Mental illness and the criminal justice system: Where are we now?

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According to the Bureau of Justice Statistics Special Report on Mental Health Problems of Prison and Jail Inmates published in 2006, 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates had a mental health problem.[1] Studies suggest that up to 15% of persons in city and county jails and state prisons have severe mental illness.[2] A study by Steadman and colleagues published in 2009 evaluating the prevalence of serious mental illness (defined as major depressive disorder; depressive disorder not otherwise specified [NOS]; bipolar disorder I, II, NOS; schizophrenia spectrum disorder; schizoaffective disorder; schizophreniform disorder; brief psychotic disorder; delusional disorder; and psychotic disorder NOS) among jail inmates found rates of 14.5% for male inmates and 31.0% for female inmates.[3] The term "severely psychiatrically disabled" may be defined as those individuals demonstrating psychopathology similar to those of acute inpatients in state mental health facilities.[4]

Deinstitutionalization, meant to increase the freedom of the mentally ill, started in the 1960s and peaked in the 1970s.[5,6] According to a publication by Lamb et al. in 1998, the number of state hospital beds went from 339 to 29 per 100,000 in the U.S. over 40 years. [2] It is commonly thought that the number of mentally ill persons in the criminal justice system is larger than before deinstitutionalization, and although some literature supports this belief, methodologically sound studies of mentally ill persons in this setting are few prior to deinstitutionalization.[2,5] It was also believed that after deinstitutionalization, patients were, and may still be, caught in the "revolving cell door" or "revolving door phenomenon", repeatedly entering and exiting hospitals, jails/prisons, and the community or that those with mental illness were entering the criminal justice system due to the overcrowding of mental hospitals.[2,4]

A number of other factors also contribute to the "criminalization of the mentally ill", in addition to deinstitutionalization, including increased restriction on civil commitment criteria, lack of adequate resources, the role of police, and society attitudes.[2] In terms of committing a person for psychiatric evaluation, fewer and shorter commitments of mentally ill individuals are a result of new laws mandating specific criteria (e.g. immediate harm to self or others) and explicit provisions that patients have rapid access to courts in order to protect the rights of the patient.[2] With regards to resources, in most areas, mental health treatment, housing, and rehabilitation resources are inadequate and community mental health resources may not meet the needs of patients.[2] Mentally ill persons are discharged into communities that may be ill-equipped to address their needs.[5] One example is the expectation that patients will follow-up with outpatient providers for treatment upon hospital discharge, when outreach services may be more appropriate due to reasons such as poor level of functioning or lack of transportation.[2] Another example is that mentally ill persons in jail may not be able to gain access to treatment after release based on a stigma associated with having gone through the criminal justice system and the real risk to treatment facilities that they may not have the capability to keep staff and other patients safe.[2] When an acute mentally ill person is identified, police are generally first notified.[2] Police must then make a decisions whether to refer the accused person to the criminal justice system or emergency room; the perception may be that persons entering the criminal justice system may be dealt with in a more systematic way than if the person were to be brought to the emergency room, where waiting times may be long and the person may ultimately be denied admission.[2] According to Freeman et al., "although specific data are difficult to gather, it seems likely that the mentally ill are more likely to be detected if they commit a given crime, than are the non-mentally ill, by virtue of their social ineptitude and sometimes bizarre appearance, if for no other reason.[5]" Lastly, society's fear of mentally ill persons who commit crimes may lead to patients entering the criminal justice system rather than the healthcare system.[2]

Steps that have been recommended and may be taken to reduce or prevent mentally ill persons from entering the criminal justice system include education and case management programs.[2] Mental health expertise and law

enforcement collaboration can result in successful interventions in terms of diverting mentally ill persons to treatment rather than the criminal justice system, when appropriate.[2,4,6] Persons that do enter the criminal justice system should be routinely and formally screened for mental disorders and provided with the appropriate services in a timely manner.[2,4,6] Half of all jail suicides occured within the first 24 hours, and many of these persons did not receive screening for suicidality.[6] Suicide occurs 95% of the time by hanging and is recognized as a leading cause of death in jails.[6] Ensuring mentally ill persons receive appropriate case management whether through assertive case management programs or other outreach services can advocate for the patient.[2,6] Also importantly, families of patients can be educated on ways to stabilize the patient.[2]

The February 2012 issue of the Mental Health Clinician is dedicated to educating members about the relationships between mental illness and the criminal justice system. This issue will detail potential roles of pharmacists in this setting, give insight into psychotropic medication abused by inmates, and provide resources for further reading. Among the features will be a video interview with Judge Steven Leifman, the closing keynote speaker at the 2012 CPNP Annual Meeting in Tampa, Florida. Judge Leifman discusses the criminalization of mental illness and provides an overview of the Florida Supreme Court report outlining recommendations to decrease inappropriate and costly involvement of mentally ill persons in the justice system. Judge Leifman has also contributed a list of criminal justice/mental health online resources for the MHC Toolbox this month. Dr. Douglas Del Paggio discusses and comments on the use of psychotropic medications in correctional facilities. Dr. Jennifer Nelson describes a multifaceted correctional healthcare facility and her role as a Clinical Pharmacy Specialist in Psychiatry at the Dallas County Jail. Dr. O. Greg Deardorff and pharmacy student Stephanie Burton share clinical pearls learned from a case involving a female escorted to the emergency room after stabbing a cab driver with a pencil. Last but not least, Dr. Jerry McKee answers several frequently asked questions regarding medication use in the correctional setting. This month's MHC issue strives to provide insight into a specialized area that CPNP members may not yet be familiar with and the hopes of providing our members with the opportunity to serve as advocates for mentally ill patients in the criminal justice system.

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