

Reversing Criminalization

As of June 2007, there were at least 360,000 persons with major psychiatric disorders, and perhaps as many as half a million, in our jails and prisons (1, 2). With such huge numbers, can we really say that deinstitutionalization has taken place? These numbers underscore a pressing need for reliable hard data about these severely mentally ill persons who have been criminalized. In an article in this issue, Baillargeon et al. provide valuable hard data (3). They found that inmates with major psychiatric disorders, and especially those with bipolar disorders, had a substantially increased risk of

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multiple incarcerations. Clearly, this study tells us that criminalization is not being reversed. This is an important finding, for we have known about this extremely serious problem for many decades, and only relatively recently have we begun in earnest to take steps to deal with it.

The study’s findings point up the need to provide effective alternatives to prison for persons with severe mental illness. Incarceration poses a number of important problems and obstacles to treatment and rehabilitation. Even when quality psychiatric care is provided, the inmate/patient still has been doubly stigmatized—as both a mentally ill person and a criminal. Moreover, jails and prisons have been established to mete out punishment and to protect society; their pri-

mary mission and goals are not to provide treatment. The correctional facility’s overriding need to maintain order and security, as well as its mandate to implement society’s priorities of punishment and social control, greatly restricts the facility’s ability to establish a therapeutic milieu and provide the necessary interventions for treating mental illness successfully.

As further observed by Baillargeon et al., with the very large and increasing number of persons with severe mental illness in jails and prisons, there have been increased efforts in recent years to divert these persons from the criminal justice system to the mental health system. Diversion before the person is actually booked into jail, or prebooking diversion, is exemplified by efforts to create mobile crisis teams of police officers and/or mental health professionals (4). In addition, coordination between police and mental health professionals as well as mental health training for law enforcement officers may help in reducing arrests.

Postbooking diversion strategies are being used increasingly by special courts, called mental health courts (5). These courts hear only cases involving defendants with mental illness; they use a nonadversarial team of specially trained professionals (e.g., judge, attorneys, mental health clinician); they are linked to the mental health system that will provide treatment; and they use some form of adherence monitoring that may involve sanctions by the court. Initially these courts were limited to hearing cases involving persons with mental illness charged with misdemeanors; more recently, they have increased their purview to include those charged with felonies (6). The concept of mental health courts is based on the principle of therapeutic jurisprudence, which emphasizes that the law should be used, whenever possible, to promote the mental and physical well-being of the people it affects (5).

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The community treatment of persons with severe mental illness who are or may become offenders has become an increasingly important and urgent issue. Diversion is of little value unless there are community treatment resources to which mentally ill offenders can be diverted. We need a vast expansion of modalities such as assertive community treatment—community-based, sometimes court-ordered, mobile mental health treatment teams that provide an array of treatment, rehabilitation, and housing services that are available 24 hours a day (7); intensive case management; the ready availability of psychiatric medications; adequately and appropriately structured and supportive therapeutic housing arrangements; treatment of co-occurring disorders (8); vocational rehabilitation; and close working relationships between mental health and criminal justice professionals—to name but a few of these needed resources.

It is essential to facilitate access to psychiatric hospital care for patients who need it. It is important to acknowledge that the community is not necessarily the most benign treatment setting for all mentally ill people at all times. Success in reducing criminalization in this population will require access to hospital care for those who need it, for as long as they need it.

Currently, a large number of people with severe mental illness receive their acute psychiatric inpatient treatment in the criminal justice system rather than in the mental health system (9). Clearly, if there were not a shortage of acute inpatient beds in the mental health system, many acutely psychotic persons might not come first to the attention of law enforcement officers, or if they did, they could be transported to acute psychiatric facilities rather than arrested. In most cases, acute psychiatric inpatient treatment should be the responsibility of the mental health system. As Baillargeon et al. point out in their article, acute inpatient beds should be a high priority in community mental health, and lengths of stay should not be unreasonably short.

Another important resource that can help prevent criminalization is assisted outpatient treatment (10). Assisted outpatient treatment is court-ordered civil commitment that is initiated by the mental health system to ensure that persons with mental illness and a history of hospitalizations and/or violence participate in services in the community; it is for those who are capable of living in the community with the help of family, friends, and mental health professionals but are resistant to psychiatric treatment, including medication. Without such treatment, they may relapse and require hospitalization or be arrested, incarcerated, and criminalized. Such at-risk individuals are ordered to participate in outpatient psychiatric treatment with their progress closely monitored by the court.

A large proportion of persons with severe mental illness who have committed criminal offenses and are now in jails and prisons are found to be highly resistant to psychiatric treatment (9). They may refuse referral, miss appointments, fail to adhere to their medication regimen, engage in substance abuse, and refuse appropriate housing placements. Many of these persons suffer from anosognosia, a biologically based inability to recognize that one has a mental illness—and thus a biologically based lack of insight (11). Moreover, in comparison with inmates who have no psychiatric disorder, the mentally ill subjects in the Baillargeon et al. study were significantly more likely to have committed violent offenses—20%–25% had done so. Thus, prisons have become a common disposition for those with a tendency to become violent when stressed as well as for those who are resistant to treatment. It would appear that prisons have been given the responsibility for many of those persons with severe mental illness who are the most challenging to treat.

To meet those challenges outside of the criminal justice system, most of what has been described thus far is involuntary, or often has an involuntary component. Included are pre- and postbooking diversion; many forms of community treatment, including assisted outpatient treatment; and hospitalization. Everyone wishes that all therapeutic interventions could be voluntary. However, it is clear that if criminalization

is to be reversed for persons with major psychiatric disorders, mental health professionals and society will need to do what needs to be done, by voluntary means when possible, but by involuntary means when need be.

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