MENTAL HEALTH POLICY IN THE UNITED STATES

MENTAL ILLNESS AND CRIMINAL JUSTICE

By
Michael B. Friedman, LMSW
Adjunct Associate Professor
Columbia University School of Social Work

Abstract: Changes in the criminal justice system are a critical element of mental health policy reform. Approximately 1 in 4 people with serious mental illness have histories involvement in often problematic criminal justice processes. This lecture provides an overview of the points of interaction between people with mental illness and the criminal justice system including (1) on the street, (2) pre-trial, (3) during trial, (4) post adjudication, and (5) at and after release. Key policy issues are noted such as use of the police during psychiatric crises, treatment alternatives to incarceration, competency to stand trial, treatment for mental and/or substance use disorders in jails and prisons, use of solitary confinement, treatment after release, and more. I also review different beliefs about how to reduce the shameful number of people with serious mental illness incarcerated in jails or prisons.

Changes in the criminal justice system are a critical element of behavioral health policy reform. Approximately 1 in 4 people with mental illness come into contact with the criminal justice system at some point in their lives.[1] A shameful number of people with serious mental illness are incarcerated in jails and prisons. Reliance on police to deal with psychiatric crises in the community has become a major concern. In fact, the interactions between people with mental illness and the criminal justice system are often problematic at all stages of the criminal justice process including:

- On the street and at arrest
- Pre-trial, including detention in jails
- During trial
- Post adjudication whether incarcerated or on probation
- At and after discharge.

On The Street

The police are often involved with people with mental illness when they (1) have committed, or have been accused of committing, crimes ranging from jumping a subway turnstile to mass murder or (2) have been involved in domestic disputes ranging from heated arguments to physical violence or (3) are experiencing acute psychotic crises ranging from bizarre behavior to

threatening violence to themselves or others or (4) are homeless and living on the street in apparently dangerous or disruptive conditions; and more.

It may be that most interactions between the police and acutely disturbed people are handled routinely and without unnecessary use of force and that many police officers either by nature or because of excellent training handle these situations well.[2] But interactions between police and people with mental illness unfortunately go awry too often. The few highly publicized cases when police kill people with mental illness[3] are widely believed to be the tip of the iceberg of unnecessary violence in interactions between the police and mentally ill people.

According to the *Washington Post,* approximately 1 in 5 of police killings are of people with serious mental illness.[4] Why so many? Some of these terrible incidents may reflect pure bigotry regarding people with mental illness and/or people of color, but often they reflect the fear of inadequately trained police that they or others are in grave danger even when they are not.

Once an incident is under control, police officers have great latitude regarding a person who is "disturbed" and who may, or may not, have committed a crime.[5] They can either calm a situation and do nothing further or they can take a person who is actively disturbed to an emergency room/crisis center or they can start the process of bringing criminal charges. These are difficult choices that require more than common sense and which are probably affected by the emotional state of police officers at the time.

Because of incidents of excessive force and the difficulty of making sound judgments in highly charged situations, mental health advocates call for more and better training for police officers. In recent years, more and more advocates also call for the development of crisis intervention teams (CIT) consisting of mental health professionals and police officers with special training and skills for dealing with people with mental illness.[6] Some advocates call for excluding police from psychiatric crisis altogether.

Since the murder of George Floyd by a police officer in 2020 and the rise of the Black Lives Matter movement, there have been increased calls for the development of mobile crisis teams of mental health professionals who would respond to psychiatric crisis situations rather than the police. Unfortunately, the expression "defund the police" is often used by advocates on the left when they talk about improving response to psychiatric crises. This is entirely misleading. Not only is "defund the police" an inaccurate description of the use of mental health professionals to respond to crises; it also politicizes what should be a straightforward, evidence-based reformulation of crisis intervention policy.

Coupled with the rollout of a new three digit number to call in psychiatric emergencies—988, there is now great enthusiasm for the use of crisis intervention teams. And there are localities around the country where they appear to work well. Whether they will work as well in large cities like NYC, where it may not be possible to have enough teams to respond immediately to every situation, is, I think, still open to question. Certainly, the experience with mobile crisis teams, which sometimes take as long as 48 hours to respond to a crisis call, raises questions about the feasibility of using them to replace police intervention, which is available for rapid response 24 hours a day, 7 days a week.

Pre-trial Procedures

Diversion: Prosecutors have great latitude regarding what to do with people with mental illness and others who have been arrested. They, of course, must make judgments about whether there is enough evidence to prosecute at all. But, even when there is sufficient evidence, there are options open to prosecutors to divert the person who has been charged with a crime to **drug,[7] mental health,[8] or veterans' courts[9]** or to programs known generally as "**treatment alternatives to incarceration (TAI)**".[10]

Competency and Sanity Evaluations: In addition to evaluations that are done to guide prosecutorial decisions regarding referral to special courts or TAI services, there are often evaluations regarding competency to stand trial (a defendant must be able to participate in his/her defense)[11] and sanity at the time of the offense.[12]

Standards of competence and especially sanity are matters of debate. For example, legal sanity does not mean absence of mental illness or even absence of psychosis. It means knowing the consequences of your action and knowing that it is wrong. Should there be other grounds for pleading not guilty by reason of insanity? For example, should the presence of hallucinations and/or delusions at the time of a crime be exculpatory? Currently, they are not.

There is also some debate about whether a legally insane person is not guilty of the crime they committed. In some states, it is possible to plead "guilty but insane".[13]

Being found either not guilty by reason of insanity or guilty but insane results in incarceration in a secure psychiatric facility for an indefinite period of time.

Competence to stand trial has different criteria from insanity defense. A person who is psychotic, cannot grasp reality, is irrational and/or out of control generally is not fit to stand trial because they are unable to

understand the proceedings and therefore cannot participate in their own defense. This sometimes results in a very interesting moral conundrum. Generally, a person who is not currently dangerous cannot legally be forced to take medication. But sometimes defendants are forced to take medication so as to be competent to stand trial and possibly found guilty of an offense that will result in long-term incarceration or even execution. Fair?

Jail: While waiting for trial, people charged with crimes who do not get, or who cannot afford, bail are kept in jail. Conditions in jail are often as restrictive, or even more restrictive and punitive, as conditions in prison even though inmates awaiting trial have not yet been convicted of a crime. Some would argue that this violates the fundamental right not to be punished for a crime without due process.

In addition to the question of whether people with mental illness who are currently jailed should be, there are a number of crucial questions about their treatment in jail. Many people who are incarcerated in a jail have had a mental and/or substance abuse disorder prior to arrest. Many others develop mental health problems in reaction to the conditions in which they are living. For this reason, most jails provide some behavioral health treatment. The adequacy of these services is open to great question both with regard to quantity and quality. In addition, it is questionable that mental and substance abuse treatment do much to counter the terrible impact of life in jail. Anxiety is probably an appropriate emotional reaction to the dangers of jails. And imagine the impact on people with psychotic conditions—an inordinate number of whom spend time in solitary confinement for behavior they truly cannot control. Many mental health advocates demand more and better behavioral health treatment in jails. Hard to argue, except to say that diversion from jail would be far better for the mental health of those accused of crimes.

So, many mental health advocates call for reform of our nation's bail policies, which were devised centuries ago[14] to help non-dangerous people accused of crime to remain in the community until they are tried. Because this system relies on money as the motivation to return to court, it inevitably makes it more difficult for poor people to remain out of jail—clearly a discriminatory outcome. The disproportionate impact of the bail system on people of color[15] certainly reflects the realities of distribution of wealth in this country and probably also reflects racist beliefs and attitudes.

Technology is now available to track people awaiting trial who live in the community, making it unnecessary to rely totally on bail, and some states have moved in this direction. Unfortunately, in some jurisdictions people awaiting trial have to pay for their tracking devices, which effectively defeats the purpose of removing bail for poor people.

Bail reform, which has taken place in a number of states, has become increasingly controversial because of several incidents in which people on bail have committed crimes, including murder. To some this suggests a need to temper bail reform. To others it suggests that bail reform is a failure and should be dropped.[16]

Release from jail: A great many people who spend time in jail awaiting trial are found not guilty, put on probation, or have charges dismissed prior to completion of their trial. They are released back to the community generally without **meaningful discharge planning**. This can be a grave problem for prisoners with mental and/or substance use disorders.

For example, at one time in NYC, discharge from Riker's Island took place at 4 in the morning when the subway station nearest the jail opened. Prisoners were given one token. Generally, no follow up arrangements had been made. The Urban Justice Center sued NYC in a class action case known as "Brad H."[17] It resulted in a requirement that the jail develop appropriate discharge plans and post-release services. While this appears to have been helpful, by all reports the service that was created to implement Brad H is tied up in bureaucracy, making it far less effective than had been hoped.

Another major issue is the **loss of Medicaid eligibility[18] and income supports[19]** if imprisoned for more than 30 days. Reinstating benefits often is delayed, creating a huge problem getting housing, income, and needed treatment. Over the years, various solutions have been proposed, including presumptive eligibility for Medicaid upon release, but to the best of my knowledge the fundamental problem remains.

Trial

As I have already noted, there are a variety of alternatives to incarceration prior to trial. There are also alternatives during trials.

One such alternative is referral out of criminal court to a mental health, substance abuse, or veterans' court. These courts are generally used only for minor offenses, but they are sometimes used for serious crimes such as robbery.

Another alternative is "adjournment in contemplation of dismissal" (ACD).[20] The judge can effectively mandate treatment instead of incarceration by telling the person on trial that the trial will be adjourned for, say, six months. If during that time, the person has gone for treatment and stayed off drugs and out of trouble, the judge will dismiss the charges. If not, the trial will go ahead and probably result in a finding of guilt and a prison sentence.

Although this is in effect court-mandated treatment, it should not be confused with involuntary outpatient commitment, which is used for people with mental illness who have NOT been accused of committing a crime.

A judge also has options at sentencing. Rather than incarcerating the person convicted of crime, a judge can put him or her on probation. It then becomes the job of a probation department, which is likely to be understaffed and may or may not have probation officers with training in mental health and substance abuse, to monitor their behavior and to help the person manage in the community. A person on probation can be imprisoned at any time for a violation of probation.

It is important to note that probation officers have dual roles—to help and to monitor the convict. It is not easy to balance these two functions successfully.

As previously noted, a finding of not guilty by reason of insanity or guilty but insane results in incarceration in a secure psychiatric facility for an indefinite term. It is possible to be discharged in weeks or months, but it is also possible to be held for life even for crimes that would have had limited prison terms.

Prison

Issues for people with mental disorders in prison are essentially the same as those in jail. What is the psychological impact of life in prison? Good treatment services are important. Whether they can be effective is open to some question.

Solitary confinement[21] is an additional critical issue. Both in jails and prisons, prisoners who "misbehave" are subject to solitary confinement in very small cells for potentially very long periods of time. They are entitled to be out of the cell for 1 hour per day. Needless to say, the impact on a person's mental health can be devastating even if they had no mental illness prior to solitary confinement.

Ending the use of solitary confinement has become a major goal of mental health advocates working on criminal justice reform.

Release

Issues regarding release from prison are also essentially the same as issues regarding release from jail. There needs to be adequate discharge planning, which includes access to medication and treatment, housing, and income

after release. This is often contingent on eligibility for Medicaid and other benefits post-discharge.

Over the years much advocacy has been devoted to assuring coverage and financial assistance for convicts when they leave prison. For reasons that elude me, this has been extremely difficult to achieve.

Should People With Mental Illness Be Imprisoned?

Mental health advocates who decry the overuse of incarceration for people with mental illness sometimes seem to believe that no person with a mental illness should be punished for a crime. This raises a **fundamental question about the capabilities and responsibilities of people with mental and/or substance use disorders**.

It seems to me that if we mental health advocates want to maintain that people with mental illness are capable enough to hold jobs and that stigma is very often the reason they do not get jobs, we need to acknowledge that some people with mental illness can reasonably be held criminally responsible. But at the same time, we should advocate for treatment during the criminal justice process that reflects a compassionate understanding of mental and substance use disorders.

Reducing Incarceration of People With Mental and/or Substance Use Disorders

Despite the sharp ideological divide among mental health advocates, there is total agreement that the number of people with serious mental illness in jails and prisons is shameful.

The exact, or even approximate, number is elusive.* Estimates vary depending on definitions of "mental illness", on methodology, and on whether it is a point-in-time, annual, or lifetime number. 15-20% with "serious" mental illness of the 2.2 million people in jails and prisons at any point in time strikes me as a reasonable estimate.[22] By that estimate 330-440,000 people with serious mental illness are in jails or prisons today, about 3-4% of all people with serious mental illness.[23]

But that estimate is arguable. For example, The Bureau of Justice estimates that over ½ of prisoners have a "mental health problem".[24] That would be over 1 million people. Of course, having a mental health problem is not the same as having a serious mental illness. So, the real number of people with

* The numbers included here undoubtedly need tweaking because of population growth over the past few years.

significant mental illness in jails and prisons at any given time remains unclear.

Whatever the actual number, this is a very serious problem.

It is very important to note that people with mental illness in prison are highly likely to also have a history of substance use disorder—85% according to the National Institute on Drug Abuse.[25]

Although there is widespread agreement that the number of people with mental illness in jails and prisons in the U.S. is shameful and that life in jail and prison often has a terrible impact on a person's mental health, there is widespread disagreement about what changes in mental health policy are needed to reduce this number.

Some mental health advocates believe that the very large number of people with mental illness in jails and prisons reflects the failure of deinstitutionalization and the loss of beds in state hospitals. Prisoners, they believe, have been "transinstitutionalized" from state hospitals to jails and prisons. They generally argue that the solution is to increase the number of hospital beds, especially long-term beds. Some have gone so far as to call for a "return to asylums". [26]

Other mental health advocates decry the idea of recreating asylums.[27] In addition to reminding us how horrible the asylums were—how overcrowded, how dangerous, how lacking in effective treatment—these advocates also question the premise that deinstitutionalization is the cause of the large number of people with mental illness in jails and prisons. They note that the size of jail and prison populations has increased dramatically and that mandated prison sentences for drug offenses have been a major contributor to this increase. They also note that the percentage of people with mental illness in jails and prisons appears to have only slightly increased over the past 60 years.[28]

Advocates who doubt that deinstitutionalization and transinstitutionalization are the cause of the rise of the population of people with mental illness in jails and prisons generally believe that community-based diversion services combined with more housing for people with severe mental illness could vastly reduce the number of people with mental illness in jails and prisons for relatively minor offenses. Some also maintain that decriminalization of the use of illegal substances could result in a vast reduction of the prison population.

In addition, it seems clear that our nation's bail system is a major contributor to overpopulation of people with mental illness in jails. Over half of people in jail are there because they cannot make bail. Using alternative

incentives for people to return for trial would certainly reduce the number of people unnecessarily held in jail.

Unfortunately, the incarceration of people with mental and or substance use disorders in jails and prisons is another area of mental health policy that is poisoned by ideological disputes about the need for inpatient vs. community services and by the political divide between the American right and left.

---

[1] Contact Between Police and People With Mental Disorders: A Review of Rates | Psychiatric Services (psychiatryonline.org)

[2] Police Encounters, Mental Illness and Injury: An Exploratory Investigation - PMC (nih.gov)

[3] People with Untreated Mental Illness 16 Times More Likely to Be Killed By Law Enforcement - Treatment Advocacy Center

[4] Policing mental health: Recent deaths highlight concerns over officer response (nbcnews.com)

[5] "Keeping the Peace: Police Discretion and Mentally Ill Persons (NIJ Journal, July 2000) (ojp.gov)

[6] CIT International - What is CIT?

[7] What Are Drug Courts? | HHS.gov

[8] What Are Drug Courts? | HHS.gov

[9] What Is A Veterans Treatment Court? - Justice for Vets

[10] Alternatives to incarceration | National Institute of Justice (ojp.gov)

[11] Competency to Stand Trial | Nolo

[12] Insanity defense | Wex | US Law | LII / Legal Information Institute (cornell.edu)

[13] https://www.law.cornell.edu/background/insane/insanity.html

[14] A Brief History of Cash Bail | ACLU of Ohio (acluohio.org)

[15] How the Cash Bail System Endangers the Health of Black Americans | Commonwealth Fund

[16] Bail reform emerges as new flashpoint in midterm messaging on crime (nbcnews.com)

[17] Brad H. v. City of New York - Mental Health Project (urbanjustice.org)

[18] Medicaid's Role Advancing Health People Involved Justice System | Commonwealth Fund

[19] Arrested? What Happens to Your Benefits If You Go to Jail or Prison? (kitsapgov.com)

[20] Adjournment in contemplation of dismissal - Wikipedia

[21] Solitary confinement facts | American Friends Service Committee (afsc.org)

[22] Mosher, F. et al (2012). *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery.*

[23] Frank, R. and Glied S. (2006). "Assessing the Well-Being Of People With Mental Illness", Chapter 7 of *Better, But Not Well*, Johns Hopkins University Press.

[24] Mental Health Problems of Prison (ojp.gov)

[25] Criminal Justice DrugFacts | National Institute on Drug Abuse (NIDA) (nih.gov)

[26] Improving Long-term Psychiatric Care: Bring Back the Asylum | Bipolar and Related Disorders | JAMA | JAMA Network

[27] Return to Asylums? NEVER! | Psychiatric News (psychiatryonline.org)

[28] Frank and Glied op.cit.