Submission to Mental Health Select Committee Inquiry into the opportunities to improve mental health outcomes for Queenslanders.

Bob Green

I provide the following submission as retired social worker with 38 years experience working for Queensland Health in the mental health field, as well as the father of an adult son who has a psychotic disorder.

From my perspective fundamental to mental health care is the establishment of a positive relationship between a patient and a mental health professional/team who know the patient well and are responsive to their needs and risks. The key components of effective mental health care are:

- Accessible mental health treatment
- Support, professional and non-professional
- Facilitation of stability across major life domains such as accommodation and activity/employment
- Facilitation of a life meaningful to the patient

My son has benefitted from a long-term relationship with the same mental health professional for about 15 years. Unfortunately this is not the case for many other persons. Effective mental health care is heavily reliant on a skilled, knowledgeable and responsive workforce. High staff turnover, employment of short-term locums, inexperienced staff and a range of factors are barriers to the provision of effective and safe mental health care and treatment. Safety is compromised when staff don't have the skills, don't know patients well and don't have the resources and options to manage risk of self-harm or harm to others. The attraction and retention of skilled staff, relevant training as well as engagement and partnership with families and support services are necessary.

There have been a number of reviews of the mental health system generally, specific health services as well as reviews following critical incidents. These are a rich source of issues already identified, recommended actions as well as failures in implementation. Many issues recur across reviews. A relatively recent review was the 2016 'When mental health care meets risk: a Queensland sentinel events review into homicide and public sector mental health services'. A fundamental point is that at the time, there is often a pressure to address recommendations (as distinct to addressing the issue that the recommendation pertains to) which can become a tick the box response. Consequently impetus and ensuring recommendations are addressed diminishes over time. Systematically reviewing these previous reports, their findings and recommendations would be useful, to not only avoid reinventing the wheel but to examine what happens to recommendations.

Critical incident reviews of Severity Assessment Code (SAC) 1 clinical incidents (e.g. suicides and some homicides) conducted by Hospital and Health Service (HHSs) and also examined by the Mental Health Branch, contain many recurring themes. The previously

mentioned 2016 review recommended the establishment of a committee to review homicides committed by persons in contact with mental health services. While homicides are statistically rare events, which may necessarily able to be foreseen, they often highlight system issues and issues relevant to mental health care generally, e.g. communication between families and teams, timely response to relapse, accessibility to services, substance abuse and adequacy of assessments.

Any examination of the mental health system needs to look at it as entire process, not just a problem at a single stage. For example, addressing bed shortages isn't simply a matter of creating more beds or finding ways to discharge people more quickly. Some matters that need to be considered are what is happening prior to seeking an admission, would increased support or better access to services at an earlier stage mitigate against the need for admission. Similarly, what are the barriers to discharge, does a person need a level of support that isn't available, or is there a shortage of available community services. Is the service able to respond to persons with complex needs who either presents multiple times or is readmitted soon after discharge. A problem at one point in a system often reflects problems at another point in the system.

A basic issue facing the mental health system is that demand exceeds resources, so that points of contact such as emergency departments can be overwhelmed. Not all persons who present to such services can or need to be admitted and for someone to be admitted, often someone else needs to be discharged, often prematurely. Increased acute beds is one need, but so are alternatives to hospitalisation, support services and referral pathways for person who may not need admission. Conversely, there are a group of people in acute units who either don't meet the criteria of Secure Mental Health Rehabilitation Units (SMHRU) or Continuing Care Units (CCUs) or are admitted to such units, though don't manage well in the community and are soon readmitted. These patients may end up homeless or in custody. These two US articles highlight the issues and options:

Cournos, F., & Melle, S. L. (2000). The young adult chronic patient: a look back. *Psychiatric Services*, *51*(8), 996-1000.

Lamb, H. R., & Weinberger, L. E. (2020). Deinstitutionalization and other factors in the criminalization of persons with serious mental illness and how it is being addressed. *CNS spectrums*, *25*(2), 173-180.

The other consideration, is the inpatient experience itself. With a focus on addressing acute mental health presentations it is difficult to adequately address the range of needs for both the patient and their family. Creating safe and therapeutic environments is important for service consumers and staff. An area in need of special attention is persons with first episode psychosis. Rates of serious violence are elevated in this group and experiences at this first point of contact can shape a lifelong trajectory and how services are viewed. A relative recently relayed a friend's experience: "picking him up from the ward was like in the movies when someone is released from prison and they walk out the door and meet you at the front, no one provided me a handover or any instructions".

In addressing such issues an issue facing staff, are not just increases in direct patient workload but also other demands that reduce staff time to work with patients. Seeking staff input on such factors would be useful. Adding roles without resources is also an issue. The

introduction of Assessment and Risk Management Committees (ARMC) was an initiative that resulted in some clinical benefits, but involved significant staff time but was without any resources to support implementation.

Medication and its monitoring is an important aspect of mental health care, however, services to address: psychological needs (the impact of trauma and trauma informed services), stability in accommodation (much could be said about accommodation needs), time use (work and activity) and substance use are important. Engagement to promote social inclusion can be problematic. From July 1, 2021 only people receiving an income support payment are eligible for Disability Employment Support. While this is a Commonwealth Government matter, it can have significant impact in persons not receiving Centrelink payment and is a gap in service provision.

There is no shortage of reports which address issues such as those raised above. Alone, there are Productivity Commission reports such as ‘Service delivery in remote and discrete Aboriginal and Torres Strait Islander communities’ (2017), ‘Inquiry into Imprisonment and Recidivism’ (2019), Mental Health (2020) and The NDIS market in Queensland (2021) all of which contain many recommendations relevant to mental health care. The challenge is being able to prioritise and focus on key issues that will make a difference.

A relevant issue in this regards is the variability in implementation of such issues. The Hospital and Health Service model allows for flexibility of service delivery and responsiveness, though this is at the cost of standardisation of practice in key areas, as well as difficulties providing statewide services. Service quality should not be due to postcode. Clearly there needs to be local autonomy, but examining areas where consistency of service provision could be improved, is indicated.

The bulk of my experience has been in forensic mental health. However, forensic mental health services often come into contact with patients who other services struggle with or become aware of service gaps, through interactions with a broad range of services. My submission has focussed on the broader mental health system. No mental health service is perfect and there will unfortunately always be adverse incidents, however, much could be done to enhance the current system.

Suggestions:

1) Undertake a systematic review of previous QHealth, Productivity Commission and SAC reviews to examine recurring themes and recommendations but also to explore what hasn’t been implemented and barriers to implementation, including this committee’s recommendations. This also requires a process of monitoring progress over the longer term.
2) Recommendations should consider the system as a whole and examine issues and impacts at each stage of the mental health system. Points of transition between services, access and exit points are of particular importance. Recommendations should be supported by funding and consider impact on staff resources to implement them.
3) Engagement with the patient and family is essential for a working, therapeutic relationship. Victoria has a model of carer consultants, which have involvement at all

levels of service delivery, including forensic mental health, which can promote such engagement.

4) First episode psychosis services are a crucial component of mental health care. All persons in their early stages of mental health contact should have such services made available.
5) The accommodation and support needs of persons with complex needs (labelled in the literature as young chronic patients) needs specific attention. These are the patients who do not neatly fit into models of care, become involved with multiple agencies, including the criminal justice system and generally have poorer outcomes. Another area of need is enhancing capacity of services to address substance use in this population. There will be some services that do this well – identification of such best practice models and how services might implement them, should be examined.
6) Recommendations should consider the current HHS: Mental Health Branch relationship. Some level of centralised oversight is required or at the very least, mechanisms to ensure consistent implementation across the state, where this is required.
7) Retention of skilled staff and developing new staff is critical, especially Indigenous staff. Presumably there are teams looking at this issue. It would useful to review issues and strategies they have in place. Training that is relevant to practice is essential and often there isn't time for staff to provide or attend such training. The pandemic has opened up a range of technology options, that could be employed to provide more flexible, relevant and interactive training, in assessment and intervention.
8) Models such as Safewards are an important initiative in attempting to balance risk and recovery in acute wards, and providing humane care.
9) Consultation with staff could assist in identifying barriers to providing services.

Bob Green

The Young Adult Chronic Patient: A Look Back

Francine Cournos, M.D.
Stephanie Le Melle, M.D.

Editor's Note: **In the commentary below, Francine Cournos, M.D., and Stephanie Le Melle, M.D., discuss the article on page 989, reprinted from the July 1981 issue of *Hospital and Community Psychiatry.* That article described a new group of chronic patients, young adults with poor social functioning who were draining the resources of public-sector programs. Drs. Cournos and Le Melle place the emergence of this patient group within a larger context of shifts in funding streams for social welfare programs and a lack of resources for community-based care. They describe studies published in this journal in the 1980s that examined many issues related to the treatment of young adult chronic patients—homelessness, outpatient commitment, and comorbid substance abuse—and they call on mental health professionals to advocate for more resources to improve patient care. *(Psychiatric Services* 996–1000, 2000)**

In 1981 a seminal paper by Pepper, Kirshner, and Ryglewicz (1) brought attention to a new group of young adult chronic patients who cycled in and out of mental health programs, alternately demanding and refusing services. They often got into trouble with their use of alcohol and drugs and intermittently entered the criminal justice system. They were unwilling or unable to think of themselves as mental patients.

This new group did not have the same passivity or dependence on psychiatric institutions as those who had previously experienced long-term institutional care (2). On the contrary, they tended to be superficially independent, moving from program to program, inpatient setting to outpatient setting, and place to place. They became the "revolving-door" patients who frustrated family, friends, and psychiatric caregivers (3). And they were now presenting for treatment at community mental health centers (CMHCs), which had not been set up to deal with their problems.

Each of the themes Pepper and his colleagues drew from their observations in New York State would come to dominate our discourse about patients throughout the country whom our system was failing. Mental health practitioners and the press would come to focus on the mental health system's decision to carry out a poorly conceptualized policy of deinstitutionalization as the explanation for the emergence of this new population of difficult patients and the growing problem of homelessness. Yet in retrospect the picture is much more complex and confusing.

Previous articles in this historical series have detailed many of the critical events that shaped the mental health system in the second half of the 20th century. This paper looks at why the needs of young adult chronic patients overwhelmed the mental health service system by examining the forces our field can minimally influence—social welfare and health care benefits, housing markets, and the larger system of values and legal decisions in which we operate. We believe that although it is important for us to be self-critical, we cannot solve the problem of providing adequate care to patients with severe mental illness until we see ourselves as advocates for the resources we need to practice medicine properly rather than as professionals who intentionally deprive our patients of needed services.

Financing services and deinstitutionalization

Every system of care we have ever created for people with severe mental illness has had its limitations, not only because we cannot cure these diseases but also because each new system develops in the context of social and economic upheavals over which mental health professionals have little influence. Each reformist surge leaves a "lasting residue of pessimism, retrenchment, and neglect" (4).

Many factors contributed to deinstitutionalization. Of these, only one involved a clinical advance: the introduction of antipsychotic drugs (5). Other factors included an

Dr. Cournos *is director and* ***Dr. Le Melle*** *is assistant director of the Washington Heights Community Service at the New York State Psychiatric Institute, 1051 Riverside Drive, Unit 112, New York, New York 10032.*

increasing societal bias against the use of large, traditional institutions (6) as well as a number of important legal decisions concerning the rights of patients (7). However, the evidence suggests that the most important factor was the opportunity of state governments to shift patients from large hospitals, where care was paid for by states, to alternative care, where newly expanded federal entitlement programs would cover much of the cost (8).

The care of people with chronic mental illness relies heavily on funding streams that are contained within social welfare programs designed for all poor and disabled people and therefore not under the control of mental health agencies. In the second half of the 20th century, the available funding streams included welfare entitlements, Social Security disability payments, Medicare, Medicaid, food stamps, and housing assistance programs, none of which were designed for mentally ill people. Deinstitutionalization occurred as mental health systems shuffled and shifted to respond to funding changes. It was perhaps not until the creation of managed care that mental health practitioners could no longer deny the painful limits of their own authority (9). The view that the mental health care field created deinstitutionalization and the many ills that followed provides a good example of our naïveté.

The term deinstitutionalization was inaccurate, since the use of institutional care was in no way diminished. Rather, there was a depopulation of state hospitals while the number of people living in other types of institutions grew. According to the U.S. census, 1.05 percent of the population resided in institutions in 1950, 1960, and 1970, and the percentage rose slightly to 1.1 percent in 1980 (10).

But the kinds of institutions differed, and they included an increasing number of new settings for the elderly population. In 1950 some 40 percent of institutionalized people were in mental hospitals, and 20 percent were in homes for the aged and dependent. By 1980 only 10 percent of the institutionalized were in mental hospitals, and more than 50 percent were in homes for the aged and dependent (10). States were able to reduce their costs by using federal money, on a matching basis, to pay for nursing home care (11). Elderly state hospital patients either died or were transinstitutionalized, and new admissions of the elderly often were to nursing homes, which grew into a large new industry as state hospitals shrank. By the start of the 1980s some 750,000 mentally disabled elderly people were in nursing homes; 400,000 of them had "senility without psychosis," and 350,000 had other mental disorders (12).

Deinstitutionalized middle-aged state hospital patients, who were accustomed to treatment compliance after years of institutional care, could be discharged to single-room-occupancy hotels and other forms of cheap and substandard housing. Although these settings often lacked needed services, they at least provided shelter, and most discharged patients preferred living outside the hospital even if the supports were meager (13). It was hoped that younger patients who had never experienced long-term institutional care could anticipate a brighter future in the community (14).

By 1980 the census of the state hospital system had dropped by 76 percent, from its 1955 peak of 559,000 patients to just 132,000 (15). Hospital care remained important, but it shifted to the use of briefer admissions that increasingly occurred on psychiatric units in general hospitals (14). This trend was also supported by economic forces—in this case by changes in both private and federally funded health care benefits (9). Between 1969 and 1982 the number of acute psychiatric admissions increased 116 percent, from 9.76 million to 21.12 million (15).

Community care and its problems

With hospitalization limited to brief stays, the care of severely ill patients increasingly shifted to the community. However, as has often been stated, adequate services did not follow the patients. For example, Lipton and colleagues (16) noted that from 1978 to 1980, the New York State Office of Mental Health spent $4.5 billion on state hospitals but only $540 million on community-based services, despite a 70 percent decline in the state hospital population since 1965 from 85,000 to 25,000 beds.

Yet this shift was also a complicated issue, for now patients were hospitalized for active treatment that had grown much more expensive and had to be conducted with much higher standards than custodial care, greatly increasing the operating costs of the state hospital beds that remained (17). And so we found ourselves caught in a paradox: on the one hand, we complained that there were too few hospital beds for those who needed this level of supervision, but on the other hand, we bemoaned spending too much money on the hospital care that we had.

Lack of sufficient funding for comprehensive mental health care was not the only economic issue the mental health system faced. Still another set of forces would cause a growing number of patients to shift from unsupervised living in run-down housing to homelessness. The mid-1970s and early 1980s would see the gentrification of inner-city neighborhoods with the loss of almost all single-room-occupancy housing, reduced public money for new low-cost housing, the federal government's attempt to remove people with mental illness from the disability benefits programs of the Social Security Administration, and the reduced value of other entitlements that did not keep pace with inflation (11). People with mental illness competed for shrinking benefits and inexpensive housing with others who were poor and disadvantaged. It is estimated that between 1980 and 1988 the number of single adults living in shelters rose from 35,000 to 115,000 and the number of single adults living in public places rose from 86,000 to 209,000 (18). Estimates varied, but probably one-quarter of these people had severe mental illness (18).

Still another important institutional shift was a large expansion of the prison population, a trend that grew out of government efforts to control illicit drug use by pressing for higher arrest rates and longer prison sentences. Young chronic patients who engaged in such drug use were alternately handled by brief hospitalization or through the criminal justice system. And so jail became the asylum for

an increasing number of people with dual diagnoses (19).

The mental health system was not lacking in ideas about how to provide innovative community-based care, but rather in the resources to carry them out. Expanded outpatient services, emergency services, home care, day treatment, rehabilitation initiatives, and group and family therapy programs were all under way by the 1950s when the depopulation of state hospitals began (14,15). These new programs were thought to lead to "increasing respect for the dignity of each patient" (14). Considering the poor conditions in many state hospitals at the time of deinstitutionalization (20), these changes undoubtedly benefited many people. But funding for new services was insufficient even for patients who wanted them. Given this context, the greatest challenge would be how to "address the issue of people who are not in treatment, who resist treatment, and who become marginalized and destitute" (14).

The mental health system was not lacking in ideas about how to provide innovative community-based care, but rather in the resources to carry them out.

Perhaps the best example of mental health leadership falling short was in the wake of the 1963 passage of the Mental Retardation Facilities and Community Mental Health Centers Construction Act. This legislation provided federal funds to build CMHCs, and these funds were increased in 1975 (17). The CMHC programs that were developed were run by activist community leaders and mental health professionals who put most of their efforts into psychotherapy, liaisons with the community, and other rehabilitation models geared toward higher-functioning patients (11).

For the most part, CMHCs did not address the more traditional mental health services, which were geared toward the severe and persistently mentally ill population. But even if they had been more interested in serving chronic patients, the money appropriated to CMHCs was limited. So, for example, all federal payments received by CMHCs between 1963 and 1981 were less than the estimated payments for Supplemental Security Income and Social Security Disability Insurance received directly by the mentally disabled during 1981 alone (10).

A growing awareness of the unmet needs of severely ill patients led to the development in the late 1970s of community support programs. However, these programs, initiated by the National Institute of Mental Health, often served an older population, especially in New York State, where the median age of community support program patients was 56 years (21,22). Young chronic patients remained the group with the fewest services tailored to their needs.

American psychiatry from 1981 to 1985

The evolving concept of the young chronic patient was reflected in many articles published in *Hospital and Community Psychiatry* from 1981 through 1985. Attempts were made to define subgroups of this population by symptoms (23) and by demographic characteristics (24). Others tried to look at the clinical needs of this population (3,25–28). In general these studies found that although this group had a wide variety of diagnoses, they had some common problems and needs.

Most visible was the need for stable housing as homelessness became an ever more obvious problem. Referring to the homeless as the "walking wounded," Lipton and colleagues (16) cited the economic factors that contributed to the homelessness problem: the slumping national economy, inflation and unemployment, cuts in federal and state support, lack of low-cost housing resulting from redevelopment of inner-city areas, and the discharge of large numbers of psychiatric patients to communities over the past 20 years without adequate community resources.

Some housing programs for mentally ill persons existed, and the concept of supportive community-based housing evolved with the acknowledgment that chronic patients were heterogeneous and functioned at different levels, thus requiring an array of housing options offering different levels of supervision (29). However, residential programs were in short supply and were not suitable for many of the young adult chronic patients whose behavior could be disruptive and who were loath to accept the loss of personal freedom. (28)

A concern about the link between homelessness and treatment refusal led to much debate about legal and ethical issues surrounding the right to refuse treatment (30–32). Yet there were many treatment-seeking patients as well. A connection was made between homelessness and the increase in acute hospitalizations as self-referred patients arrived at hospitals "searching for a safe and secure environment" (33). In one study, Arce and colleagues (34) observed that 86 percent of homeless mentally ill people agreed to take medications when treatment was offered, suggesting that many might in fact want help if it was presented in an acceptable way. This situation became another controversy: were mentally ill homeless people refusing care, or was appropriate treatment for this population largely unavailable? Throughout the debate, young chronic patients remained ever visible in decompensated states on the streets.

In hopes of hospitalizing those who were most obviously ill, the psychiatric community began to reconsider the criteria for court-mandated hospitalization (35–38). Treffert

(30) noted that because of the strict standards of civil commitment laws, "obviously ill psychiatric patients are left to deteriorate in order to qualify for treatment, or, just as wrongly, to be treated in jails or prisons, or, just as cruelly, to wander the streets untreated and suffering."

Several articles dealing with outpatient commitment to treatment also appeared. It seemed that this approach could be a compromise between forced hospitalization and treatment refusal, allowing patients to remain in the least restrictive environment. In a 1984 study looking at the use of outpatient commitment in North Carolina, Miller and Fiddleman (39) found that only 3.1 to 4.7 percent of all commitments were outpatient commitments. Nationwide the results were similar: outpatient commitment constituted less than 5 percent of all commitments (40). Miller and Fiddleman (39) attributed these small figures to lack of knowledge of existing statutes and to the reluctance of CMHCs to treat unwilling patients. They concluded, "Society seems disinclined to abandon involuntary treatment for its mentally ill, and many patients seem equally disinclined to seek treatment voluntarily, even as an alternative to involuntary inpatient commitment."

Patients continued to cycle in and out of short-term hospital care (26), and we struggled with poor treatment compliance and failure of community programs to effectively engage patients. Lamb (28) highlighted the innate lack of insight associated with chronic psychotic illness, "the natural rebelliousness of youth," and the newly emerging substance abuse problem that contributed to recidivism. "A large proportion of new chronic patients," he wrote, "tend to deny a need for mental health treatment. . . . Instead many medicate themselves with street drugs; thus they also gain admittance to the drug subculture, where they can find acceptance despite their lack of status in the conventional sense." Many saw "ego deficits" as an important part of the population's problems, and Schwartz and Goldfinger (25) noted that "there is a lack of fit between this group's characteristic style of interaction and existing community-based programs."

Treatment adherence problems were complicated by the fragmentation of care. The decentralization of services outside of the state hospital setting led to a lack of coordination as various agencies and bureaucracies became involved with these patients in a piecemeal way, thus leading to ineffectual distribution of services (34). Talbott (41) referred to the available services as an "antiquated, unresponsive, scandal-ridden, mental health 'nonsystem.'"

Efforts were undertaken to reach homeless persons with mental illness. In 1984 Ball and Havassy (42) described a new program called Project HELP: Homeless Emergency Liaison Project. The authors noted the low priority that their target populations accorded the psychiatric and social services offered them by community mental health agencies, instead blaming their inability to avoid hospital readmissions on lack of basic resources for survival such as housing, work, and benefits. The relative contributions of poverty on the one hand and mental illness on the other to the problem of homelessness would remain a much debated issue.

The theme of substance use became increasingly prominent. We were slow to recognize that many of our patients suffered from comorbid substance use disorders, a problem that had occurred less frequently when long-term hospitalization limited patients' access to alcohol and drugs. Schuckit (43) recommended that substance use problems become part of the differential diagnosis of almost all psychiatric patients, noting that "unless therapists consider these diagnoses in every patient, they may be offering inadequate care to one out of five patients they treat." And the first mention of AIDS appearing on a psychiatric inpatient unit was published in 1985 (44), heralding the future spread of this epidemic among people with severe mental illness, especially those who used illicit drugs (45).

For many of the young chronic patients who were unable to engage in available treatment or survive independently in the community, the only reliable source of concern and support was their families, and there much of the burden of care fell. Hatfield (46) noted that "families have become the primary resource for patients, and if the community care experiment is to survive, good collaborative relationships between families and professionals are crucial." This sentiment began to grow with the founding of the National Alliance for the Mentally Ill and other advocacy groups (17), and eventually we began to see the wisdom of joining forces with families to fight for parity, reduce stigma, and fund new research.

Conclusions

Much has happened since the early 1980s. Outreach and housing programs have expanded to serve homeless people; several models have been developed for the treatment of mentally ill patients with comorbid substance use disorders; community-based programs have assumed more responsibility for treating severe mental illness; new medications have been introduced; and there is a growing emphasis on recovery. However, many of the problems remain: the limited supply of affordable housing; lack of sufficient funding for programs and of a centralized funding mechanism that would promote the integration of care; continuing problems with substance abuse, the spread of HIV, and other health care problems; the large number of mentally ill people in prison; medications that are still only somewhat effective; and problems with adherence.

The young adult chronic patients of the early 1980s are now middle-aged and have been joined by a new cohort of young adult chronic patients. Managed care has taught us the limits of our power. Perhaps we are ready to pursue our goals with a greater political understanding that it is in our domain to develop clinical advances, but not to fund them. We must join with patients and families in the difficult task of advocating for the financial resources that are necessary to create a more humane and comprehensive system to care for the treatment of young people who are stricken by chronic mental illness. ♦

References

1. Pepper B, Kirshner MC, Ryglewicz H: The young adult chronic patient: overview of a population. Hospital and Community Psychiatry 32:463–469, 1981

2. Lamb HR: Deinstitutionalization and the homeless mentally ill. Hospital and Community Psychiatry 35:899–907, 1984

3. Bachrach LL: Young adult chronic patients: an analytical review of the literature. Hospital and Community Psychiatry 33:189–197, 1982

4. Morrissey JP, Goldman HH: Cycles of reform in the care of the chronically mentally ill. Hospital and Community Psychiatry 35:785–793, 1984

5. Duval AM, Goldman D: The new drugs (chlorpromazine and reserpine): administrative aspects. Mental Hospitals 7(2):30–34, 1956

6. Goffman E: Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. Garden City, NY, Anchor Books, 1961

7. Appelbaum PS: The Draft Act Governing Hospitalization of the Mentally Ill: its genesis and its legacy. Psychiatric Services 51:190–194, 2000

8. Frank RG: The creation of Medicare and Medicaid: the emergence of insurance and markets for mental health services. Psychiatric Services 51:465–468, 2000

9. Sharfstein SS: Whatever happened to community mental health? Psychiatric Services 51:616–620, 2000

10. Cournos F: Clinical services for schizophrenia. Psychiatric News, Feb 2, 1990

11. Bloche MG, Cournos F: Mental health policy for the 1990s: tinkering in the interstices. Journal of Health Politics, Policy, and Law 15:387–411, 1990

12. Goldman HH, Gattozzi AA, Taube CA: Defining and counting the chronically mentally ill. Hospital and Community Psychiatry 32:21–27, 1981

13. Segal SP, Aviram U: The Mentally Ill in Community-Based Sheltered Care: A Study of Community Care and Social Integration. New York, Wiley, 1977

14. Barton WE: Trends in community mental health programs. Hospital and Community Psychiatry 17:253–258, 1966

15. Redick RW, Witkin MJ: State and County Hospitals, United States, 1970–1980 and 1980–1981. Mental Health Statistical Note 165. Rockville, Md, National Institute of Mental Health, 1983

16. Lipton FR, Sabatini A, Katz SE: Down and out in the city: the homeless mentally ill. Hospital and Community Psychiatry 34:817–821, 1983

17. Geller JL: The last half-century of psychiatric services as reflected in Psychiatric Services. Psychiatric Services 51:41–67, 2000

18. Jencks C: The Homeless. Cambridge, Mass, Harvard University Press, 1994

19. Lamb HR: Keeping the mentally ill out of jail. Hospital and Community Psychiatry 35:529, 1984

20. Rothman D: Conscience and Convenience. Boston, Little, Brown, 1980

21. Baker F, Intagliata J: The New York State community support system: a profile of clients. Hospital and Community Psychiatry 35:39–44, 1984

22. Intagliata J, Baker F: A comparative analysis of the young adult chronic patient in New York State's community support system. Hospital and Community Psychiatry 35:45–50, 1984

23. Green RS, Koprowski PF: The chronic patient with a nonpsychotic diagnosis. Hospital and Community Psychiatry 32:479–481, 1981

24. Sheets JL, Prevost JA, Reihman J: Young adult chronic patients: three hypothesized subgroups. Hospital and Community Psychiatry 33:197–203, 1982

25. Schwartz SR, Goldfinger SM: The new chronic patient: clinical characteristics of an emerging subgroup. Hospital and Community Psychiatry 32:471–474, 1981

26. Caton CL: The new chronic patient and the system of community care. Hospital and Community Psychiatry 32:475–478, 1981

27. Tessler RC, Manderscheid RW: Factors affecting adjustment to community living. Hospital and Community Psychiatry 33:203–207, 1982

28. Lamb HR: Young adult chronic patients: the new drifters. Hospital and Community Psychiatry 33:465–468, 1982

29. Campanelli PC, Lieberman HJ, Trujillo M: Creating residential alternatives for the chronically mentally ill. Hospital and Community Psychiatry 34:166–167, 1983

30. Treffert DA: The obviously ill patient in need of treatment: a fourth standard for civil commitment. Hospital and Community Psychiatry 36:259–264, 1985

31. Appelbaum PS: AE & RR: Utah's compromise on the right to refuse treatment. Hospital and Community Psychiatry 32:167–168, 1981

32. Byrne G: Conference report: Wyatt v Stickney: retrospect and prospect. Hospital and Community Psychiatry 32:123–126, 1981

33. Appleby L, Desai PN: Documenting the relationship between homelessness and psychiatric hospitalization. Hospital and Community Psychiatry 36:732–737, 1985

34. Arce AA, Tadlock M, Vergare MJ, et al: The psychiatric profile of street people admitted to an emergency shelter. Hospital and Community Psychiatry 34:812–817, 1983

35. Stromberg CD, Stone AA: A model state law on civil commitment of the mentally ill. Harvard Journal on Legislation 20:275–396, 1983

36. Appelbaum PS: Special section on APA's model commitment law: an introduction. Hospital and Community Psychiatry 36:966–967, 1985

37. Zusman J: APA's model commitment law and the need for better mental health services. Hospital and Community Psychiatry 36:978–980, 1985

38. Durham ML, Carr HD, Pierce GL: Police involvement and influence in involuntary civil commitment. Hospital and Community Psychiatry 35:580–584, 1984

39. Miller RD, Fiddleman PB: Outpatient commitment: treatment in the least restrictive environment? Hospital and Community Psychiatry 35:147–151, 1984

40. Miller RD: Commitment to outpatient treatment: a national survey. Hospital and Community Psychiatry 36:265–267, 1985

41. Talbott JA: The fate of the public psychiatric system. Hospital and Community Psychiatry 36:46–50, 1985

42. Ball FL, Havassy BE: A survey of the problems and needs of homeless consumers of acute psychiatric services. Hospital and Community Psychiatry 35:917–921, 1984

43. Schuckit MA: Alcoholism and other psychiatric disorders. Hospital and Community Psychiatry 34:1022–1027, 1983

44. Polan HJ, Hellerstein D, Amchin J: Impact of AIDS-related cases on an inpatient therapeutic milieu. Hospital and Community Psychiatry 36:173–176, 1985

45. Cournos F, McKinnon K: HIV seroprevalence among people with severe mental illness in the United States: a critical review. Clinical Psychology Review 17:259–269, 1997

46. Hatfield AB: Therapists and families: worlds apart. Hospital and Community Psychiatry 33:513, 1982

CNS Spectrums (2020), **25**, 173–180. © Cambridge University Press 2019
doi:10.1017/S1092852919001524

REVIEW ARTICLE

Deinstitutionalization and other factors in the criminalization of persons with serious mental illness and how it is being addressed

H. Richard Lamb[1†] *and Linda E. Weinberger*[2*]

[1] Emeritus of Psychiatry and the Behavioral Sciences, Keck School of Medicine of USC, Los Angeles, California, USA
[2] Emerita of Clinical Psychiatry and the Behavioral Sciences, Keck School of Medicine of USC, and Chief Psychologist, USC Institute of Psychiatry, Law and Behavioral Sciences, Los Angeles, California, USA

One of the major concerns in present-day psychiatry is the criminalization of persons with serious mental illness (SMI). This trend began in the late 1960s when deinstitutionalization was implemented throughout the United States. The intent was to release patients in state hospitals and place them into the community where they and other persons with SMI would be treated. Although community treatment was effective for many, there was a large minority who did not adapt successfully and who presented challenges in treatment. Consequently, some of these individuals' mental condition and behavior brought them to the attention of law enforcement personnel, whereupon they would be subsequently arrested and incarcerated. The failure of the mental health system to provide a sufficient range of treatment interventions, including an adequate number of psychiatric inpatient beds, has contributed greatly to persons with SMI entering the criminal justice system. A discussion of the many issues and factors related to the criminalization of persons with SMI as well as how the mental health and criminal justice systems are developing strategies and programs to address them is presented.

Received 26 April 2019; Accepted 22 August 2019; First published online 10 October 2019

Key words: Criminalization, deinstitutionalization, treatment, mental, illness.

The United States prison population, including both federal and state prisons and county and city jails, was 2,162,400 inmates as of December 31, 2016.[1] The percentage of jail and prison inmates assumed to be seriously mentally ill (as defined in various studies as schizophrenia, schizophrenia spectrum disorder, schizoaffective disorder, bipolar disorder, brief psychotic disorder, delusional disorder, and psychotic disorder not otherwise specified) has generally been estimated at about 16%.[2] Using these numbers (2,162,400 × 16%) yields an estimate of 345,984 incarcerated persons with serious mental illness (SMI) in jails, and state and federal prisons. The actual number may be somewhat higher or lower, depending on the accuracy of the percentage.

*Address correspondence to: Linda E. Weinberger, PhD, USC Institute of Psychiatry, Law, and Behavioral Science, P.O. Box 86125, Los Angeles, CA 90086-0125, USA.
(Email: leweinbe@usc.edu)
†Deceased.

The figures noted above represent a substantial number of persons with SMI in correctional facilities. In a previous era, many more persons with SMI who came to the attention of law enforcement would have been hospitalized rather than arrested and incarcerated.[3] The extent to which persons with SMI have been arrested has significantly impacted both the mental health and criminal justice systems. This phenomenon has been referred to as the "criminalization of the mentally ill."

One of the major concerns in present-day psychiatry is that placement in the criminal justice system poses a number of important problems for and obstacles to the treatment and rehabilitation of persons with SMI.[4,5] Even when quality psychiatric care is provided in jails and prisons, the inmate/patient still has been doubly stigmatized as both a person with mental illness and a criminal. Furthermore, correctional facilities have been established to mete out punishment and to protect society; their primary mission and goals are not to provide treatment. The correctional institution's overriding need to maintain order and security, as well as its mandate to

Downloaded from https://www.cambridge.org/core. UQ Library, on 10 Jan 2022 at 23:42:40, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S1092852919001524

Inquiry into the opportunities to improve mental health outcomes for Queenslanders Submission No. 005

implement society's priorities of punishment and social control, greatly restrict the facility's ability to establish a therapeutic milieu and provide all the necessary interventions to treat mental illness successfully.[6]

How can we explain these large numbers of people with SMI being arrested and falling under the jurisdiction of the criminal justice system? They come to the attention of law enforcement because they appear to have engaged in illegal behavior. It may well be that they have done so because their mental illness is not being treated adequately in the community. Some of the reasons for this are given in the following sections.

Psychiatric hospitalization and deinstitutionalization

Beginning in the late 1950s, the number of hospital beds declined precipitously. For example, in 1955, when the number of patients in state hospitals in the United States reached its highest point, 559,000 persons were institutionalized in state mental hospitals out of a total national population of 165 million (339 beds per 100,000 population). However, by 2016 (as a result of hospital closures and bed eliminations), the number of persons in state mental hospitals dropped to 37,679 for a total population of approximately 324,000,000, or 11.7 beds per 100,000 population. This rate is similar to that found in 1850 when persons with SMI received little care and concern.[7]

What were some of the reasons for the reduction of the number of involuntary psychiatric beds? It was the confluence of the following factors: the introduction of Thorazine and other powerful antipsychotic medications; the development of more efficacious community treatment interventions, such as assertive community treatment (ACT); the creation of federal programs (eg, SSI, SSDI, Medicaid, and Medicare), which funds community treatment and housing for persons with mental illness; the influence of the civil rights movement; and the high cost of institutionalizing persons with mental illness.[8]

Deinstitutionalization is one of the leading causes that has been viewed as increasing the number of persons with mental illness entering the criminal justice system. The community mental health system was developed in the 1960s and 1970s as a more appropriate setting than psychiatric hospitals to provide treatment for persons with mental illness who had moderate needs and could be maintained in the community. Consequently, the number of public psychiatric hospital beds was reduced with the belief that current and future psychiatric patients could be treated adequately in the community mental health system. Although deinstitutionalization held the promise of persons with SMI being able to live successfully in the community, that outcome did not occur for a sizeable number of people. Part of the reason for the failure was attributed to a lack of planning before or during deinstitutionalization as well as a lack of adequate funding for the community mental health systems. As a result, many of the important components of a community care system were not sufficiently provided (ie, housing, medical and psychiatric care, social services, and social and vocational rehabilitation) for the formerly hospitalized patients.

Despite this, the majority of deinstitutionalized patients were able to adapt successfully in the community; however, this was not the case for a substantial minority. Some of these individuals presented challenges in treatment—such as not seeing themselves as mentally ill, not taking their medications, abusing substances, and in many cases, becoming violent when stressed. Many of these persons needed highly structured care to replace that which had been provided to them, albeit imperfectly, in psychiatric hospitals. The flawed implementation of deinstitutionalization would thus appear to be a significant factor accounting for many persons with SMI migrating to jails and prisons as well as to homelessness (between one-fourth and one-third of homeless persons have a SMI).[9]

Initially, concerns about deinstitutionalization tended to focus on those persons with SMI who were discharged into the community after many years of living in state hospitals. However, treating the new generation that has appeared since the implementation of deinstitutionalization policies has proven to be even more difficult.[10] These individuals are different from those who were hospitalized for long periods and who tended to become institutionalized and not experienced in living outside a highly structured setting. When they are placed in a community living situation that has sufficient support and structure to meet their needs, most tend to remain there and to accept treatment. However, this has not been the case for the new generation of persons with SMI; they have not been institutionalized, they have not lived for long periods of time in hospitals and have developed considerable dependence on others, and for the most part they have spent only brief periods in acute care facilities. The lack of community resources capable of adequately treating this challenging new generation of persons with SMI, who often posed difficult clinical problems in treatment and rehabilitation, and may also suffer from homelessness, have contributed to their inappropriate incarceration.

Civil commitment criteria

In 1969, California enacted new legislation regarding civil commitment law, known as the Lanterman–Petris–Short Act (LPS). One of the intents of LPS was to "end the inappropriate indefinite and involuntary commitment of mentally disordered persons."[11] Under LPS, the commitment procedures and criteria were better defined than before; consequently, fewer people were involuntarily committed. Within a decade, every state made similar changes to their civil commitment codes. Such universal and significant changes are virtually unprecedented.

Downloaded from https://www.cambridge.org/core. UQ Library, on 10 Jan 2022 at 23:42:40, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S1092852919001524

Inquiry into the opportunities to improve mental health outcomes for Queenslanders Submission No. 005

The new civil commitment laws tended to incorporate three major changes. The first change referred to the criteria for involuntary psychiatric hospitalization. The criteria changed from being general in their focus on mental illness and the need for treatment to becoming more specific in addressing how the individual's mental illness contributed to the person's danger to self or others or the person's ability to care for oneself. The second change impacted the duration of commitment; that is, the length of involuntary psychiatric hospitalization went from an indeterminate period to one with specific time durations that were often brief. The third change addressed the patient's civil liberty and due process rights to have prompt access to independent hearings and trials as well as the assistance and representation of patient advocates and attorneys at the various hearings/trials.

These revised civil commitment laws resulted in fewer, as well as shorter, commitments. In fact, many patients who were discharged from the psychiatric hospitals because they no longer met the strict criteria for involuntary hospitalization were released into the community, often without the resources to help them adjust. They may have had difficulties maintaining psychiatric stability, controlling their impulses, living in unstructured community settings, and adapting to the demands of community living. Thus, some of these individuals might have decompensated to the point where they committed criminal acts and entered the criminal justice system.

Community support systems tend to be inadequate

Another factor that both leads to and perpetuates the criminalization of persons with SMI is the lack of adequate support systems in the community. This includes mental health treatment, case management, housing, and rehabilitation resources. The inadequacy of these support systems has three important aspects.

First, given the very large numbers of persons with SMI in the community, there may not be sufficient resources to serve them. For instance, case management has come to be viewed as one of the essential components of an adequate mental health program.[12] However, the mental health system is ill prepared to provide quality case management services to all persons with SMI who require it, including those leaving jails and prisons.

Second, the community treatment services that are available may be inappropriate for some of the population to be served. For example, there may be an expectation that persons with SMI go to the clinic when in fact a large proportion of them need outreach services.

Third, persons with SMI who have been released from correctional facilities may not be accepted into community treatment or housing, even when it is available. Clinicians may not want to treat this population because they are thought to be resistant to treatment, dangerous, and serious substance abusers. These individuals can be intimidating because of previous violent and fear-inspiring behavior. Working with this group is very different from helping passive, formerly institutionalized patients adapt quietly to life in the community. Thus, these are individuals who generally may not be considered desirable by most community agencies and staff. Moreover, some of these agencies may not have the capability to provide the structure and limit setting necessary to enhance safety for staff who work with these persons.

A difficult population

A large proportion of persons with SMI who commit criminal offenses are found to be highly resistant to psychiatric treatment. They may refuse referral, may not keep appointments, may not be adherent with psychiatric medications, may not abstain from substance abuse, and may refuse appropriate housing placements. There is evidence that many of these persons suffer from a disorder called anosognosia (a biologically based inability to recognize that one has a mental illness, and thus a biologically based lack of insight).[13] Consequently, such individuals are less likely to believe they need treatment and seek it when needed.

It should also be mentioned that some researchers suggest that criminogenic factors are a stronger predictor for criminal recidivism than mental illness.[14] On the other hand, active psychosis has been found to be a risk factor for violent behavior, independent of criminogenic factors such as antisocial personality characteristics or substance abuse.[15]

The plight of family members

Generally, family members can be an important source of support for persons with SMI. However, they will have to overcome a number of hurdles. These include coping with the symptoms of their relative's mental illness, dealing with their own emotions (eg, frustration, denial, anxiety, guilt, feeling inadequate), and ambivalence about involving the police when the relative is violent.[16] Given the many obstacles in dealing with their relatives with SMI as well as obtaining treatment for them, family members may feel overwhelmed and discouraged in their attempt to help their loved ones. As mentioned earlier, these challenges include not being able to obtain adequate involuntary treatment because of the insufficient number of inpatient psychiatric beds as well as the increasingly restrictive civil commitment criteria. In addition, community treatment services may not be sufficient in addressing the needs of the mentally impaired relative. Moreover, the nature of the individual's mental illness, which may also include substance abuse disorders, may pose additional problems for both the family and their relative with SMI. Finally,

Downloaded from https://www.cambridge.org/core. UQ Library, on 10 Jan 2022 at 23:42:40, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms.
https://doi.org/10.1017/S1092852919001524

resistance to obtaining treatment is a common phenomenon among those with SMI and thus can contribute to the family's frustration which results from their inability to resolve their relative's problems.

Police and criminalization

Police play an important role in the criminalization of persons with SMI. Often, instead of directing the individual with mental illness to treatment, the person may be arrested and placed in jail.[17] There are several reasons for this.

When urgent situations arise in the community involving persons with mental illness, the police are typically the first responders.[18] Consequently, they play a major role as a mental health resource in determining what to do with the individuals they encounter. The police have dual roles. They are responsible for recognizing the need for the treatment of an individual with mental illness and connecting the person with the proper treatment resources as well as making the determination whether the individual has committed a type of illegal act for which the person should be arrested. These responsibilities thrust them into the position of primary gatekeepers who determine if the individual will enter the mental health or the criminal justice system.

For many years, police have had the legal authority to transport persons with SMI whom they believe are a danger to self, others, or gravely disabled to psychiatric institutions for involuntary treatment. This authority forces police to make decisions about the individual's mental condition and welfare. Police also have the discretion to use informal tactics, such as attempting to calm the individual by talking to them or taking them home instead of transporting them to a psychiatric hospital.

Generally, the police have a great deal of discretion in determining what to do when they encounter a person with acute mental illness in the community. In some cases, however, public policy limits the police officer's discretionary power. For instance, if the person with mental illness is alleged to have committed a major crime, the disposition is clear—that person is taken to jail because of the seriousness of the offense. However, in cases where persons with SMI are believed to have committed a minor offense the officer may use discretion; that is the officer may arrest the individual, transport the individual to an inpatient psychiatric facility for treatment or refer the individual to an outpatient clinic for mental health treatment. A major issue is that law enforcement officers do not have the training and experience that mental health professionals have in recognizing symptoms of mental illness in their determination of dispositions.[19] Mental illness may appear to the police as simply alcohol or drug intoxication, especially if the person with mental illness has been using these substances at the time of the interaction with the police. Moreover, in the heat and confusion of an encounter with the police and other citizens, which may include forcibly subduing the person with mental illness, signs of a psychiatric disorder may go unnoticed.

Another major issue contributing to the criminalization of persons with SMI is that even if the police recognize the individual's need for treatment, treatment services are not always available. For example, there are often very few accessible hospital beds for psychiatric inpatients; however, the police are well aware that if they arrest a person with mental illness, that person will be dealt with in a more systematic and predictable way under the criminal justice system.

Efforts to Address the Criminalization of Persons with SMI

Diversion from the criminal justice system

There have been extensive efforts to divert persons with SMI from the criminal justice system to the mental health system. Diversion before the person is actually booked into jail, or pre-booking diversion, has gained recent attention and is exemplified by large-scale efforts to create community mobile crisis teams of police officers and/or mental health professionals.

A number of jurisdictions use sworn police officers who have special and extensive mental health training to provide crisis intervention services as part of crisis intervention teams (CIT programs) and to act as liaisons to the mental health system.[20] This approach is often referred to as the "Memphis model" because it was developed in Memphis, Tennessee. These specially trained officers may deal with mental health emergency situations on-site or act as consultants to the officers at the scene. This model places a heavy reliance on psychiatric emergency services that have agreed to a "no refusal policy" for persons brought to them by the police. Although this strategy has a close liaison with mental health, it does not require the actual participation of mental health professionals in the field.

In addition, mental health training for all law enforcement officers, and not only those who are on mobile crisis teams, may help them gain a better understanding of mental illness and result in their seeking treatment for such individuals rather than arresting them. The interventions of mobile crisis teams and law enforcement education of mental illness can reduce the number of people who previously may have been arrested and entered the criminal justice system.[21]

However, not all people with mental illness are diverted by law enforcement officers prior to booking. For those who are arrested and taken to jail, post-booking diversion occurs through a variety of other forms. These

Downloaded from https://www.cambridge.org/core. UQ Library, on 10 Jan 2022 at 23:42:40, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms.
https://doi.org/10.1017/S1092852919001524

include specialized mental health courts that handle exclusively offenders with mental illness. Mental health consultation to other courts may also assist the judge by offering recommendations for treatment in lieu of incarceration.

Mental health courts

Post-booking diversion strategies are being used increasingly by special courts called mental health courts.[22] The first widely known mental health court was established in Broward County, Florida, in 1997. Since then, the number of mental health courts in the United States has increased greatly. Initially, these courts were set up to hear cases of persons with mental illness who were typically charged with misdemeanors, but now also include those charged with felonies. In mental health courts, all the courtroom personnel (ie, judge, prosecutor, defense counsel, and other relevant professionals) have experience and training in mental health issues and available community resources. These mental health courts have a particular set of characteristics: they hear specialized cases involving defendants with mental illness; they use a non-adversarial team of professionals (eg, judge, attorneys, and 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.

Underlying the concept of mental health courts is the principle of therapeutic jurisprudence, which emphasizes that the law should be used, whenever possible, to promote the mental and physical wellbeing of the people it affects. The concept of therapeutic jurisprudence operates on the belief that the application of the law can have therapeutic consequences.[23] It should be emphasized that therapeutic jurisprudence does not diminish the importance of public safety, which is fully taken into account by the court.

Under the tenets of therapeutic jurisprudence, people with SMI charged with crimes may be diverted into programs designed to address their treatment and service needs rather than simply being incarcerated with their treatment needs either being neglected or not fully addressed. Even individuals with SMI convicted of serious crimes can be provided with humane and appropriate treatment while incarcerated. Generally, mental health courts facilitate linking offenders with SMI to appropriate needed services and supports on discharge from jail in order to enable them to successfully re-enter their communities.

Mental health courts were developed as a strategy to divert persons with mental illness from the criminal justice system into the mental health system. When offenders with mental illness are arrested, their case may be handled by mental health courts in lieu of traditional courts. Mental health courts work in a collaborative effort among the personnel in the criminal justice and mental health systems to devise, coordinate, and implement a treatment plan that includes medications, therapy, housing, and social and vocational rehabilitation, all in an effort to address the individual's mental illness and reduce the risk of recidivism.

Mental health consultation to the court

In non-mental health courts, the use of mental health consultation for persons with SMI who are being tried for criminal offenses may be helpful in influencing the court's disposition. By providing mental health evaluation, it may become clear to the court what factors may have played a role in the defendant's criminal behavior. If these appear to be more likely the result of inadequate treatment regarding the individual's mental illness rather than the person's criminal tendencies, the court may be inclined to place the individual in a mental health treatment program instead of jail or prison.

Clearly, the quality of services plays an influential role in the success of mental health courts. However, as seen in the past, community psychiatric treatment, rehabilitation, and housing capabilities have been historically insufficient to accommodate all persons with SMI. Will the necessary resources be provided for those who are diverted? Can the mental health system expand adequately to what is needed to serve this particular population? Another question is whether those in the mental health system would be willing to work with those who are diverted from the criminal justice system given their denial of illness and tendency for many to be violent.

Outpatient Treatment to Reverse or Prevent Criminalization

In order to decriminalize persons with SMI, it is necessary to find ways to help them become stabilized outside of jails and prisons and, to the extent possible, not enter the criminal justice system at all. Thus, the community treatment of persons with SMI who are or may become offenders has developed into an increasingly important and urgent issue. Many criminalized persons with SMI can be treated at mainstream mental health clinics on their release from jails and prisons, especially those who were arrested for non-dangerous and minor crimes.

Moreover, it must be acknowledged that there are a number who are discharged from correctional institutions who have multiple problems that cannot be adequately treated in traditional community-based facilities. This would include persons with SMI who have a history of violence. Rather, these individuals need special, highly structured and adequately secured (metal detectors, alarm buttons, security personnel) clinics staffed by

Downloaded from https://www.cambridge.org/core. UQ Library, on 10 Jan 2022 at 23:42:40, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms.
https://doi.org/10.1017/S1092852919001524

professionals who understand dangerous offenders with mental illness and are willing to provide treatment to them. Usually, these clinics are an actual part of the criminal justice system (eg, run by parole departments).

Finally, it should not be assumed that persons with SMI engage in criminal behavior solely as a result of their mental illness; there may be other influencing factors such as antisocial characteristics or situational circumstances (eg, poverty, homelessness). If so, the following treatment interventions may not be very effective in reducing their criminal recidivism, unless concerted efforts are made to modify those particular risk factors, if possible.

Treatment of co-occurring disorders

It is estimated by professionals and other personnel in the criminal justice system, who are knowledgeable about incarcerated persons with SMI, that many of them also meet criteria for substance use disorders.[24] Clearly, if treatment after release is to be successful, both the mental illness and the substance abuse must be addressed. These services should be integrated in the community for the released offender. Treatment of co-occurring disorders very frequently needs to be a long-term process.

Assisted outpatient treatment

An important treatment modality that is available in almost all of the states is assisted outpatient treatment (AOT). AOT is an outpatient court-ordered civil commitment initiated by the mental health system and not the criminal justice system. The purpose of AOT is to ensure that persons with mental illness and a history of hospitalizations or violence participate in services in the community that are appropriate to their needs.[25] AOT is for persons with mental illness who are capable of living in the community with the help of family, friends, and mental health professionals but have a history of and are presently resistant to psychiatric treatment, including medications. Without such treatment, they may continue to relapse and become violent and/or dangerous to themselves and require involuntary hospitalization. Because of these characteristics, this population is also prone to be arrested, incarcerated, and criminalized. To prevent recurrent decompensation, these persons with SMI can be ordered to participate in outpatient psychiatric treatment, with their progress closely monitored by the court.

For AOT to be successful, intensive and evidence-based practices of treatment should be used. These include assertive community treatment (ACT) and forensic assertive community treatment (FACT). ACT is a community-based program with mobile mental health treatment teams that provide an array of treatment, rehabilitation, and housing services that are available 24 hours a day. Although similar to ACT, FACT is for individuals who have been convicted of crimes and includes legal leverage from the criminal justice agencies (eg, adding probation officers to the treatment team, use of court sanctions to encourage participation) in an effort to reduce recidivism.[26] The goal of ACT and FACT is to help persons with SMI stay out of the hospital and avoid incarceration as well as develop skills for living in the community.

Working in collaborative efforts

Not all persons with SMI who have a history of incarceration are obtaining treatment in the community with ACT or FACT. There are many who are being released from jail or prison on probation or parole and are required to attend outpatient treatment in community mental health clinics. Given these requirements, agents of the criminal justice system, including probation and parole officers as well as judges, are vested in knowing the mental health status of the client. Consequently, the treating mental health clinicians may be asked to communicate directly with these justice personnel regarding the client's psychiatric condition and progress, as well as the client's potential threat of harm. Similarly, clinicians may want to obtain information about their clients' criminal history in order to better understand the extent of their clients' problems. Therefore, clinicians should feel comfortable maintaining a liaison with the criminal justice personnel.

The importance of structure

The need for structure is an essential concept for persons with SMI. Often, they lack internal controls and have difficulty coping with stressful life demands. Structure provides external controls and organization which is needed by these individuals. Generally, mental health professionals who treat this population believe that their patients' days should be structured through meaningful, therapeutic activities such as work, day treatment, and various forms of social therapy.

Another form of structure that is essential for most of this population is that treatment be mandatory, and compliance be reviewed by the court or other criminal justice agent. Knowing that their community status may be revoked can be an influential factor in motivating these clients to adhere to treatment.

Management of violence

Not all persons with SMI who are incarcerated have been convicted of violent offenses or have a history of violence. However, for those who do, the need for them to control their impulses and inappropriate expressions of anger should be a priority in treatment. Persons whose violence is rooted in a major mental illness often experience their violence as a frightening loss of control. A clinician who is not aware of their destructive potential may be perceived

Downloaded from https://www.cambridge.org/core. UQ Library, on 10 Jan 2022 at 23:42:40, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S1092852919001524

as unable to protect them. They tend to establish that knowledge by testing the clinician for limits. Therefore, the clinician must not only be aware of their potential for violence, but must also be continuously alert and firm in order not to risk being perceived as uncaring and unable to protect their patient from their destructiveness.

Persons with SMI, especially those with histories of violent behavior, generally need continuous rather than episodic care as well as adherence to psychiatric medications. Thus, regular monitoring is needed, especially when symptoms are absent or at a low ebb, in order to deal with individual and situational factors that may arise and result in violence. In addition, behavioral, cognitive, and psychoeducational techniques emphasizing anger management have been widely used and have been successful in the treatment and management of violence.

Therapeutic living arrangements

An important factor in determining community survival for the majority of persons with SMI appears to depend on an appropriately supportive and structured living arrangement.[27] Often, this can be provided by family members. In many cases, however, the kind and degree of structure the client needs can be found only in a living arrangement outside of the family home with a high staff–patient ratio, dispensing of medication by staff, enforcement of curfews, and therapeutic activities that structure most of the client's day.

Working with the family

The role of family members or significant others can be critical in the treatment of offenders with mental illness. However, their involvement may not always be possible. The treatment team should determine whether these individuals were the victims of the client's aggression, whether they have maintained contact with the client, and whether they are able and interested in continuing such contact.

Clinicians should help family members in understanding the client's mental condition, teach them to recognize symptoms of decompensation, emphasize the importance of self-protection, and explain the client's current legal situation.

Twenty-four-hour structured inpatient care

Community treatment is not necessarily the most efficacious or benign intervention at all times for all people with SMI.[10] There is a substantial minority who need the structure and support of acute, intermediate, or long-term care in a hospital setting or a highly structured, locked 24-hour care community facility. Providing access to care in psychiatric facilities when needed and for as long as required is absolutely essential if deinstitutionalization and the reduction of criminalization are to be successful.

A final word

In this time of extreme overcrowding in our jails and prisons, decarceration has become a necessity. Inmates with SMI have been included in those released from correctional facilities. Acknowledging that sufficient treatment resources did not exist following deinstitutionalization and that this contributed to the criminalization of persons with SMI, we are now at a place where we can aim to prevent the recurrence of this event. Mental health professionals are poised to provide persons with SMI the mental health treatment and supportive social services that were lacking for so many, and thus leading to their decompensation and criminal behavior. If the goals of reducing the criminalization of persons with SMI are to be accomplished, the mental health and criminal justice systems must be provided with all the necessary resources and funding, as mentioned in this chapter, to identify and treat these individuals in the most appropriate setting. It cannot be emphasized enough that the criminal justice system should not be used as a substitute for the mental health system in the treatment of persons with SMI.

Disclosures

Regarding disclosures of financial or other potential conflicts of interest, there are none for H. Richard Lamb or Linda E. Weinberger.

REFERENCES:

1. Kaeble D, Cowhig M. Correctional populations in the United States, 2016. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Web site, https://www.bjs.gov/content/pub/pdf/cpus16.pdf. Published April 2018. Accessed February 26, 2019.
2. Torrey EF, Kennard AD, Eslinger D, Lamb R, Pavle J. More mentally ill persons are in jails and prisons than hospitals: a survey of the states. Treatment Advocacy Center Web site, https://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf. Published May 2010. Accessed February 26, 2019.
3. Lamb HR, Weinberger LE. Decarceration of our jails and prisons: where will persons with serious mental illness go? *J Am Acad Psychiatry Law*. 2014; **42**(4): 489–494.
4. Olley MC, Nichols TL, Brink, J. Mentally ill individuals in limbo: obstacles and opportunities for providing psychiatric services to corrections inmates with mental illness. *Behav Sci Law*. 2009; **27**(5): 811–831.
5. Blevens, KR, Soderstrom, IR. The mental health crisis grows on: a descriptive analysis of DOC systems in America. *J Offender Rehabil*. 2015; **54**(2): 142–160.
6. Adams, K. Ferrandino, J. Managing mentally ill inmates in prisons. *Crim Justice Behav*. 2008; **35**(8): 913–927.
7. Torrey EF, Fuller DA, Geller J, Jacobs C, Ragosta K. No Room at the inn: trends and consequences of closing public psychiatric hospitals 2005-2010. Treatment Advocacy Center Web site, https://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf. Published July 19, 2012. Accessed February 26, 2019.

Downloaded from https://www.cambridge.org/core. UQ Library, on 10 Jan 2022 at 23:42:40, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S1092852919001524

8. Harcourt BE. Mass incarceration: causes, consequences, and exit strategies: reducing mass incarceration: lessons from the deinstitutionalization of mental hospitals in the 1960s. *Ohio St J Crim L*. 2011; **9**: 53–88.
9. Folsom DP, Hawthorne W, Lindamer L, *et al.* Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. *Am J Psychiatry*. 2005; **162**(2): 370–376.
10. Lamb HR, Bachrach LL. Some perspectives on deinstitutionalization. *Psychiatr Serv*. 2001; **52**(8): 1039–1045.
11. Section 5001 Welfare and Institutions Code.
12. Anthony WA, Cohen M, Farkas M, Cohen B. Clinical care update: the chronically mentally ill—case management—more than a response to a dysfunctional system. *Community Ment Health J*. 2000; **36**(1): 97–106.
13. Lehrer DS, Lorenz J. Anosognosia in schizophrenia: hidden in plain sight. *Innov Clin Neurosci*. 2014; **11**(5-6): 10–17.
14. Andrews DA, Bonta J, Wormith SJ. The recent past and near future of risk and/or need assessment. *Crime Delinq*. 2006; **52**(1): 7–27.
15. Lamberti, JS. Understanding and predicting criminal recidivism among adults with psychotic disorders. *Psychiatr Serv*. 2007; **58**(6): 773–781.
16. Rowaert S, Vandevelde S, Lemmens G, *et al.* The role and experiences of family members during the rehabilitation of mentally ill offenders. *Int J of Rehabil Res*. 2016; **39**: 11–19.
17. Lamb HR, Weinberger LE, DeCuir WJ. The police and mental health. *Psychiatr Serv*. 2002; **53**(10): 1266–1271.
18. Patch PC, Arrigo BA. Police officer attitudes and use of discretion in situations involving the mentally ill: the need to narrow the focus. *Int J Law Psychiatry*. 1999; **22**(1): 23–35.
19. Lurigio AJ, Smith A, Harris A. The challenge of responding to people with mental illness: police officer training and special programmes. *Police J*. 2008; **81**(4): 295–322.
20. Compton MT, Bahora M, Watson AC, Oliva JR. A comprehensive review of extant research on crisis intervention team (CIT) programs. *J Am Acad Psychiatry Law*. 2008; **36**(1): 47–55.
21. Ritter C, Teller JLS, Marcussen K, Munetz MR, Teasdale B. Crisis intervention team officer dispatch, assessment, and disposition: interactions with individuals with severe mental illness. *Int J Law Psychiatry*. 2011; **34**(1): 30–38.
22. Redlich AD. The past, present, and future of mental health courts. In: Wiener RL, Brank EM, eds. Problem Solving Courts: Social Science and Legal Perspectives. New York: Springer; 2013: 147–163.
23. Wexler DB, Winnick BJ. Therapeutic jurisprudence as a new approach to mental health law policy analysis and research. *Univ Miami Law Rev*. 1991; **45**(5): 979–1004.
24. Peters HP, Wexler KW, Lurigio AJ. Co-occurring substance use and mental disorders in the criminal justice system: a new frontier of clinical practice and research. *Psychiatr Rehabil J*. 2015; **38**(1): 1–6.
25. Swartz MS, Wilder CM, Swanson JW, *et al.* Assessing outcomes for consumers in New York's assisted outpatient treatment program. *Psychiatr Serv*. 2010; **61**(10): 976–981.
26. Lamberti SJ, Deem A, Weisman RL, LaDuke C. The role of probation in forensic assertive community treatment. *Psychiatr Serv*. 2011; **62**(4): 418–421.
27. Slate RN, Buffington-Vollum JK, Johnson WW. *Criminalization of Mental Illness*. 2nd ed. Durham, NC: Carolina Academic Press; 2013.

Downloaded from https://www.cambridge.org/core. UQ Library, on 10 Jan 2022 at 23:42:40, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/S1092852919001524