in Reno.

Quickly, Leslie says, police, other judges and advocates for the mentally ill were on board. The Reno court supervises mental health court participants for one to three years, depending on the seriousness of the charge, which can include felonies as well as misdemeanors.

“The person is much more important than the charge,” says Leslie. Some of their actions, like assault with a deadly weapon, sound horrible, Leslie said, “but when you really look at the incident and individual, you sometimes see a very acute mental illness more than a violent offender,” she says.

Leslie acknowledges that some of her colleagues in courts and in the Legislature question how many specialty courts are high on drugs or alcohol, which can contribute to erratic behavior and be confused with signs that a person is suffering from a mental illness.

PAYING FOR MENTAL HEALTH SERVICES—FACTS AND FIGURES

◆ In any given year, about 5 percent to 7 percent of adults have a serious mental illness. A similar percentage of children—about 5 percent to 9 percent—has a serious emotional disturbance.

◆ In 2001, $85 billion was spent on the treatment of mental disorders in the United States. These expenditures represented 6 percent of all health care spending.

◆ Between 1996 and 2001, the average annual increase for mental health spending was 6.7 percent, a rate comparable to the 6.4 percent rate for general health costs.

◆ About a fifth of people who use mental health services have Medicare coverage, about 10 percent use Medicaid as their primary source of coverage, and private insurance covers just over half. As many as one in five people with a mental health need is uninsured.

◆ Public money plays a greater role in financing mental health services than in health care generally and its role as a payer is increasing relative to other payers. In 1991, Medicaid accounted for 19 percent of expenditures, private insurance for 22 percent, and Medicare for 3 percent. In 2001, Medicaid accounted for 27 percent of mental health expenditures, private insurance held steady at 22 percent, and Medicare accounted for 7 percent. State payments to mental health providers outside the public or private insurance systems made up 27 percent of expenditures in 1991 and 23 percent in 2001.

◆ With responsibilities for Medicaid, state mental health payments, and other smaller funding sources, states manage most of the public money that supports mental health services.

◆ The types of services provided to people with mental health needs have shifted away from inpatient care in recent years. Outpatient, residential and especially prescription drug services account for an increasing share of mental health expenditures. Prescription medicines represented one of every $14 spent on mental health in 1991, but one in five in 2001, a share equal to that now spent on inpatient care.

◆ Public health care financing programs do not provide reliable funding for housing, employment and other support services needed in a community setting. States are trying a variety of ways to finance community support services and to connect them with medical services, but significant service gaps remain.

—Donna Folkemer, NCSL
Remembering Victims When Defense Is Insanity

When people with mental illness commit crimes, their victims are often left frustrated with the criminal justice system. Legal procedures surrounding the insanity defense are confusing and victims’ rights can be diminished.

“In many instances, victims don’t receive notices of hearings or even of a release,” says John Gillis, director of the federal Office for Victims of Crime. “When an offender becomes a mental patient, you have two different agencies with different interests involved,” he says. “It’s important that victims not get lost in that.”

Although many criminal offenders have mental health problems, insanity pleas are used in relatively few cases, and successful in even fewer. The legal test for insanity varies from state to state, but generally involves a severely abnormal mental condition that significantly impairs a person’s perception of reality and understanding of the charges faced. A defendant’s mental health is decided by a judge or jury after evaluation and testimony by experts, usually psychiatrists.

State legislation in recent years has begun to address what victim advocates consider a gap in providing appropriate rights and services to crime victims.

◆ Alabama, Arizona, Arkansas, Indiana Maine, Minnesota, Pennsylvania and Tennessee require notifying a victim of a defendant’s release from a mental institution.
◆ North Dakota gives victims the right to prompt notice if their offender is transferred to a mental health facility. Virginia requires notice to the victim if the offender is allowed an unescorted community visit from the institution.
◆ Laws in Arizona, Connecticut, Maryland, Missouri and Pennsylvania allow victims to present and make statements at any applicable court or board hearings regarding the release of a mentally ill offender.
◆ Illinois allows victims to pursue a cause of action against a defendant who has committed a crime against them but has been found not guilty by reason of insanity or guilty but mentally ill. The case may be tried and damages recovered as any other civil case.

Whether a defendant is “not guilty by reason of insanity,” or “guilty but mentally ill,” these policies represent steps to see that the rights of victims are not discarded.

More information on victim rights and services is available in NCSL’s recently published Victims Rights Laws in the States. You can reach NCSL’s bookstore by calling (303) 364-7700 x 1621 or by logging on at www.ncsl.org/bookstore/index.htm.

—Sarah Hammond, NCSL

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General Assembly increased by $26 million the funding to 40 community service boards that administer crisis intervention and case management services.

An objective of that funding is a better community mental health infrastructure that can divert offenders to treatment, according to Hamilton.

“We hope the result of this will be to at least reduce the numbers of mentally ill people in prisons and jails and relieve some of the pressure on the corrections system,” Hamilton says. “Prisons and jails were never meant to be mental health facilities.”

In Indiana several years ago, lawmakers created a seven-county pilot “forensic diversion program” to provide community mental health and addiction services to non-violent offenders. Those programs now are being reviewed to identify the most effective common elements, according to Senator Joe Zakas, the Senate majority whip.

State divisions of community corrections and mental health and addiction are working together to oversee the locally run programs as a prison alternative for suitable offenders.

“These people have struggled,” says Deana McMurray, director of the Community Corrections division. “They don’t have good jobs and health insurance. Many have alienated their families, as well,” she says.

Most of the felony defendants in Indiana’s program are offenders who have substance abuse problems as well as a mental health condition, according to McMurray. Untreated, she says, this population re-offends at a high rate.

“Decreasing recidivism was the primary motive for the forensic diversion programs,” Senator Zakas says. “The cost of prison housing is enormous. Using community corrections is much less expensive.”

The study group looking at the pilot programs is recommending a $13 million increase in community corrections programs to continue and expand forensic diversion. The money is for treatment, case management and supervision of these offenders in the community, McMurray says.

She says that collaboration between community corrections and mental health providers is not just for those sent to a diversion program, but also when offenders coming out of prison need mental health services.

There are two big things in corrections today, McMurray says. One is “evidence-based practices,” or programs that have research to support their effectiveness. The other is re-entry, which includes policy and programs to help move offenders from prison back into the community. Both share the common goal of reducing recidivism, she says, and mental health services contribute effectively to both.

“We can do only so much with an offender if we can’t address the issues that put him here,” McMurray says. “This is creating opportunity to meet needs and help keep people out of the corrections system.”

“Prisons and jails were never meant to be mental health facilities.”

—VIRGINIA DELEGATE PHIL HAMILTON