Decriminalizing Mental Illness: Diverting the Mentally Ill Away from Criminal Incarceration

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Abstract

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Justin D. Greuel

Under the Supervision of Dr. Michael Klemp-North

Statement of the Problem

Criminal actions of those suffering from severe mental illnesses have been treated as criminal actions instead of as symptoms of a much larger mental health issue. As a result, inmates suffering from severe mental illness make up higher percentages of the jail and prison population than their prevalence in regular society. The Epidemiologic Catchment Area Survey showed the prison population has a three to six times greater prevalence of schizophrenia and other major affective disorders than the community as a whole (Chaimowitz, 2012). Decreased funding for mental health services and closing of state mental health facilities created a culture in which jails and prisons were being used to house persons with severe mental illness that were not able to be treated in the community (Ringhoff, Rapp, and Robst, 2012).

When looking further into those numbers, there is a significant lack of diversion programs in the United States for those with untreated, severe mental illnesses. Stettin, Frese, and Lamb (2013) studied data from the Substance Abuse and Mental Health Services Administration (SAMHSA), a program within the US Department of Health and Human Services. Stettin, Frese, and Lamb calculated mental health courts served 48% of the total population of the United States. They also found Crisis Intervention Team trained Police Officers served 49% of the population.

Methods of Approach

Information for this study will come from a qualitative review of secondary research analyzing the current criminal justice system and mental health courts. An analysis of best practices in reducing recidivism of those with severe mental illnesses will also be conducted. A review of one such successful mental health court in Georgia will be conducted, in which successful graduates of the program have significantly lower recidivism rates (Burns, Hiday, and Ray, 2013). Also, study of the Memphis CIT program will be done, which is the model for many CIT programs in the United States.

Anticipated Outcomes

The lack of adequate funding for community behavioral health programs have led to the criminal justice system being on the front lines of the mental health crisis. Crisis Intervention Team training and Mental Health Treatment Courts have been identified as best practice programs to reduce the number of individuals with severe, untreated mental illnesses from entering jails and diverting them to community-based treatment programs. However, less than half of the total population in the United States is serviced by police departments with CIT trained officers or circuit court systems with Mental Health Courts.

Table of Contents

INTRODUCTION: INCARCERATION OF THE SEVERELY MENTALLY ILL

Beginning in the 1800's and leading into the 1960's, substantial reforms to the way individuals with severe mental illnesses were treated were made in the United States. As a result of those reforms, many people were released into communities for treatment. However, those communities did not receive an adequate level of funding to handle the increase of behavioral health cases. Individuals were not treated properly, and as a result, many people with severe mental illnesses were allowed to become symptomatic, causing "criminal" behavior. Since law enforcement and the community in general, were not adequately trained to handle these individuals, jails became the informal "treatment" centers for the mentally ill. However, jails did not treat the illnesses either, and local jails and prisons became revolving doors for the mentally ill.

Through evidence based research, best practices were identified for the criminal justice system and the community to deal with those individuals suffering from severe, untreated mental illnesses. Crisis Intervention Team training, as well as Mental Health Courts, has been successful in diverting the severely mentally ill away from the traditional jail setting and into community-based treatment programs. Those programs have been successful in keeping the severely mentally ill on track with their treatment, as well as out of jails.

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Purpose of the Study

The purpose of this study is to identify the criminalization of mental illness within the criminal justice system and identify best practices in reducing the rate of incarceration. In order to reduce the recidivism of those with severe mental illnesses and prevent unnecessary incarceration, the criminal justice system needs to be proactive in diverting those offenders from the traditional system of punishing criminal behavior to behavioral health facilities, mental health courts, and community resources to ensure proper treatment of the mental illness. This includes the use of Crisis Intervention Team training for law enforcement for early identification of severe mental illness, Mental Health Courts in the legal system, and partnerships with community-based treatment and support programs.

Significance and Implications of the Study

Individuals suffering from untreated mental illnesses are in every community. At times, the symptoms of their mental illness may bring them into contact with law enforcement and the criminal court system. Studies have shown effective diversion of those individuals will keep them out of criminal incarceration and into treatment programs that will reduce the recidivism due to their mental illness. Diversion and treatment is important since classical theories of criminology (Rational Choice Theory and Deterrence Theory) cannot account for the mentally ill in crisis, as those individuals cannot make rational decisions and cannot understand traditional ideas of deterrence.

By studying successful diversion programs, which includes Mental Health Courts and Crisis Intervention Team programs, best practices will be identified. Criminal justice jurisdictions will be able to incorporate those best practices into their standard operating procedures.

LITERATURE REVIEW: OVERVIEW OF MENTAL ILLNESS AND DIVERSION PROGRAMS.

The way mentally ill individuals have been cared for has changed dramatically throughout history. With the deinstitutionalization of the mentally ill back into communities, treatment has gone from being a structured event to a plan that needs regular participation by the patient. Based on a lack of structure, there are mentally ill individuals within communities that are not being treated, and as a result, have law enforcement contact. The following section delves into an overview of mental illness treatment, police interaction, and diversion programs meant to keep severely mentally ill individuals out of jails and into community based treatment programs.

Overview of Mental Illness

Prior to the 1800's, individuals with severe mental illnesses remained in their homes and were treated by their families and other close friends. As the century progressed, the role of families in treatment diminished. The role of the family was taken over by larger mental health facilities by mid-1800. Within those large institutions, patients were treated for their symptoms with very broad treatment plans. There were no individualized treatment plans, and much of the treatment was meant to sedate the patient and not actual treatment of the illness (Grob, 1994). Many of these facilities were ill equipped to handle the severely mentally ill, and they became infamously known. Health conditions and the overall treatment of patients lead the call for reform toward the end of the century.

By the 1960's, there were significant advances in pharmacological treatments for mental illnesses. Individualized care could be made with the advent of antipsychotic and antidepressant medications. One such example was the implementation and prescription of chlorpromazine.

Instead of sedating the patient, this medication allowed for the reduction of symptoms and thus, the patient was able to function within society (Drake, Green, Mueser & Goldman, 2003). As a result of the health care advances, the Community Mental Health Act of 1963 was passed. The intent of the act was to move mentally ill individuals out of large facilities into community-based care programs. As a result of this act, psychiatric beds in state mental hospitals, as well as general hospitals equipped with behavioral health units, were significantly reduced. In 1955, the United States had approximately 559,000 psychiatric beds. This was reduced to approximately 68,000 in 1990 (Ringhoff, Rapp, and Robst, 2012). By the mid 1980's, 22 million Americans were reaching out for help with varying degrees of mental health issues, which equated to approximately 9% of the total population. As a result of the deinstitutionalization of those with mental illness, the ratio of inpatient and outpatient care "episodes" changed from 3:1 in 1940 to 1:3 in the 1980's (Novella, 2010).

By bringing care into the community and outside of institutions, the treatment would center on the patient, allow for overall transparency in the process, incorporate everyday activities within the community the patient lives, and require active participation of the patient in order to be successful (Murphy and Rigg, 2014).

The theory of this process seemed to be a better alternative to keeping individuals, who with treatment can be functioning members of society, locked in an institution without the treatment aspect of care. However, to be able to effectively provide care to those individuals in the community, funding for community mental health services needed to be increased substantially. Unfortunately, this was not anticipated well enough and funding, both to community based programs and the individuals, remained inadequate. As a result, many individuals entered the community without adequate housing, community support systems, and

without the ability to make money. The mental illnesses were not being treated and the individuals were being transferred back and forth between jails and inpatient behavioral health facilities (Ringhoff, Rapp, and Robst, 2012).

Given the lack of funding for community programs, the ability for the mental health field to treat individuals was severely reduced. As a result, many individuals suffered severe symptoms of their illnesses, and because there were no other adequate ways of dealing with the individuals, they would be arrested and put into the criminal justice system (Ringhoff, Rapp, and Robst, 2012).

In a 1984 study, 884 police-citizen encounters involving 757 different individuals were observed. 506 of those individuals were considered suspects in a criminal investigation. Of those suspects, 147 were arrested based on the investigation. The troubling part of this study, however, is the rate of which a suspect was arrested based on the presence of a mental disorder. If the person showed obvious signs of mental illness, they were arrested 46.7% of the time. Those suspects not showing signs of mental illness were arrested only 27.9% of the time. As a result, suspects showing signs of a mental illness were almost 20% more likely to be arrested than those not showing symptoms of a mental illness (Teplin, 1984).

Once incarcerated, jails and prisons are not adequately equipped to treat those with severe mental illnesses. Once released, individuals are forced to rebuild whatever functional life they had prior to arrest. According to Novella (2010), only 10-20% of persons affected by severe mental illness in the United States are employed. Many, once released from jail, have to live a transient lifestyle, as they are homeless, unable to work, and are unable/unwilling to receive outpatient behavioral health assistance. The individual then continues to suffer from the illness and have significant symptoms, which can be mistaken as criminal behavior. According to a

study done by the National Institute of Mental Health (NIMH), the criminal justice system has replaced the mental health system as the primary provider of care for many homeless mentally ill people. The study goes on to say homeless individuals are not "inherently more prone to criminal behavior," but rather the homeless lifestyle "leads to victimization and criminal involvement" (Shenson, Dubler, and Michaels, 1990). According to the Substance Abuse and Mental Health Services Administration, 20-25% of all homeless individuals suffer from a severe mental illness. This is compared to just 6% of the total population in the US suffering from a severe mental illness (National Institute of Mental Health, 2009). As a result, in 2007 there was an estimated 2.1 million incarcerations of individuals suffering from severe mental illnesses (Hawthorne, et. al, 2012).

A revolving door has been created in the criminal justice system. Those with severe, untreated mental illnesses are being arrested, incarcerated, released, and arrested again. If the individuals are not treated for their mental illnesses and likely co-occurring substance abuse problems, they will continue to recidivate and fill the country's jails and prisons. Diversion programs within the criminal justice system have shown to be effective in keeping those suffering from severe mental illnesses out of the traditional criminal justice system and into community based behavioral health treatment programs.

Diversion Programs

Crisis Intervention Teams

Police agencies are at the front lines of the criminal justice system. As a result, police officers are likely the first people in the system to encounter individuals with severe mental illnesses whom are experiencing a crisis. It is estimated that 10% of police contacts involve at

least one individual with a mental illness (Watson, 2010). Since it is the symptoms of mental illness that causes crime (mental illness is not a criminogenic trait), it is vital for officers to recognize when an individual is in crisis and not just making the conscious decision to commit crime.

In 1987, Memphis Police Department responded to a call involving a mentally ill individual with a knife. After several attempts to get the young man to put down the knife, officers shot and killed him. The officers were white and the man was black, which caused a large protest of the event. Unlike many of the violent protests of today, the uproar in Memphis lead to a productive dialog with police and the community, and a Crisis Intervention Team (CIT) training was established to de-escalate individuals suffering a mental health crisis and established options for officers other than jail. With backing from the National Alliance on Mental Illness (NAMI), as well as community- based leaders, hospitals, churches, and treatment facilities, CIT Memphis was created (CIT Center, 2016).

In what would become known as the Memphis Model, a select number of officers would be trained in techniques to de-escalate individuals in crisis, recognize their actions are caused by symptoms of a mental illness, and divert those individuals away from jail to appropriate mental health facilities. This additional training reduces injury to the suspect, officers, and innocent people around the crisis, all the while getting the person in crisis to an appropriate facility for treatment of the mental illness and not confinement within a jail (CIT Center, 2016).

In order to be successful, CIT officers received extensive training in many topics, including psychiatric medication, issues of drug abuse and dependence, mental health diagnosis, mental health law, and cross-cultural sensitivity. Most importantly, officers receive extensive

training in verbal de-escalation skills, all the while still maintaining good officer safety skills (CIT Center, 2016).

Steadman, Deane, Borum, and Morrissey (2000) studied Birmingham, Alabama, Knoxville, Tennessee, and Memphis, Tennessee Police Departments and how they responded to emotionally disturbed persons (EDP). They specifically studied what the outcome of the case was (arrest or diversion to mental health facilities). Site records were studied for approximately 100 dispatched calls in which an EDP was reported.

Each of the three departments deploys very distinctly different programs for handling EDPs. Birmingham PD deploys Community Service Officers (CSO) to assist officers in mental health emergencies. CSOs are civilian employees with professional training in social work or other related fields. They are not in a uniform, operate unmarked cars, and are dispatched via police radio (Steadman, Deane, Borum, and Morrissey, 2000).

Memphis PD deploys specially trained CIT officers (with the training mentioned previously). CIT officers are available in each precinct and have 24-hour coverage, so any case involving an EDP will have a CIT officer respond as well (Steadman, Deane, Borum, and Morrissey, 2000).

Knoxville PD deploys a mobile crisis unit, which also covers a five county area with a population of 475,000. The mobile crisis unit handles phone calls from officers, jail staff, and can respond into the community during a case involving an EDP in crisis. Again, the unit has 24-hour coverage (Steadman, Deane, Borum, and Morrissey, 2000).

Upon looking at the data, there were remarkable differences in the responses by the departments. In Birmingham, only 28% of the 100 EDP calls received a response by a CSO. Researchers found BPD employs only six CSOs, and only one is on call during the weekend.

Knoxville mobile crisis units responded to only 40% of EDP calls. Police officers cited a significant response time factor for the mobile crisis unit as to why they were not always used. Finally, Memphis PD CIT officers were utilized in 95% of the studied EDP calls. This is especially remarkable given there were only 130 CIT officers in the department of 1,354 total officers at the time of this study (Steadman, Deane, Borum, and Morrissey, 2000).

As a result of this response data, it should be no surprise as to how effective the various programs were in diverting EDPs to proper treatment facilities. In Birmingham, 20% of EDPs were taken to a treatment location, 64% of the situations were resolved at the scene, 3% were referred to treatment without transport, and 13% were arrested. In Knoxville, 42% of EDPs were taken to a treatment location, 17% of the situations were resolved at the scene, 36% were referred to treatment without transport, and 5% were arrested. Finally, in Memphis, 75% of EDPs were taken to a treatment location, 23% of the situations were resolved at the scene, 0% referred to treatment without transport, and 2% were arrested (Steadman, Deane, Borum, and Morrissey, 2000).

This study is significant, as it shows when specially trained officers are deployed to situations involving EDPs, those officers are able to recognized the root of the problem (mental illness) and divert those individuals to the proper destination rather than transporting them to jail without solving the problem. Another study done with Chicago PD showed their CIT officers diverted 18% more EDPs to treatment/services than their non-CIT coworkers. CIT training allows for the most immediate response time, the highest probability of coverage at any given time, and the most successful outcomes for the EDP.

Mental Health Courts

There are times when treatment cannot be forced. If a person does not pose an immediate threat of harm to himself/herself, and does not pose an immediate threat of harm to others, many states will not allow forced emergency detentions. When this happens, and EDPs are not willing to voluntarily seek treatment themselves but still are affecting others, committing crimes, or are not fully taking care of themselves, an arrest might be an appropriate response if the county has a functional Mental Health Court (MHC). This arrest would divert those with severe, untreated mental illnesses out of the criminal system and into community based treatment programs. Effective mental health courts reduce recidivism for those with severe mental illnesses (McNiel, D., & Binder, R., 2007).

After being charged with a crime, based on the act of the individual and the underlying mental illness, the court can divert subjects from the traditional court system to MHCs. By doing this, the criminal justice system has the ability to require treatment of the mental illness through bond conditions and deferred jail/prison sentences. MHCs can also divert into probation/supervision, which again requires the mental health treatment.

Since MHC's are a growing trend without significant history, there are few performance reviews and evaluations completed. Burns, Hiday, and Ray (2013) identified a MHC in northern Georgia with an average of 25 cases a year. The court was established in 2004 and the study involved all defendants enrolled in 2005-2010. The study also evaluated arrests two years prior to entry into the MHC, as well as two years after discharge. Participants are voluntary and must have a primary diagnosis of severe and persistent mental illness or other Axis I disorders that are "considered primary" to the participants involvement in the criminal justice system. The mean time spent by the participants in MHC is 14 months. The minimum time was less than one

month, while the maximum time was 35 months. The range varies based on willingness to follow rules and severity of crime and treatment mandates.

The dependent variables of the study include graduation from the MHC and criminal recidivism. The independent variables were total number of days spent in jail prior to entry into MHC, days served in jail while enrolled in MHC, age gender, race/ethnicity, employment status, homelessness, and primary diagnosis (Burns, Hiday, and Ray, 2013).

Burns, Hiday, and Ray (2013) conducted a multivariate analysis using a logistic regression model "predicting the odds of graduation on the basis of sociodemographic, clinical, criminal history, key arrest, and MHC process characteristics." Secondly, they used logistic regression models to predict post-exit re-arrest based on MHC completion status. Finally, they used binomial models to predict jail days following court exit.

The study showed 43.4% of participants successfully graduated from the MHC program. In addition, 43.5% of participants were terminated from the program. The remaining 13.1% chose to exit the MHC and return to traditional court proceedings. Of the participants terminated, 79.1% were terminated for being noncompliant with treatment plans (Burns, Hiday, and Ray, 2013).

For those that graduated the MHC program, only 24.6% were rearrested in the two years post-graduation. That is a significantly lower arrest rate than those who opted-out of the program (76.9%) and those who were terminated (90.7%). Also significant is the average amount of days spent in jail post-exit. For graduates, the mean number of days spent in jail during the two years after graduation was 2.8 days. The group that opted-out of the MHC program averaged 113.6 days in jail, and the terminated group spent an average of 202.3 days in jail post-termination (Burns, Hiday, and Ray, 2013).

Finally, Burns, Hiday, and Ray (2013) examined predictors of graduation. They found participants with a co-occurring substance abuse diagnosis were 91% less likely to graduate compared to those without a substance abuse diagnosis. They also found if a participant spent more than 30 days in jail prior to entry into the MHC, the participant was 78% less likely to graduate than those participants that had not spent time in jail.

This study is encouraging for those who graduate the MHC program. It appears a more focused group of participant characteristics, especially excluding those involved in significant substance abuse, would produce even more encouraging outcomes.

Eau Claire County, Wisconsin, established a mental health court in the mid 2000's, with a reevaluation and adjustment of who is eligible for the program done in 2013 (broadened the eligibilities to allow more into the court). The goal of the program is to "improve the response of the Eau Claire County criminal justice system to people with mental illness" (Eau Claire County Treatment Courts, 2014). The goal of the court is to divert subjects with mental illness from jail to treatment programs. Subjects accepted into the Eau Claire County Mental Health Court (ECCMHC) suffer from serious mental disorders and are charged with misdemeanors and non-violent felonies (those not involving weapons, great bodily harm or death to another, etc.). Participants must apply and agree to follow all treatment plans set out by the court. This includes treatment programs, prescription medication assignments, and remaining crime free. Participation is voluntary and participants can expect to receive assistance in obtaining housing, job training, medical care, and other assistance.

In order to qualify for ECCMHC, the participant must be at least 18 years-old and a resident of Eau Claire County (crime can occur in any county if participant agrees to have the proceedings transferred to Eau Claire County), have a DSM-IV-TR mental health diagnosis

(sexual paraphilia is not accepted), have a primary developmental disability if all other treatment avenues have been exhausted, be a moderate to high risk offender, apply and agree to terms of the program, follow all court ordered treatments, be placed on probation or extended supervision for 18 months, and must be deemed likely to respond to the treatment available (Eau Claire County Treatment Courts, 2014).

Finally, the mental illness must be at the root of the criminal behavior. The person is likely either not responding to other treatment prior to entering the criminal justice system, or the person has an undiagnosed mental illness. Mental illness is not a criminogenic trait since treated mental illnesses do not cause a person to commit crime. However, effectively treating the mental illness prevents criminal behavior from being expressed in otherwise law-abiding individuals (Eau Claire County Treatment Courts, 2014).

According to Melissa Ives, the Eau Claire County Treatment Court Program Supervisor, 80% of ECCMHC graduates have not reoffended within two years of discharge, and 75% have not reoffended within three years of discharge. With the proper treatment that would not have occurred in the traditional court setting, mentally ill individuals are being kept out of jail and are successful in the community.

National Alliance on Mental Illness

The National Alliance on Mental Illness (NAMI) is the largest grassroots organization in the United States centered on educating communities on mental health issues. With chapters in communities around the country, NAMI provides education and therapeutic support for patients, families, friends, and the community at large. NAMI was established in 1979, and has since provided peer-to-peer support programs, family member support discussions for those not directly suffering from mental illness, community presentations to educate the public at large,

and statewide and national advocating for mental health programs funded by the government (NAMI, 2016).

NAMI provides the services necessary for those being adequately treated for their mental illness to have a solid support system within the community. This allows for individuals to talk to and receive support from others that know what they are dealing with and provide a base for help if needed.

As shown above, there are successful community based programs that keep severely mentally ill individuals functioning well within the community. When those individuals are not following their treatment plans, the criminal justice system has been able to react and divert those people to the necessary treatment facilities and out of jail. It is difficult to have an accurate predictor of when a person will stop taking their medication and commit crime, because unlike most criminal behavior, there is not a conscious, malevolent thought process to the crime. This leads into criminological theory and an attempt to rationalize the behavior of mentally ill individuals into predictable and preventable categories.

THEORETICAL FRAMEWORK: DETERRENCE THOERY, RATIONAL CHOICE THEORY, AND RECENT RESEARCH.

Throughout the history of criminology theory, scholars have attempted to explain why people commit crimes based on their surroundings, biology, psychology, the way they were raised, and many other factors. Some of the most basic/classic theories include Deterrence Theory and Rational Choice Theory. While those theories have been able to explain why some people choose to commit crime, the issue of mental health and individuals in crisis has not been as thoroughly researched. Much of the research into mental health and criminology theory has focused on symptom treatment; however, some of the most recent criminology research is beginning to look at the underlying living support system when the individual is not symptomatic. The following will discuss classic criminology theories and how they cannot be applicable to individuals with severe mental illness in crisis. There will also be a brief overview of more recent theory analysis, which will need future examination, to see if any links can be made to the mentally ill in crisis and their likelihood to commit violent crime.

Deterrence Theory

In 1764, Cesare Beccaria wrote *On Crimes and Punishments*. This publication, which Beccaria published when he was 26 years old, was the framework for the classical school of criminology, as well as the foundation to what would later be called the deterrence theory (Tibbetts & Hemmens, 2010).

Prior to Beccaria's work, many people believed people were either born good or bad and destiny was decided by a higher religious power. Beccaria believed, however, that individuals had choices and were free to choose their destiny, and as such, were free to make the decision to commit crime or remain crime free. As a result of this free fill to commit crime, Beccaria argued

there are three deterrent characteristics that an individual must consider before committing a crime; swiftness, certainty, and severity (Tibbetts & Hemmens, 2010).

Beccaria wrote the more swiftly a punishment is imposed, the more "just and useful it will be" (Tibbetts & Hemmens, 2010). This also applies to the court process as well. At the time of his writings, the criminal justice system was marred in slow court proceedings and unfair/unjust punishments. Often times, sentences would be imposed that were shorter than the time it took to deliver the punishment after the time of arrest. Based on human nature and the way the mind works, the longer the delay in punishment, the less likely it is for the offender to build an association between the punishment and the offense (Tibbetts & Hemmens, 2010).

The second criterion for the choice to commit crime is the certainty of punishment. Beccaria believed this was the most vital to the effectiveness of deterrence. This criterion requires that punishment be absolutely imposed when caught committing a crime (Tibbetts & Hemmens, 2010).

Finally, the severity of the punishment must outweigh the potential benefits of the crime. However, the punishment cannot be so severe that it is considered unreasonable and could lead to further criminality (Tibbetts & Hemmens, 2010).

In more modern times, Deterrence Theory has also come to include both formal deterrence (criminal justice system) and informal deterrence (family, work, community). The informal consequences to crime, according to some, may have a greater effect than the formal punishments. In either case, a person is deterred from committing crime because of some fear of punishment (Tibbetts & Hemmens, 2010).

This theory does explain why some people choose to commit crime, and why some choose not to engage in criminal activity. However, this theory is not one in which severely

mentally ill individuals, going through a crisis, would be able to rationalize and consider. During a crisis, and more specifically during a psychotic episode, an individual's perception of reality is altered. That person may be hearing voices telling him/her to do something. That person believes the voices are real and will do what they say without measuring the consequences of their actions. Punishment for killing someone does not matter when the person cannot comprehend anything other than what the voice is telling them what to do.

Rational Choice Theory

Rational Choice Theory was adapted from economists and their use of it, which they use to explain that a wide variety of decisions are made in regards to a wide variety of a person's behaviors. When directed to criminology, rational choice emphasized both formal and informal decisions/factors that influence a person's decision to commit crime (Tibbetts & Hemmens, 2010).

In 1986, Cornish and Clarke authored *The Reasoning Criminal: Rational Choice Perspectives on Offending.* This, coupled with Katz's *Seductions in Crime* in 1988, is widely considered the pieces of writing that brought Rational Choice Theory into mainstream criminology. Rational Choice Theory states that formal and informal consequences for criminal activity, as well as the benefits of committing crime, will determine whether a person will engage in criminal activity or not. Those that study rational choice tends to state that the informal consequences of committing crime have a greater effect on decision making than the formal consequences of arrest, jail, or other criminal justice punishments (Tibbetts & Hemmens, 2010).

Informal influences include public perception, shame or loss of self-esteem an individual would experience, loss of employment, the shame others would feel being associated with the

criminal, and other emotions/judgments that would occur from loved ones. Finally, rational choice requires the potential criminal to consider the previously mentioned factors, as well as the possibility of gain or positive feels that can come from committing the crime, to make a well thought-out, rational decision whether or not to commit the crime (Tibbetts & Hemmens, 2010).

When it comes to a person suffering a severe mental illness, rational choice and rational thought may be difficult. Again, if a person is suffering from a psychotic episode, the voices inside the person's head will most likely not be rational. The voices may be telling the person he/she is a loser, that everyone is out to get them, or that the government is watching. The voices may tell the person to assault the pizza delivery person because the pizza is poisoned and the box has a monitoring system in it. The ill person may believe killing the delivery person is necessary to stop the government intrusion, and thus follow a rational argument; however, the premise of the government watching is flawed as a result of the symptoms of the mental illness. Again, what would be an explanation to crime for well individuals is not a good explanation of criminological behavior to someone with an untreated mental illness.

Recent Research

While the previously mentioned theories could have a basis in those with mental illness that is treated, the focus on this paper is that of those individuals with severe, untreated mental illnesses. There is a trend in research that is beginning to look at whether a person's involvement in high-risk categories/behaviors when their mental illness is treated influences their behaviors when the illness is untreated, specifically in the cases of violent crime. Silver (2006) argues that Rational Choice Theory has a place for the severely mentally ill. Silver states that because some with severe mental illnesses do not form pro-social relationships with family or other friends,

they do not have to consider the consequences of the informal controls if they commit crime. Other risky behaviors, such as substance abuse and criminal associates, also play as significant a role in reoffending as the mental illness itself (Johnston, 2012). As such, the mentally ill are making rational choices to commit a violent crime. Silver (2006) also questions whether making the choice to commit a violent crime is, in-and-of-itself, an irrational decision despite having rational thought.

As mentioned before, this is an emerging area of research and needs further examination before conclusions can be made. The focus of theoretical research into mental illness, thus far, has been why are the mentally ill committing crime. This is problematic, as it does not address the symptoms, which in many cases lead to irrational decision-making, which defies the parameters of traditional criminology theory.

Criminological theory has its place in determining why individuals commit crimes. However, as of this time, it is difficult to associate rational decision making with those suffering from severe mental illness in crisis. The best practice for the criminal justice system is to recognize those suffering symptoms of the severe mental illness and divert them away from traditional forms of punishment for criminal offenders.

RECOMMENDATIONS: IMPLEMENTATION OF CIT FOR POLICE, MENTAL HEALTH COURTS, AND DIVERSION TO COMMUNITY RESOURCES

Based on the research done thus far on mental health and the criminal justice system, there are no singular solutions to keep the untreated severely mentally ill individuals out of jails and into community treatment programs. However, a multi-level approach for communities can be effective in diverting as many of those individuals as possible from jail.

Implementation of CIT for Police

Crisis Intervention Teams are critical for law enforcement agencies. The training provides a basis for officers to recognize the signs and symptoms of a person suffering from an untreated, severe mental illness. This recognition is critical to keep those individuals, who may have committed a crime, away from jail and into the mental health treatment community. Studies have shown departments with CIT implemented severely reduce the number of individuals in mental health crisis placed in jail and substantially increase the numbers diverted to mental health facilities. Those facilities are much more equipped to treat the underlying mental illness than jails are to prevent future criminal activity leaving the mental illness untreated.

Training officers in CIT can be difficult. It is a very intense 40-hour training program that could easily be stretched to 80-hours without a problem. Departments need to determine whether or not all officers will be trained in CIT, or if they will create a specialized unit of CIT officers to handle mental health crises. For departments like Memphis, Chicago, and other very large jurisdictions, it would be extremely difficult to train everyone to be a CIT officer. In those jurisdictions, training an appropriate number of officers, to cover all shifts at all time, is critical. Having some CIT trained officers is better than having none. However, in smaller departments,

training everyone in CIT can be extremely effective. An example is the Eau Claire Police Department. Administration has mandated all 100 sworn officers to attend the CIT training course in order to best serve the community. As such, there will always be a CIT trained officer working.

In either case, CIT is essential to the partnership between the mental health treatment community and the criminal justice system. Stettin, Frese, and Lamb (2013) found that only 49% of the population is served by a police jurisdiction that incorporates CIT. Although that is close to half, it is unknown how many of those "population groups" are covered by only one CIT officer, and how many groups are served by a well-functioning program like Memphis PD. In any case, over half of the total population of the United States will not be served by CIT officers, which will lead, again, to severely mentally ill individuals being placed in an ineffective criminal justice system. CIT needs to be implemented in all communities nationwide.

Mental Health Courts

When those individuals with severe mental illnesses are identified and are unwilling to voluntarily accept treatment at a hospital, the criminal justice system can have some recourse to encourage mental health treatment. By arresting the individual and having the state bring criminal charges, the person is left with an option of going through the traditional system and face substantial jail time, or "voluntarily" going through the mental health court. As such, the person receives outpatient care of the mental illness, and upon successful completion, will be transitioned to community based resources to continue a healthy lifestyle.

In order for mental health courts to be successful, they must incorporate several evidence-based properties (Bureau of Justice Assistance, 2005). Those properties include:

- Strict medication adherence
- Proper treatment venue (out-patient facility)
- Integrated treatment programs (co-occurring mental health and substance abuse treatment programs)
- Strive for consumer satisfaction (consumers are more likely to continue with treatment if they are treated well)
- Quality of life measures to ensure success after court (stable home, community resource enrollment, employment, education opportunities)

In addition, individuals that commit violent crimes should be allowed into the program on a case-by-case basis based on their ability to be successful in the program. The key to mental health courts is to also allow for treatment of substance abuse issues. Substance abuse and untreated mental health issues are often times related, and as such, need equal attention to prevent further relapse.

When mental health courts are implemented in conjunction with CIT programs, the correct type of offender suffering from an untreated severe mental illness can be easily identified and diverted to the proper court, thus reducing the likelihood of jail for those individuals. As previously referenced, Stettin, Frese, and Lamb (2013) found that only 48% of the population has a mental health court available to them. This also needs to be improved and the quality of the mental health courts improved to ensure proper care and handling of those that enter the programs.

Diversion to Community Resources

Finally, when the severely mentally ill person is identified by a CIT officer, diverted to mental health court, and treated through the court's authority, it is imperative to get that individual involved in community support resources to reduce the likelihood of relapse. Community-based groups like the National Alliance for Mental Illness (NAMI) provide support to those with mental illness. Such support includes peer-to-peer, peer-to-family, and family-to-family support groups, education and work assistance, and other discussion groups to help integrate individuals into the community. Also, NAMI is often associated with successful CIT groups to help officers identify other community resources to guide those suffering from mental illness to for assistance. NAMI also plays a role in funding CIT training, making it free, or as close to free as possible, for officers to attend. The State of Wisconsin provides a significant amount of money to NAMI for distribution to approved CIT and other mental health training programs. This partnership will help support the work CIT programs, mental health courts, and the community to ensure the severely mentally ill are not swept up into a traditional criminal justice system that does not effectively deal with mentally ill offenders.

SUMMARY AND CONCLUSION

Since the 1960's state run institutions were effectively closed, individuals suffering from severe mental illnesses were forced into the community with little or no support in dealing with their illnesses. State and Federal governments did not offer enough funding to communities to deal with the increased needs of behavioral health services, and as a result, the health care community could not handle the influx of mental health cases. Individuals needing care for their illnesses were not receiving it, and as a result, they began to exhibit symptoms of their severe mental illnesses. The symptoms resulted in behaviors that appeared criminal in nature. Police officers, untrained or inadequately trained in recognizing mental illness, began arresting those individuals and placing them in jail. Until the late 1980's, jails were used as replacement housing facilities for the mentally ill that were once institutionalized. The most unfortunate part of this was the inability for jails to treat those individuals, so jails became a revolving door without solving the problem. Since mental illnesses need medical intervention and not criminological analysis, traditional forms of criminology theory cannot be used to accurately predict or prevent crimes committed by symptomatic mentally ill patients.

After a tragedy in Memphis, Crisis Intervention Teams were created and resulted in an overwhelming change in the way police interact with the mentally ill. Significantly less mentally ill offenders were being taken to jail, but rather diverted to mental health facilities. Those that were placed in jail were done so because there were no other options.

Mental Health Courts were established to better handle those mentally ill individuals that found themselves in the criminal justice system. The goal of the MHC is to encourage, and in some cases, require participants to receive mental health treatment and participate in community resources. This would build a foundation of care that can be continued when the person

"graduates" from the court program. MHC's have been successful in diverting participants away from jail and into community-based treatment programs.

Community treatment programs are vital to the success of mental health treatment. Organizations like the National Alliance for Mental Illness (NAMI) provide important peer-to-peer programs that help individuals and families live with mental illness. The classes are generally taught by individuals that are managing their mental illness well, or by family members of someone with a mental illness. This allows for the personal experience and a true understanding of mental illness by the instructor and not just the "book smart" lectures.

Traditional criminological theories have not been successful in determining whether or not a person will commit a crime, since most individuals suffering from severe untreated mental illnesses are not capable of making rational choices. Those same individuals are not bound by societal deterrence mechanisms, since they cannot understand legal consequences while they are not in a clear state of mind. Further research is needed to look into a more modern criminological approach. Recent research has looked into determining risk factors of individuals while they are being successfully treated for their illness (alcohol/drug use, family support, financial issues) and how that corresponds to criminal activity when the individual is not being successful treated for their illness. Again, this is newer research and needs to be expanded in order to determine if there is a link.

One other limitation in this research involves the lack of substantive research involving MHC programs and their success rates. Many communities do not have MHC in their traditional circuit court system. Those communities that do, however, have not been in operation long enough to make an accurate assessment as to the effectiveness of the court. To date, the State of Wisconsin has four operational MHCs out of 72 circuit court systems (counties). As a result, the

sample size for the total population is extremely small and may not account for many mental illnesses. Further research in this field is necessary to establish a longer record of reported success in the Mental Health Treatment Court.

Moving forward, CIT, MHC, and community resources are vital to keep the severely mentally ill out of jails and within the appropriate medical realms of treatment. However, only half of the population nationwide is serviced by either CIT or Mental Health Courts. These programs need to be expanded to provide as close to 100% coverage as possible, as they are effective in reducing the number of mentally ill individuals out of jail. Ultimately, it will take an increase in funding for mental health treatment programs and hospitals to reduce or eliminate the need for criminal justice mental health diversion programs. Until that occurs, CIT and MHC programs, in conjunction with community resources, are essential for all criminal justice jurisdictions in the United States.

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