Chapter 1
Mental Illness, Then and Now

> Of all the calamities to which humanity is subject, none is so dreadful as insanity…. All experience shows that insanity seasonably treated is as certainly curable as a cold or a fever.—Dorothea Dix

Mental illness impacts millions of people as well as their loved ones. It can take many forms; it can ebb and flow throughout the life course; it can be the root of a life of suffering; yet, in most cases, it does not have to be a life sentence of misery. The intersection of *crime* and *mental health* has been a long-standing issue spanning across many decades, even centuries. In more recent times, professionals in the United States have begun to detail the "cracks" within the criminal justice system with better precision, especially in relation to inmates with mental health concerns. Unfortunately, despite the recognition of these cracks and their potential "fixes," the implementation of change continues to be a struggle. The federal system, state system, and local county/parish jail system each have their own obstacles to overcome. Furthermore, these systems do not always work together for the common cause of public health for various reasons. Even further, integrating the mental health system into the criminal justice system at these levels can at times seem impossible; yet, the capacity for coordinated change has never been more possible. This text serves to educate students and professionals not only on the system of interconnected cracks, but also on the recommendations and innovations set forth by different interests at varying levels of the said system. All of the answers may not have been discovered yet, but the impetus for change is on the horizon for those with mental illness in the criminal justice system. The hopes of change begin with discussion on the problems, particularly in a historical context. This text seeks to be that vehicle for change in the future to ensure the care and safety of justice-involved individuals with mental illness.

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1.1 A Brief History

Most detailed histories of American mental health care begin with a discussion of the vast abuses and subhuman conditions endured by those with mental illnesses in the pre-Civil War era. The plight of this vulnerable class came to light in the mid-nineteenth century primarily due to the tenacity of a woman named Dorothea Dix. In fact, it is her words that first underscore the issues of the "idiots" and the "insane," which were the most productive terms for people with mental illness available in the mid-1800s. Muckenhoupt's (2004) biography of Dix aptly describes how she "single-handedly created most of the 19th-century public institutions east of the Mississippi River that served people with mental illness" by being "unyielding and effective, a symbol of women's good works" (p. 7). In an era when the vast majority of women spent their time homemaking and serving a family, Dix never fit that mold; this, in part, allowed her to be an effective advocate for change.

1.1.1 The First Impetus for Change: Dorothea Dix

A brief explanation of Dix's life begins with a child born into a complicated family. The Dix family ascended into Bostonian wealth beginning with her grandfather, Elijah. Her father, Joseph, was the misfit of a rich family—a Harvard dropout and alcoholic with a temper who ended up marrying a woman from a less well-to-do family. This meant that Dorothea's branch of the family tree was considered a stain and an embarrassment—in other words, "the black sheep" of the family. After Elijah Dix died, he left his son Joseph with nothing while leaving Dorothea an annuity that would provide an income for her until she married (Muckenhoupt, 2004). It was this source of funds that would allow for her to run away from her parents and seek help from her grandmother, Dorothy. Madame Dix would eventually arrange for Dorothea to live with one of her well-to-do cousins. She would live there as a very independent teenager, and when she came of age, Dorothea would become an educator and operated her own schoolhouse. Ironically, she never had attended a single school in her life. She would also go on to write successfully, bringing additional income to support her independent lifestyle. Yet, it seemed Dorothea always wanted something more, just not a husband or a traditional female role. She would end up traveling Europe, turning her mind on to social justice, and bringing that passion back to America (Fig. 1.1).

The quintessential "spark" for Dix's advocacy for mental illness occurred by happenstance in the Spring of 1841. Back in Boston, Dix was offered a position to take over a Sunday school class at a local jail, the Middlesex County House of Correction (Muckenhoupt, 2004). It was here where Dix saw the suffering of "public drunks, poor men paying their debts by making shoes, and people who were mentally ill" (p. 42). She observed all of these men cramped in cold rooms without access to heat or fire. Dix first reported this issue to the warden who refused to build

Fig. 1.1 Portrait of Dorothea Dix. Courtesy of the US National Library of Medicine (2017)

a fire as it would be dangerous. Besides, he claimed, it did not seem necessary. Dix would then go to court on this matter. At the time, there was a state law requiring "a suitable and convenient apartment or receptacle for idiots and lunatic or insane persons, not furiously mad," (p. 42) which Dix would cite in her arguments for more humane treatment of inmates at the jail. The courts sided with Dix and ordered the warden to heat the cells. Quickly, she single-handedly created change, and this changed her life; this gave her a spark of inspiration and a taste for and reward of successful advocacy. Over the next few years, Dix would travel across the state visiting jails and prisons, cataloging what she witnessed. This culminated in a defining moment as an advocate for social justice for those with mental illness, *Memorial to the Legislature of Massachusetts,* delivered on January 19, 1843:

> About two years since leisure afforded opportunity and duty prompted me to visit several prisons and almshouses in the vicinity of this metropolis. I found, near Boston, in the jails and asylums for the poor, a numerous class brought into unsuitable connection with criminals and the general mass of paupers. I refer to idiots and insane persons, dwelling in circumstances not only adverse to their own physical and moral improvement, but productive of extreme disadvantages to all other persons brought into association with them….I shall be obliged to speak with great plainness, and to reveal many things revolting to the taste, and from which my woman's nature shrinks with peculiar sensitiveness…. *I tell what I have seen* - painful and shocking as the details often are - that from them you may feel more deeply the imperative obligation which lies upon you to prevent the possibility of a repetition or continuance of such outrages upon humanity.
>
> I proceed, gentlemen, briefly to call your attention to the *present* state of insane persons confined within this Commonwealth, in *cages, closets, cellars, stalls, pens! Chained, naked, beaten with rods*, and *lashed into obedience*.
>
> …[F]ound the mistress, and was conducted to the place, which was called "*the home*" of the *forlorn* maniac, a young woman, exhibiting a condition of neglect and misery

> blotting out the faintest idea of the comfort, and outraging every sentiment of decency. She had been, I learnt, "a respectable person, industrious and worthy. Disappointments and trials shook her mind, and, finally, laid prostrate reason and self-control. She became a maniac for life. She had been at Worcester Hospital for a considerable time, and had been returned as incurable." …[T]here she stood with naked arms and disheveled hair; the unwashed frame invested with fragments of unclean garments, the air so extremely offensive, though ventilation was afforded on all sides save one, that it was possible to remain beyond a few moments without retreating for recovery to the outward air. Irritation of body, produced by utter filth and exposure, incited her to the horrid process of tearing off her skin by inches; her face, neck, and person, were thus disfigured to hideousness; she held up a fragment just rent off; to my exclamation of horror, the mistress replied, "oh, we can't help it; half the skin is off sometimes; we can do nothing with her; and it makes no difference what she eats, for she consumes her own filth as readily as food which is brought to her."

These words would soon culminate in the increased capacity of the Massachusetts state insane asylum in Worcester (Worcester State Hospital) as authorized through state legislation, with broad support by the state legislators. Importantly, the new laws shifted the care of the idiots, lunatics, and insane persons, not furiously mad, from local "caretakers" to state specialists with the hopes that this would lead to "moral treatment" and humane conditions. Dix would continue on to petition other state governments: New Jersey would open an asylum as ordered by the legislature in 1845, Illinois—its first—ordered in 1847, and North Carolina ordered in 1849. All of this eventually surmounted into the Bill for the Benefit of the Indigent Insane, a Federal bill that would earmark over 12 million acres of Federal land and resources to address the "newly" identified problem. US Congress would passionately shepherd it through the legislation process, only to have then President Franklin Pierce veto the bill, demanding this issue be relegated to individual states. Dix would end up traveling abroad after this defeat, continuing her efforts in other countries.

1.1.2 Moral Treatment Thrives and Declines

Yet, the momentum spearheaded by Dix was beyond reproach. Even in her absence, broad reform continued to develop. Dedicated institutions for individuals with mental illness blossomed in the post-Dix era, particularly those that offered forms of "moral treatment," an early progressive treatment modality developed in the Enlightenment in Europe. The American concept of *moral treatment* was championed by Benjamin Rush, a prominent medical doctor in Philadelphia (Trent, 2017). Rush's thought was that the root of mental illness was chaos of a modern life that, theoretically, could be treated in a hospital setting mainly by withdrawing someone from all of life's stressors under supervised medical care. While Rush used some provocative procedures—blood-letting and prolonged restraint in a "tranquilizer chair" (that he invented) being two of the more controversial—moral treatment was grounded in medical interventions seeking to soothe a patient in a comfortable setting, engage in exercise and conversation, and explore the individual needs of each individual under care (Fig. 1.2).

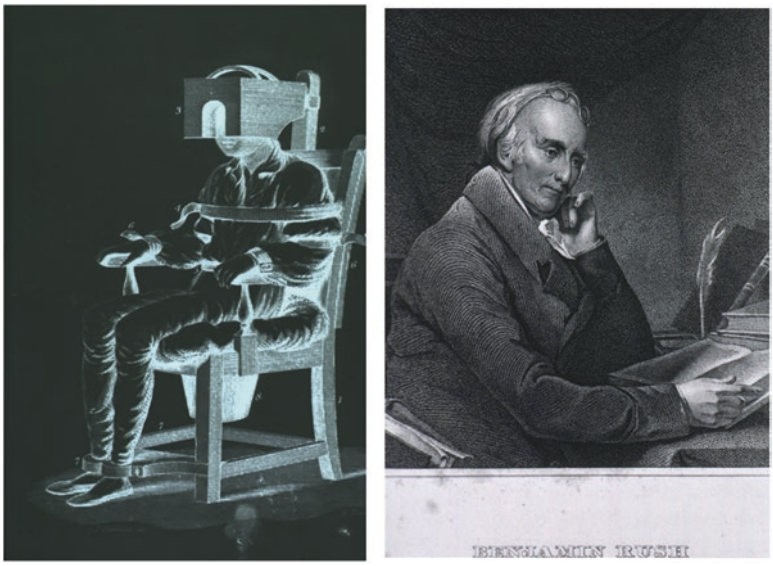

Fig. 1.2 A negative of Benjamin Rush's tranquilizer chair (left) and an image of Benjamin Rush (right), courtesy of the National Library of Medicine. A note from the NLM catalog regarding the tranquilizer chair: "A patent sitting in a chair; his body is immobilized by straps at the shoulders, arms, waist, and feet; a box-like apparatus is used to confine the head. There is a bucket attached beneath the seat"

Even with this progressive modality—which would eventually become a mainstay in the mental health care of the rich and powerful as it became perfected—the sciences of psychiatry and psychology were far too nascent to offer substantial care for this population. Outcomes were abysmal, breakthroughs were few and far between, and the growing body of mental health research reinforced a sense of pessimism. While this may not be surprising, it helps to consider that medical science figured out that surgical complications and deaths can be drastically reduced by sterilizing operator's hands in 1846 (Ignaz Semmelweis), the American Medical Association was established in 1847, crude medicines like morphine began to show marked medical utility in the mid-1850s, and the first modern American medical school (Johns Hopkins University School of Medicine) opened its doors in 1893 (Carter & Carter, 1994; Haller, 1981; Packard, 1901). But, while medicine continued to progress and grow rapidly, treatment for mental illness was stymied.

Muckenhoupt (2004) suggests that the progress Dix helped to influence hit a turning point when Pliny Earle published his research on the lack of success of mental health treatment, only affirming what most medical professionals of the era already had suspected. Nothing was working. Earle discovered that patients who were discharged and formally cleared as "sane" were consistently readmitted, casting doubt on the true number of "recoveries." This is one reason states began to divest in mental hospitals, layered with the consistent underlying and persistent stigma and lack of understanding of mental illness. Asylums gradually became

overcrowded, dilapidated, and disorderly. Working in these state institutions never gained the prestige as did being a professional in the other medical sciences—*any* other medical science. Thus, the administrators of these facilities were not typically the best and brightest.

One can easily argue that this is the point where America has come full circle in the manner it treats the idiots and lunatics or insane persons and that policy simply changed the setting in which "treatment" was given—from jails and prisons to prison-like asylums. Further, these prison-like asylums, or "hospitals," concentrated stigma and rapidly became a place for a "new" class of people. It would not be a stretch of the imagination to conceive that this concentration of the problem of the mentally ill in these ghastly institutions only helped the eugenic movement of the early twentieth century to target this class of people for sterilization or complete elimination from the gene pool. Thankfully, this is not the path history takes us.

1.1.3 The Miracle Drugs

Finally, over a 100 years into this American story, a breakthrough occurred; research on chlorpromazine, known for its trade name Thorazine®, began to surface in the 1950s (see Fig. 1.3). The drug launched quickly from laboratory, to trial use, to widespread use, all during that same decade. Physicians quickly knew Thorazine® as a wonder drug for its abilities to breakthrough psychotic symptoms, so much that when they saw marked improvements in their patients, mental hospital doctors

Fig. 1.3 Thorazine® advertisement in the *Journal of American Psychiatry* in 1980. Courtesy of GSK. Reproduced with permission

would release them in droves—even without knowing the long-term efficacy or potential pitfall of these decisions. Just think, Thorazine® was first produced in a laboratory in 1950, showed significant promise in animal studies in early 1951, was released to physicians as a research drug in the late spring of 1951, and was documented to produce dramatic improvement in psychotic symptoms by the end of the year (Healy, 2009). By late 1957, psychiatrists Kris and Carmichael (1957) observed that "modern drug therapy has brought about a considerable increase in the number of patients returning to the community" in their follow-up study of 160 patients released from the New York metro area hospitals.

This New York study, as many others like it, vetted the viability of using drug therapy to treat diagnoses such as schizophrenia, "manic-depressive" or "manic disorders," alcohol psychosis, and "involutional psychosis." The prognosis seemed positive with the following caveats: (1) patients must be reevaluated by professionals often "not only in order to avoid unpleasant complications, but also to vary the dosage according to individual needs, taking into account increased stress situations which (sic) have to be faced by these patients outside the hospital," (2) patients with "enduring" conditions (e.g., chronic and severe mental illness) must receive maintenance dosages of Thorazine® to prevent recurrence of symptoms once the drug is discontinued, (3) physicians must ensure compliance with doctor's orders (particularly with taking the correct dose at the recommended intervals), and (4) physicians must evaluate the social situations that may trigger a return to the hospital. The last point they make is interesting regarding the social situations that may trigger relapse; Kris and Carmichael go on to suggest that Thorazine® may be the most potent and valuable "weapon" against mental illness, yet they want to make clear that when it fails to treat someone effectively, social factors should be to blame, not the drug.

Drugs like Thorazine® thrived in this scientific environment so eager for a breakthrough after decades of slow progress toward finding effective treatments for diseases that we were only beginning to understand. In fact, the drug revolution brought a renaissance of psychiatric treatment of mental illness, helping to vastly expand our knowledge of the topic at a quickened pace. In his history of therapeutic medicines, Healy noted, "the 1955 meeting of the American Psychiatric Association (APA) should have been dominated by Thorazine®. But while Thorazine® was on stage, the whispers in the wings were of an even newer drug, Miltown® (meprobamate) which was launched in the second half of 1955….By any reckoning, therefore, while Miltown® might never have made a splash elsewhere (outside of the United States), Thorazine's time at the center stage in American psychiatry should have been short. The fact that it survived the inroads of Miltown® and remained at the center of the scientific stage is compelling testimony to the recognition that chlorpromazine truly was a different drug" (98–99). He goes on to describe the amazement some experts had with Thorazine®; for example, one professional was so impressed that he took equity out of his house to buy stock in the pharmaceutical company manufacturing the drug.

Thus, Thorazine® exploded onto therapeutic use in the United States, and American practitioners were more eager than their European counterparts to push the limits of the drug, increase dosage, and begin pursuing advancing outpatient care in the community now that severe symptoms were being significantly allayed.

And while there were many success stories, it truly took science over 40 years to understand the psychopharmacology of what would be known as a broader class of drugs—the antipsychotics 1.3.

1.1.4 Deinstitutionalization

Thorazine® and the first-generation antipsychotic family of drugs—called the phenothiazines—thus sparked the *deinstitutionalization* movement. Plainly, deinstitutionalization refers to the shift of caring for individuals with severe mental illness in state mental hospitals to community centers and outpatient services from the 1950s arguably through the date of this writing. Torrey (1997) calls this shift "one of the largest social experiments in American history" as he opines over the sheer magnitude of this change as demonstrated by the numbers of patients residing in state mental hospitals from the 1950s. Torrey cites that in 1955, state hospitals had a population of 558,239 persons; yet, by 1994, this population was reduced to 71,619 nationwide. The exact numbers often vary in the literature; however, three key sources have reliably documented the dramatic changes over this period—the National Institute of Mental Health, the Center for Mental Health Services, and individual states. A summary of CMHS data can be found in Fig. 1.4.

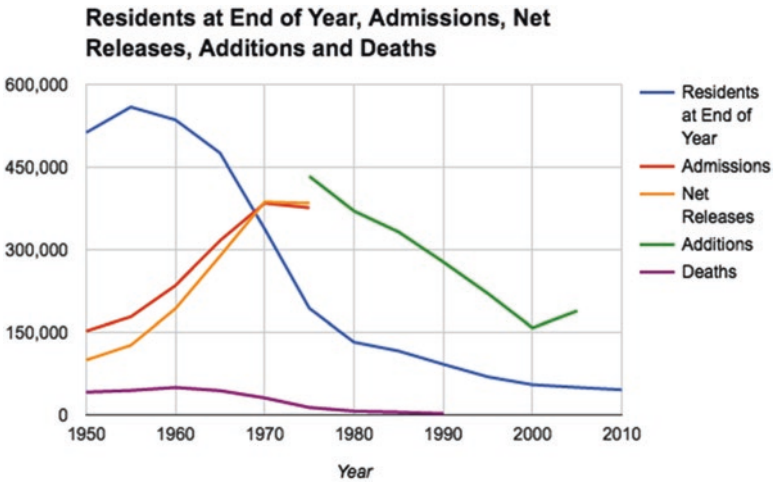

Fig. 1.4 Number of hospital residents, admissions, net releases, additions, and deaths, using CMHS data presented in a national report entitled, "Funding and Characteristics of State Mental Health Agencies, 2007" (SAMHSA, 2007) with year 2010 added from "Behavioral Health United States, 2012 (SAMHSA, 2013)

Further, psychiatry had progressed as a science enough to broadly define the types of diseases facing this population: roughly half had a diagnosis of schizophrenia, about 10–15% were diagnosed with manic depression (now, bipolar disorder) or "severe" depression, another 10–15% had mental health issues due to organic brain disease, and the remainder had diagnoses such as mental retardation with psychosis, childhood disorders, and brain disease in conjunction with an addiction (Torrey, 1997). Was it possible to effectively treat these issues outside of a hospital setting? For over 100 years, establishing effective treatments for these diagnoses eluded mental health professionals. Real change was finally happening, but was it positive change?

As these questions were being wrangled with, political pressure from various sources was pushing states to decrease the size of state mental hospitals. It was certainly easier to acquiesce to these pressures with the broader adoption of the phenothiazines; however, the combination of the Community Mental Health Centers Act of 1963 with the enactment of Medicaid and Medicare (via Title XVIII and XIX of the Social Security Act, signed into law by Lyndon B. Johnson) cemented the trend of treating mental illness outside of hospital settings (Torrey, 1997; SAMHSA, 2007). In particular, the Community Mental Health Centers Act was put in place to develop a network of community mental health centers at the local level, reversing the trend that Dorothea Dix promoted. Medicaid and Medicare helped to cover the cost of using these centers for patients. This shift may have led to positive results if, in fact, the nationwide mental health network could prove successful. This would mean that the system ensures that people with mental illness receive medication, rehabilitation services, and aftercare to ensure ongoing treatment compliance, yielding the best chances for personal success with treatment. Unfortunately, this great experiment is absent of success stories. In later decades, the narrative of mental health would become entangled in another failing policy shift of the twentieth century—American criminal justice reform, including its war on drugs.

1.1.5 The Media Coverage of Hospital Conditions and Homelessness and Social Awareness

As the Federal government pushed forward with policies favoring treatment of mental illness in local communities over state-run institutions, additional forces added to the momentum—or, at minimum, aided to continue to reduce the size and scope of state mental hospitals. The most potent of these forces is the effect of mass media coverage of the hospitals, which have become dilapidated and chaotic messes as their resources continued to dwindle in these years. For example, Life Magazine published Albert Q. Maisel's (1946) photo essay on the horrors of state-run mental hospitals, "Bedlam 1946: Most U.S. Mental Hospitals Are a Shame and a Disgrace." The impact of visualizing the suffering in photographs was certainly palpable, with the captions reading "NEGLECT. In Cleveland Hospital's bare wards a patient lies

unnoticed and unattended on stone floor," "RESTRAINT. This woman wears a camisole with sleeves tied behind her. Ulcers on leg are bandaged," "USELESS WORK. At Massillon Ohio State Hospital barefoot patients polish splintered wooden floor in 1890 building - a poor substitute for occupational therapy," and so on with explicit photographs depicting "NAKEDNESS… OVERCROWDING… FORCED LABOR… IDLENESS... [and] DESPAIR." The 13-page spread dedicated to the issue began to raise awareness on a growing problem, a problem that seemed intractable, until pharmaceutical and policy intervention. This copyrighted work—including its shocking visceral images—is available online at the time of this writing, easily searchable by the article's title.

This was certainly not the only instance of mass media's contribution to the conversation. One of the most iconic exposés of this era that brought these issues into the public spotlight was Geraldo Rivera's work on Willowbrook State School in Staten Island, New York, called "The Last Great Disgrace 1972."

> When Dr. Wilkins slid back the heavy door of B Ward, building No 6, the horrible smell of the place staggered me. It was so wretched that my first thought was that the air was poisonous and would kill me. I looked down to steady myself and I saw a freak: a grotesque caricature of a person, lying under the sink on an incredibly filthy floor in an incredibly filthy bathroom. It was wearing trousers, but they were pulled down around the ankles. It was shinny. It was twisted. It was lying in its own feces. And it wasn't alone. Sitting next to this thing was another freak. In a parody of human emotion they were holding hands. They were making a noise. It was a wailing sound that I still hear and that I will never forget. I said out loud, but to nobody in particular, "My God, they're children." Wilkens looked at me and said, "Welcome to Willowbrook." (Rivera, 2017)

There are some very notable contrasts and similarities of Rivera's words to Dix. First, the stark contrast each observer's characterization of the mentally ill is staggering: Dix refers to the vulnerable people she witnessed as idiots and lunatics, acceptable early medical labels for the mentally ill in that era, while Rivera uses the stigmatic word *freak*. Yet, the message was essentially the same. How was it possible for the government, at any level, to treat the vulnerable in such an inhumane way? In today's terms, the exposé would go viral. One cannot underestimate the impact of photojournalism and documentary-style exposes in their potential to elicit a grassroots and/or policy response; at minimum, the ongoing and visceral reporting on the issue of mental illness reinforced the political sentiment of the era to increase resources for mental health services in communities while divesting in state-run institutions, and many would argue with convincing evidence that this sets the stage to defund almost all state mental hospitals by the end of the twentieth century.

At this point in history, the issue becomes much more complex, and the following forces are at play: the mass media, professional medical organizations, the pharmaceutical industry, policymakers and political figures, and a growing socially aware populace with broader access to political influence. Deinstitutionalization has triggered the process of reintroducing a sizeable population of individuals with severe mental illness to the public, whereas in the past, this group was kept vastly segregated and out of sight. This was done largely without a scientific assurance that individuals with mental illness could live successfully, with minimal symptoms, in

the mental health networks created for their treatment. While the available treatment would, in fact, work well for some people, it would end up leaving many vulnerable, without access, and untreated. These individuals would soon become documented in a growing scientific literature on the failures of deinstitutionalization, namely, for ending up in the swelling numbers of the homeless or criminally institutionalized in the nation's jails and prisons.

Yet, as deinstitutionalization would quietly criminalize untreated mental illness, American mass media would instead become focused on homelessness. Buck and Toro (2004) point to several reasons why this occurred in the 1980s. First, Ronald Reagan's administration led the initiative of making substantial cuts to social programs in light of a recession. In response, Reagan's political opponents aligned with homelessness activists to begin a media campaign on the issue in sharp rebuke of the administration with hopes of political fallout. Second, many aging urban centers were redeveloping and becoming gentrified, leading to fewer affordable housing options. The combination was proved to be excellent kindling for a crisis with a political environment to keep this story in the news. The previous issue of vagrancy, an often-stigmatized term with a lengthy negative history, would become homelessness. Tramps and hobos would become the homeless.

In their 2004 study, Buck, Toro, and Ramos evaluated these trends in print coverage from 1972 (well before media interest began on the issue) to 2001 (well after the issue attracted front covers) in four leading newspapers: *The New York Times*, *The Washington Post*, *The Los Angeles Times*, and *The Chicago Tribune*. These researchers took 500 randomly selected articles and identified four distinct time periods, labeled pre-interest (1972–1980), rise and peak (1981–1987), decline (1988–1993), and plateau (1994–2001). They argued that the rise and peak time period seemed to be "the most revealing." It is during these years that the media departed from their previous view of the homeless and would, generally, cast a more sympathetic light on these individuals. But, while the media reported on mental health as a contributing factor and tied deinstitutionalization and related structural issues to the broader homelessness problem, Buck and Toro found that most of the coverage failed to talk about services or long-term programs to address homelessness, noting that few services or programs existed during that time. In the decline years, negative reporting returned in greater frequency, often bringing back stereotypes of skid row alcoholics and drug addicts, with the addition of the mentally ill and dangerous stigma. It is not that the media completely turned their backs to the plight of the homeless; instead, Buck, Toro, and Ramos argue that the American public grew to understand that homelessness is complex and the media coverage of the time reflects that by its broad coverage of the issue.

Instead of a broad compassionate policy response as seen in previous eras, mental illness was on a collision course with criminal justice reform. For many with mental illness, deinstitutionalization increased the risk of substance use and abuse (called co-occurring disorders—more on this later) and illegal behaviors (some may be contributed directly to the illness). Many were left vulnerable and without a safety net as the community mental health networks never became comprehensive enough to effectively treat the population previously served by state-run mental

hospitals. The war on drugs began with Richard Nixon's administration; but it was the Reagan administration and the 98th (1983–1985) and 99th (1985–1987) US Congress that initiated the criminal justice reforms that would rapidly accelerate the growth of the rate Americans incarcerate their citizens. This trend would continue into the administrations of George H.W. Bush and Bill Clinton with the full support of Congress. With a fragmented mental health treatment network as the only option for many vulnerable people, their fate amounted to a different iteration of the incarceration faced by those in state-run mental hospitals. Except, this time, their experiences would be much worse as American jails and prisons were hardly prepared to care for this population.

1.1.6 The Impact of the War on Crime and the Incarceration State

The primary drivers of moving individuals with mental illness in the community into jails and prisons are substance use and abuse and untreated or undertreated symptoms. Just as Kris and Carmichael may have predicted, untreated or undertreated symptoms would produce a return to the state hospital—except that these hospitals had shuttered, with remaining facilities having vastly reduced capacities and a bare-bones operation that would only serve the most severe cases. Further, the struggles facing this vulnerable population do not occur in isolation; in other words, poverty, homelessness, substance use and abuse and self-medication, violence and victimization, and frayed social support, to name a few, can all influence each other and influence one's mental health to deteriorate or symptoms to appear—again, a theme that was foreshadowed by Kris and Carmichael's Thorazine® study. Figure 1.5 lists the policies, the timing of the policies, and their effects on mental health and criminal justice.

The "Tough on Crime" movement has led to dramatic changes. Foremost, jails and prison populations have increased exponentially. While *total* numbers are difficult to come by for this entire time period, the Bureau of Justice Statistics (BJS)—an agency within the Department of Justice tasked with collecting data on the operation of justice systems among all levels of government—maintains a dataset called the National Prisoner Statistics Program that has followed the State and Federal prison population since 1925 (Bureau of Justice Statistics, 1982). While it excludes data on local (jail) inmates, the dataset clearly shows stability of the prison population around 100 per 100,000 persons in the United States until the mid-1970s (Fig. 1.6). By all accounts, this figure trended aggressively upward through the 1980s, 1990s, and into the new millennium—exceeding 500 per 100,000 persons. Yet, to truly understand the impact of deinstitutionalization apart from the "Tough on Crime" movement, one would also need to observe changes in all segments of the *justice-involved population*. Justice involved is a broad term that refers to individuals in State and Federal prisons, in community corrections (e.g., State and

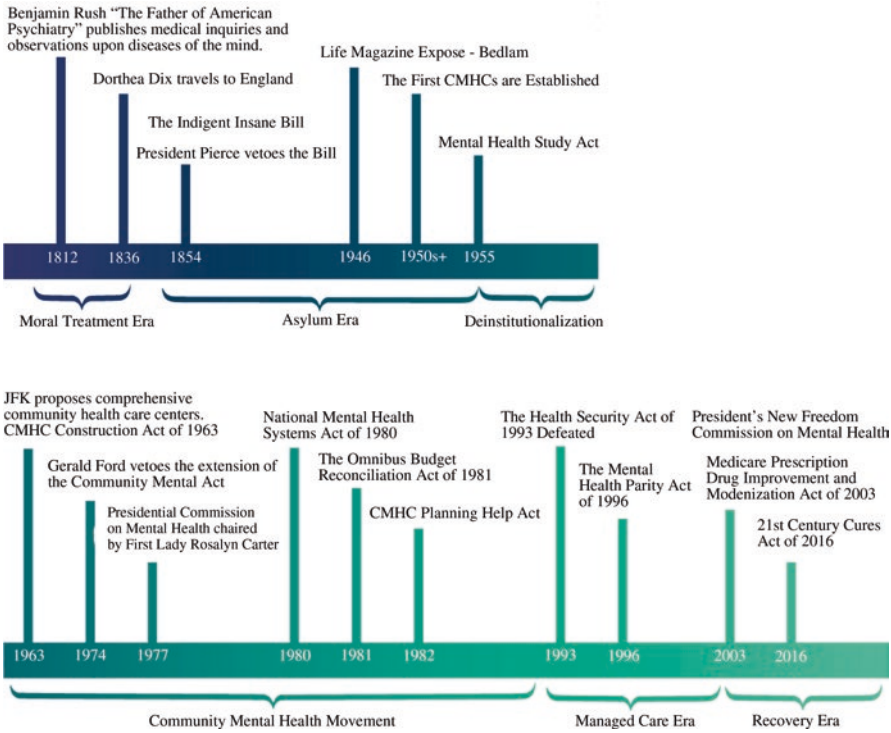

Fig. 1.5 Mental health policies over time

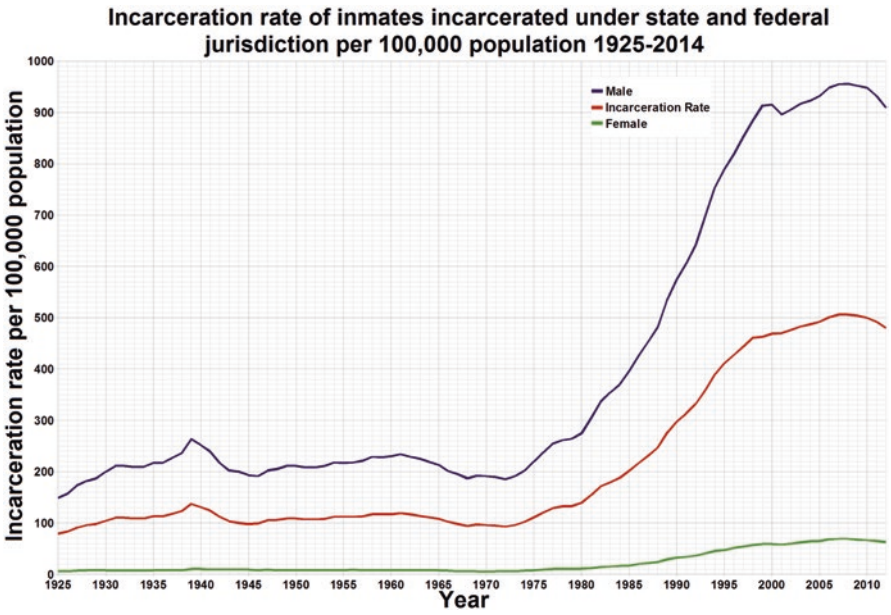

Fig. 1.6 Data from the National Prisoner Statistics Program, Bureau of Justice Statistics

Federal probation and parole), and in local jails either awaiting trial or serving time. Unfortunately, since consistent and reliable data on all segments of the justice-involved population only began to be collected in the late 1970s, it is truly difficult to follow the impact of deinstitutionalization on justice involvement.

The newly available data from the Bureau of Justice Statistics certainly suggests the use of the criminal justice system as a broad intervention tool for substance use and abuse and "criminality." Starkly, the reach of the criminal justice system peaked in 2008 at 2405 per 100,000 adult Americans involved in the system in some way, up from 800 per 100,000 in 1980 (Bureau of Justice Statistics, 2017a, b). Put another way, that amounts to just over two per every 100 adults in the United States were in prison or jail or on probation or parole, in 2008. Many of these individuals were swept up into the system for nonviolent drug offenses as a direct result of the "Tough on Crime" movement, which focused so much of its efforts on drug policy. As Jonathan Rothwell (2015) points out, while 1 in 5 state prisoners are incarcerated for drug offenses on average, there were three million admissions (just above 30% of all admissions) to both state and Federal prisons for this type of offense from 1993 to 2011, far more than any other type (e.g., violent crimes, property crimes, and all other crimes). Quite simply, drug crimes continue to be the main driver of imprisonment, even in current times.

Yet, many questions still remain—how many of those adults are mentally ill? What was the true impact of deinstitutionalization? If deinstitutionalization trends began in 1955, how can one effectively explain why prison populations did not trend upward until the mid-1970s? The capacity to answer how many justice-involved persons have mental illness is growing, and the true impact of deinstitutionalization mostly relies on anecdotal conjecture as consistent and reliable data identifying justice-involved individuals with mental illness only has recently become routine. After all, a scenario may exist that the proportion of mentally-ill, justice-involved persons has stayed consistent, with just the total population ballooning; yet, all available evidence does not bear this out.

Many observers, such as Lamb and Weinberger (2005), have argued that mental illness has effectively become criminalized over this time period. The exact numbers are still elusive to this date; however, there are a few ways to estimate the number of individuals with mental illness in the *current* justice-involved population. One way, Lamb and Weinberger suggest, is to take the estimation of the percentage of individuals in jails and prisons who could be diagnosed with serious debilitating mental illness (e.g., major depression, schizophrenia, bipolar disorders, and various other psychotic disorders) as published in current scientific literature, which at the time, ranged from 16% to 24%. Using a conservative approach, Lamb and Weinberger use the 16% for the year 2000 and estimated 113 per 100,000 individuals in jails and prisons to be severely mentally ill. "Severely mentally ill individuals who formerly would have been psychiatrically hospitalized when there were a sufficient number of psychiatric inpatient beds are now entering the criminal justice system for a variety of reasons. Those most commonly cited are: (1) deinstitutionalization in the terms of limited availability of psychiatric hospital beds; (2) the lack of access to adequate treatment for mentally ill persons in the community;

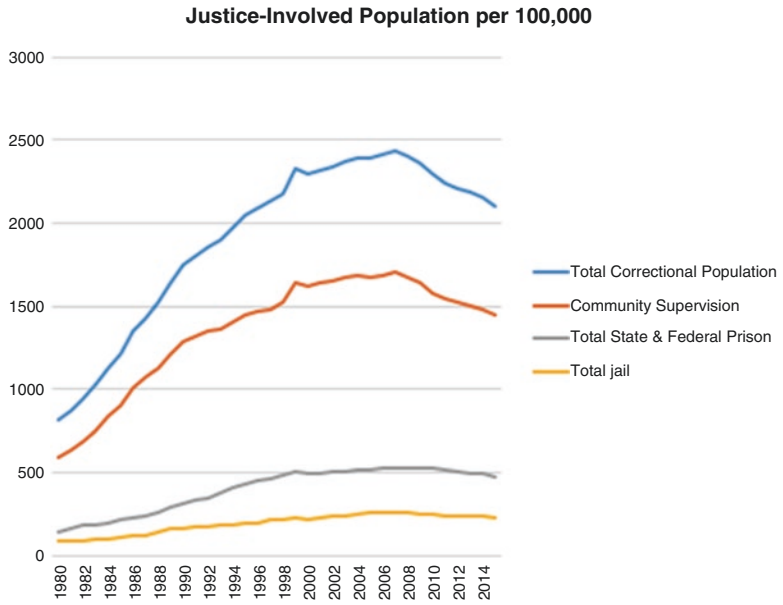

Fig. 1.7 Data from the Bureau of Justice Statistics, Key Statistic: Total Correctional Population

(3) the interactions between severely mentally ill persons and law enforcement personnel; and (4) more formal and rigid criteria for civil commitment (Fig. 1.7)."

Taking a more liberal approach, two BJS statisticians—James and Glaze (2006)—analyzed personal interviews with prisoners and local jail inmates in two surveys performed just a few years prior in a special report. In their analysis, James and Glaze were able to decipher individuals with mental health problems by one of two ways to gain better insight into this population: (1) recent history (within the last 12 months) of a clinical diagnosis and/or treatment by a mental health professional and (2) exhibiting symptoms of a mental health disorder as determined by targeted questions on the two surveys. The results were staggering: 705,600 (56%) state prisoners, 78,800 (45%) Federal prisoners, and 479,900 (64%) local jail inmates met criteria for having a mental health problem, amounting to just over *half* of the total population. These figures differ considerably from the first comprehensive accounting of mentally ill subpopulation by the BJS performed only a few years prior in 1999. At that time, BJS statistician Paula Ditton had access to survey questions asking participants directly if they suffer from a mental illness or if they had stayed overnight in a mental hospital. This line of questioning resulted in estimates of 283,800 individuals with mental illness in jails and prisons, with 16% of state inmates, 7% of Federal inmates, and 16% of local jail inmates self-reporting mental illness in this manner. The differences between these two undertakings are essentially underscoring the potential undiagnosed mental health problems endemic to this justice-involved population. More on this in later chapters.

The updated report also included a more comprehensive description of mentally ill, justice-involved individuals, giving supporting evidence to the anecdotal descriptions of this population in the literature at the time: state prisoners and jail inmates with mental health problems are more likely to report being incarcerated three or more times relative to those who do not report mental health problems; female inmates reported mental health problems more than male inmates; about three quarters of the individuals reporting mental health problems also met criteria for substance use disorder or abuse; nearly two-thirds of these individuals used drugs in the month prior to their arrest; and state prisoners with a mental health problem were twice as likely to be homeless and twice as likely to be injured in a fight since admission relative to individuals who did not (James & Glaze, 2006). There is little doubt that a sizeable portion of the people who need mental health services have, at minimum, a higher likelihood of contact with the criminal justice system since deinstitutionalization.

1.2 Current Policy

While the prognosis may appear grim, policy efforts to address the fallout from the "Tough on Crime" movement are ongoing. Further, a functional network of community-based mental health services is possible; in fact, these networks are already in place for those who have access through private health insurance. Much of the innovation for the vulnerable populations discussed above—the homeless, individuals with mental illness, and/or those with addiction—stems from the Second Chance Act of 2007 and Justice Reinvestment Initiative legislation. Briefly, the Second Chance Act was a bipartisan law easily passed under the George W. Bush administration that earmarked funding to invest in programs to reduce recidivism while ensuring public safety. To date, over $475 million has been invested in promising programs via grants, marking a formal start to the "Reentry" movement. A primary caveat to receive these funds at the local or state level is to initiate programs or services that are *evidence based*. Two Second Chance Act programs are specifically relevant here—Targeting Adults with Co-occurring Substance Abuse and Mental Health Disorders and the Statewide Adult Recidivism Reduction Strategic Planning Program. The first of the two has further refined our knowledge of what works to help individuals with mental illness return to the community and reduce their chances of being re-incarcerated, while the latter has enabled states to develop the policy initiatives to help drive this sort of change for state prisoners and local jail inmates alike.

The Justice Reinvestment Initiatives are currently a collaborative project with states and localities and the Pew Charitable Trusts, with funds authorized by Congress in 2010 via the Bureau of Justice Assistance. These initiatives require broad participation by stakeholders in each location to participate in a comprehensive analysis of their criminal justice system in order to define which evidence-based strategies could be put in place to reduce recidivism and cost while maintaining

Table 1.1 Participants served by Second Chance Act programs, 2009–2015

SCA programming	Number served
Co-occurring	9048
Family-based	8375
Mentoring	25,573
Technology careers	6632
Reentry demonstration	61,105
Reentry court	2595
Overall	113,328

Courtesy of the Bureau of Justice Assistance

public safety. Generally, these initiatives tend not to put direct focus on mental health issues; however, many initiatives have better defined the problems facing justice-involved individuals with mental illness and have generated plans to mitigate these problems (Table 1.1).

The key of both of these strategies is to promulgate evidence-based practices and services that are proven to reduce recidivism while further vetting promising practices and services that may lead to beneficial results. For justice-involved individuals with mental illness, this means provision of adequate care in *all* settings—jails, prisons, and upon return to the community. This means that a comprehensive review of these settings is beginning to take shape or has been completed since 2002. Progress is beginning to take shape across the United States, and never has American justice and mental health policy been closer to the ideal of providing mental health services in the *least restrictive* manner (Atkinson & Garner, 2002; World Health Organization, 1996)—that is, fewer locked doors, less incarceration or commitment, fewer shackles, chains, restraints, and so on.

It also should be noted that both strategies placed substantial focus on overall cost reduction of criminal justice as overall expenditures were getting out of hand, particularly during times of recession. This emphasis on "smart" cost savings has enabled broad support for policies that are affecting change since the beginning of the century. While change has been slow to come, its momentum continues to expand the array of services available to the very same vulnerable population cast aside since the days of Dorothea Dix. One recent example was the passage of the Twenty-First Century Cures Act—a bipartisan effort signed into law by Barack Obama at the end of his last term. Within the legislation, the 114th Congress embedded previous iterations of the Helping Families in Mental Health Crisis Act as Division B of the Cures Act. This section is dedicated to completely revision mental health services in the United States. Key provisions of the Act include creating an assistant secretary for Mental Health and Substance Abuse and an assistant secretary of Planning and Evaluation within the Substance Abuse and Mental Health Services Administration; creating a biennial report to tabulate progress and developing a strategic plan—all to bolster leadership and accountability of mental health services; encouraging the development of evidence-based programs and services and other innovation via grants, prioritizing development of services based on need, and disseminating this information—to ensure these efforts keep up with the best

and current science on mental health and substance abuse; supporting state innovation via block grants; and promoting access to mental health services via grants for homeless populations, jail populations, integration of primary and mental health care, revisioning suicide prevention, and much more.

Throughout the Cures Act, there are several mentions of expanding the use of inpatient beds in a strategic fashion. One priority is to use technology to better understand the availability of inpatient resources, their utilization, and their fit in a broader continuum of care by region and across the country. Thus, this reimagination of mental health care is a key, and bold, effort since deinstitutionalization policies to address this persistent need of a vulnerable class of citizens. Notably, it expands Medicaid to cover a broader array of mental health services to stymie the use of jails and prisons as the new asylum for individuals with mental illness. Yet, these institutions will remain an important component of the "new" system of care it envisions.

1.3 Key Problems Today

The four following problem areas need to be introduced early in this text: stigma, trauma, co-occurring disorders, and cost of services. Together, they represent persistent barriers to successfully address mental health care in the United States. In fact, "stigma" is directly addressed 4 times in the Cures Act, "trauma" 27 times, "co-occurring" 37 times, and "cost" *98* times. Recall that cost is the glue that makes the effort to re-envision mental health care possible; thus, any innovation will only prove to be viable if it can prove cost savings. Always keep this in mind when considering the advances of science in future years.

1.3.1 Stigma

Davey (2013), writing for Psychology Today, has a great description of mental health stigma and both the outward discussion as well as internal: "Mental health stigma can be divided into two distinct types: *social stigma* is characterized by prejudicial attitudes and discriminating behaviour directed towards individuals with mental health problems as a result of the psychiatric label they have been given. In contrast, *perceived stigma* or *self-stigma* is the internalizing by the mental health sufferer of their perceptions of discrimination, and perceived stigma can significantly affect feelings of shame and lead to poorer treatment outcomes" (Davey, 2013; emphasis as in original; citing Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Perlick et al., 2001). The stigma associated with mental illness can be a barrier for many to seek treatment in the first place; in other words, people's resistance and reluctance to be labeled mentally ill—officially or unofficially—often makes them think twice about reaching out for help, even to those they trust. Also, friends

and family members often struggle with overcoming stigma and stereotypes to remain supportive to those suffering from mental illness. Increasingly concerning, as with many illnesses, lack of treatment leads to worsening of symptoms and severity. Typically, better outcomes are tied to addressing an illness as early as it can be detected—mental health included. This is the basis of why the concept of stigma is so important, and it is vital to understand why it endures.

The typical stereotype of mental illness is a "crazy" person who commits acts of violence and could be a harm to themselves or others (Angermeyer, 1996; Nunnally, 1981; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999; Penn, Kommana, Mansfield, & Link, 1999). In reality, most individuals with mental illness are not violent. One widely cited study by Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999) details the power of this misconception through an experiment with five vignettes placed on a massive social science survey in 1996 (the General Social Survey). The vignettes were written about people with mental illness in a nonclinical way to gauge people's reaction about (1) alcohol dependence; (2) major depression; (3) schizophrenia; (4) drug dependence; and (5) a "troubled person." Importantly, the "troubled person" vignette represented a person experiencing a rough time in their life, but did not meet any criteria for mental illness, giving the researchers a basis for comparison. For example:

> John is a [ETHNICITY] man with an [EDUCATIONAL LEVEL] education. Up until a year ago, life was pretty okay for John. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. John was convinced that people were spying on him and that they could hear what he was thinking. John lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. John was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.—the vignette for schizophrenia

The results from 1444 survey participants detail the depth of the issue of stigma and the stereotype of the dangerousness of mental illness. When directly asked, "In your opinion, how likely is it that [NAME] would do something violent toward other people—very likely; somewhat likely; somewhat unlikely; very unlikely," the average responses indicated that people viewed cocaine dependence as the most dangerous (87% of respondents either chose very or somewhat likely), followed by alcohol dependence (71%), and schizophrenia (61%). This reaction is in the face of volumes of empirical evidence consistently finding that only a minority of individuals with mental illness become violent. Perhaps even more telling, when Link and his colleagues asked whether the people surveyed would be willing to live next to this person, spend an evening with them, work closely with them, and react to them marrying a relative, most respondents sought to distance themselves from the person in the vignette. The results were in line with perceived dangerousness—the vast majority of people surveyed would distance themselves from cocaine dependence (90%), alcohol dependence (70%), and schizophrenia (63%). Even the individual depicted as having major depressive disorder would be isolated by many respondents (47%).

Importantly, the researchers also felt as though the respondents felt hesitant to use the term "mental illness" when asked about the people in the vignettes.

Specifically, when respondents were asked if they believed the person detailed in the vignette was experiencing a mental illness, most, but not all, responded affirmatively. This was especially the case with major depressive disorder (69% of respondents thought the person had a mental illness), alcohol dependence (49%), cocaine dependence (44%), and a troubled person (22%). Yet, when confronted with the specific condition of the people depicted in the vignettes, the vast majority of respondents were convinced that the individuals had alcohol dependence (98%), cocaine dependence (97%), major depression disorder (95%), and schizophrenia (85%). The differences in responses here show the weight of the words "mental illness."

Stigma, social distancing, and labels are incredibly powerful interrelated and complex concepts. Not only do these concepts shape the experience of mental illness, the science in this area details the interconnectedness of deviance (including drug use/abuse), crime and criminality, vulnerability and victimization, homelessness, and mental illness with stigma as a central component. Thus, it is important to fully explore stigma and its role in the lives of people with mental illness.

1.3.2 Trauma

Trauma is often related to a significant untoward and problematic event in a person's life (SAMHSA, 2017b, 2014). It is more common than one may expect and is not bound by age, gender, race, ethnicity, socioeconomic status, or other difference between people. While many people can persevere through traumatic events without experiencing lasting negative outcomes, a broadening array of research is revealing the importance of early treatment intervention. Individuals with a support system and those who have never or rarely experience trauma are typically more resilient, but not always. Unfortunately, this trauma can linger and become a larger problem, perhaps in the form of mental illness and/or substance abuse—especially when the trauma is persistent and/or occurs with increased frequency. Furthermore, it is important to note that the negative effects of trauma are magnified when they occur during childhood. Thus, children and teenagers are at most risk for developing lasting conditions such as substance abuse disorder (including smoking cigarettes and drinking alcohol) and mental health problems (including depression, anxiety, and post-traumatic stress disorder) or engage in risky behaviors such as self-injury and risk taking.

Trauma may be the result of harm, violence, and victimization from a variety of experiences. In fact, SAMHSA offers toolkits (2014) that offer an excellent summary across the broad domains of experiencing trauma and helpful resources that can help both laypersons and professionals link up with evidence-based treatments to address these sources of trauma. Broadly, these domains include sexual abuse or assault; physical abuse or assault; emotional abuse or psychological maltreatment; neglect (e.g., failure of a caretaker to provide care, food, shelter, and other basic necessities); serious accident, illness, or medical procedure; victim of or witness to

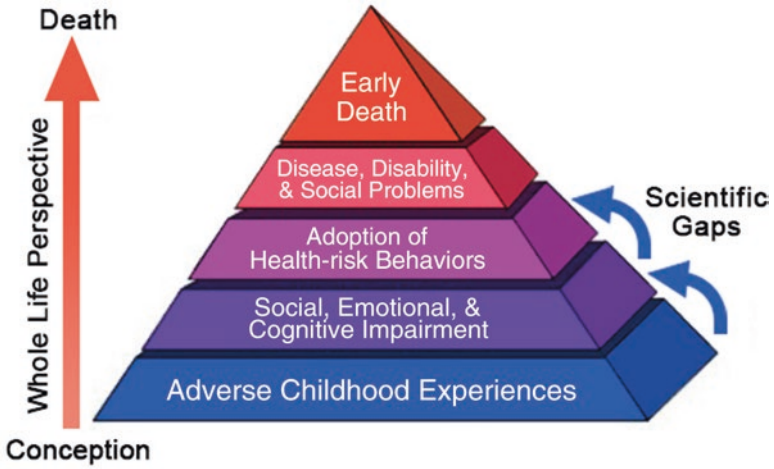

Fig. 1.8 Relationship among adverse childhood experiences and potential later life outcomes, courtesy of the Substance Abuse and Mental Health Services Administration

domestic violence; victim of or witness to community violence (e.g., gang violence, racial conflict, police-citizen confrontations, and riots); historical trauma (e.g., traumatic experiences tied to a group or culture, e.g., American slavery, Jim Crow, and post-Jim Crow); school violence and bullying; natural or man-made disasters; forced displacement; war, terrorism, or political violence; military trauma (e.g., for military members and their families as a result of deployment and/or military service); victim of or witness to personal or interpersonal violence; traumatic grief or separation; and system-induced trauma and retraumatization. While this list may not be exhaustive, it does offer a structure to begin to investigate the sources of trauma.

Further, a great deal of recent research has been focused on early life trauma, called adverse childhood experiences (ACEs). This research has clearly shown that these events pose a significant risk factor for the development of mental health disorders in later life (in particular, substance use disorders) and can have an impact on future prevention efforts (SAMHSA, 2017b). This research was kick-started by a collaborative effort between of the Centers for Disease Control and Prevention and Kaiser Permanente; in 1998, these entities published their research on ACEs in 17,337 participants studied across two waves in the *American Journal of Preventive Medicine* outlining. Their findings were remarkable: (1) ACEs are common (28% of participants reported some form of physical abuse and 21% reported some form of sexual abuse); (2) ACEs tend to occur in clusters or in multiples (i.e., 40% of participants reported a history of two or more ACEs and 12.5% experienced four or more); and (3) ACEs predict health problems with strong, positive statistical relationship (or, in other words, the more ACEs one experiences strongly predicts the risk of a variety of health problems in later life, including substance use and co-occurring disorders) (see Fig. 1.8; read the next section for a definition of co-occurring disorders).

The reason why trauma is considered a key problem here is that the effects of trauma can be tricky to diagnose and treat, and without addressing this root cause of mental health and/or drug abuse problems, symptoms, and negative outcomes can persist and can confound prevention efforts. For example, if an underage drinking prevention program with a proven track record of success is adopted in a high-risk community, it may not have the same level of success *or any success* if the programming does not address adverse experiences. Or, alternatively, if this program has the ability to recognize the signs of ACEs, it may link with other programming that can address coping skills, dysfunction in the home, the effects of divorce, and so on.

1.3.3 Co-Occurring Disorders

Co-occurring disorders, once known as dual diagnosis, exist when a person has both mental health and substance use disorders at the same time. According to the National Survey on Drug Use and Health in 2014, more than 7.9 million Americans had co-occurring disorders. With this large number, adding on issues related the criminal justice system can only further complicate recovery for individuals.

One of the major hurdles with co-occurring disorders is establishing high-quality and appropriate treatment. Treatment for this type of disorder lends itself to the "chicken or the egg" adage—does the mental health diagnosis occur before the substance use disorder or does substance misuse/abuse occur before other mental illness? The answer to this question can radically shape an appropriate treatment protocol in one direction or another very different direction. Even further, clinicians need to ask, do the mental health concerns fuel the struggles with substance use, or does the substance use struggle fuel the mental health concerns? From the clinician's perspective, the signs and symptoms of both mental health and substance use disorder can be difficult to separate, which leads to further difficulty in treating the disorders adequately. Clinicians may require longer periods of time to document and diagnose these issues, perhaps delaying the delivery of the best treatment to address these compounding symptoms. Yet, the system of care for mental health services in many locations may not allow for optimal care and treatment; many treatment programs may only treat one disorder while not addressing the other which often does not help in the overall wellness and health of the individual. For example, a person may suffer from bipolar disorder and cocaine use disorder. With bipolar disorder, the individual can experience both depressive episodes and manic episodes. Cocaine is a stimulant, so in this scenario, it could be difficult to differentiate between symptoms from the manic episode from bipolar disorder versus the "highs" of the cocaine use disorder. Additionally, the idea of "self-medicating" can be often brought up in the clinical discussion regarding co-occurring disorders. For example, a person suffering from depression may use alcohol to "self-medicate" and mask negative feelings when experiencing tough times. In this way, alcohol will also fuel the depression and symptoms. Therefore, in both of these examples, treatment professionals may have difficulties with treatment plans. Often, to fully realize the true nature of the mental illness side, the person must fully detox from the substance(s).

Additionally, and further complicating matters for mental health professionals, the level of severity of co-occurring disorder can vary wildly across and within individuals. For example, both of the following may fit the "co-occurring" definition: (1) a person experiencing mild anxiety who misuses alcohol to help with sleep by engaging in frequent binge drinking and (2) a person diagnosed with schizophrenia who may abuse opiates to avoid or shut out the hallucinations they may be experiencing. The intensity and frequency of the issues depicted here can vary in one's life depending on stressors, life circumstances, and so on. Since either the mental illness or the substance use disorder can develop first, it often can be difficult to determine which is fueling the other. Substances can pose a problem by also worsening or, at times, creating problems with a person's mood and throwing off one's brain chemistry leading to behavior issues. Therefore, most treatment options for co-occurring disorders involve an integrated approach.

According to information provided by the National Alliance on Mental Illness, "about a third of all people experiencing mental illnesses and about half of people living with severe mental illnesses also experience substance abuse" (NAMI, 2015). That is a significant number of people impacted by these illnesses, and these figures are important to keep in mind from a treatment perspective. In particular, helping the person and their loved ones understand how both mental illness and substance abuse interact and impact their daily life is important for transformative change. Further, "in the substance abuse community, about a third of all alcohol abusers and more than half of all drug abusers report experiencing a mental illness" (NAMI, 2015). It is also important to note that men are more likely to develop co-occurring disorders than women. Also, those of a lower socioeconomic status, people with more medical illnesses, and military veterans are more likely to be at risk of co-occurring disorders.

SAMHSA literature points out that "the consequences of undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or even early death" (SAMHSA, 2016). In the criminal justice system, many people have co-occurring disorders, and using integrated treatment is essential to success. Further, appropriate screening to identify co-occurring disorders is important to ensure inmates are receiving the proper care within the system. Addressing both mental health and substance use both during and after incarceration can also reduce the likelihood of recidivism.

1.3.4 Dollars and ~~Cents~~Sense

One of the biggest obstacles, and one major common theme throughout this book, is funding. Recall that the most recent landmark mental health law, the Cures Act, mentioned cost more than any other concept; thus, this is not only a theme for this book, it is the top driving force for American policy decision-making. At the more localized level, budgets for jails and state prisons are being cut substantially, primarily due to the overuse of incarceration as a solution for social problems (largely,

drug problems). Incarceration is a very expensive solution to maintain at current levels; the addition of any financial strains, such as from the fiscal pressures of recession, has resulted in cutting services to bare minimums in many circumstances. Further, expenses related to the justice and mental health services are more vulnerable (if not *the most* vulnerable) to cuts as lawmakers tend to be more protective over services that directly affect their constituents—such as schools, roads, parks, and local community services. Divestment in justice and mental health services lead to not only increases in need but decreases in jobs and quality options. If funding for treatment is cut, then jobs and options for treatment providers are also diminished, making for a bleak outlook. Burnout and frustration in the workforce will also heighten; think—if our criminal justice and behavioral health systems were overwhelmed before budget cuts (as they have tended to be historically)—how are they professionals in the aftermath of divestment?

One struggle with lack of mental health treatment options is the waste of the little resources involved primarily due to the inefficiency of the system; many critiques of the system do not account for this. Professionals often know of "frequent flyers," or individuals who are well known for returning to facilities with recurrent symptomatology because their care is often incomplete. Their treatment is likened to a person with an open wound who is treated with a Band-Aid and an over-the-counter pain reliever instead of full ambulatory care (think stitches, antibiotics, and follow-up to ensure that an infection has not occurred). In other words, providing effective treatment for an individual suffering from mental illness costs a finite amount of resources, which depends on the type of treatment (inpatient, outpatient, etc.), medication, doctor visits, follow-ups, counseling services, and so on. Consider then, like any other illness, prolonging treatment by lack of options, resources, long wait times, or access to medication can often worsen the condition and time to achieve a healthy outcome—and cost volumes more in the long run. Further, the traumatizing experience of incarceration because one's symptoms cause legal problems can create additional negative mental health outcomes and may complicate treatment in the long run and cost even more money.

Incarcerating a person in need of treatment puts the financial burden onto the criminal justice system, thus creating a different problem. In this case, the criminal justice system now bears the burden of housing and treating a person with mental illness. Currently, the system is overcrowded and underfunded. Adding more people to the situation only furthers the burden while also complicating matters with their illness. Utah, like many other states, has seen an increase of deaths in jails, specifically to suicide. In one county alone, Weber County, there have been 31 deaths in the jail since 2000 and 14 of those were to suicide.

1.4 Rethinking Mental Health

Removing the stigma associated with mental illness and treating it as any other concern is one of the major needs of our society. However, more central to fundamental change are the interconnected linkages that need to be built throughout a

comprehensive system of care. This system must be able to communicate effectively across its entire footprint, including those tangibly involved or providing services but are not formally connected with the system.

What if mental illness was treated the way that cancer or diabetes is treated? If it was even viewed in a similar light, the outcomes could drastically be different. For example, with cancer, primary care physicians commonly are knowledgeable about how to refer patients out to specialists—at times, high-profile specialists at the Moffitt Center or MD Anderson—and ensure that patients' follow-up to be seamlessly handed off to their specialists for treatment. This treatment can involve imaging, labs, consultants with specialists, and so on. Each of these appointments can also be made seamlessly, often with reminders that occur automatically. What if we put this practice into commonplace mental health care?

1.4.1 A Continuum of Care

The continuum of care is a difficult but essential element of the process to ensure the health of an individual. The continuum of care refers to all of the steps and actions involved in the overall care cycle for a person—including all the key players at and between each point of contact and between the "system" and patient. For example, an individual exhibiting symptoms of depression may make an appointment with their primary care doctor. During their visit, the primary care doctor may refer the person to a psychiatrist. Upon seeing a psychiatrist, the individual may be prescribed an antidepressant medication and/or referred to a therapist to begin talk therapy. In an ideal situation, the psychiatrist and therapist would discuss that patient/client's treatment on a regular basis to ensure the wellness of the person continues throughout the span of their care.

In the criminal justice realm, there are many more professionals involved, which can often lead to many more options for problems or issues "falling through the cracks." The care and obstacles depend on many variables: is this person incarcerated in a jail or prison? If prison, is it state or federal? Has this person been treated before for mental illness or is their onset within jail/prison? (Fig. 1.9)

The term continuum of care, also known as organized delivery systems, has certainly become a "buzz" word in the health-care delivery industry. As it progressed to include first responders, law enforcement, courts, and jails, the continuum of care is a complex concept that focuses on a simple outcome—that no patient or client falls through the cracks of a complex care system. In other words, as a patient enters the health-care system, this person will be properly triaged and evaluated and referred to the best source(s) to handle the next steps in his or her care, and if further care is needed, follow-ups occur, further referrals are given, treatment is delivered, and this continues until the issue bringing this person into the system is resolved. Additional aftercare is delivered to ensure that success continues. With first responders, correctional officers, officers of the court, and more professionals being pulled into a broader continuum of care for many individuals, this has set the American

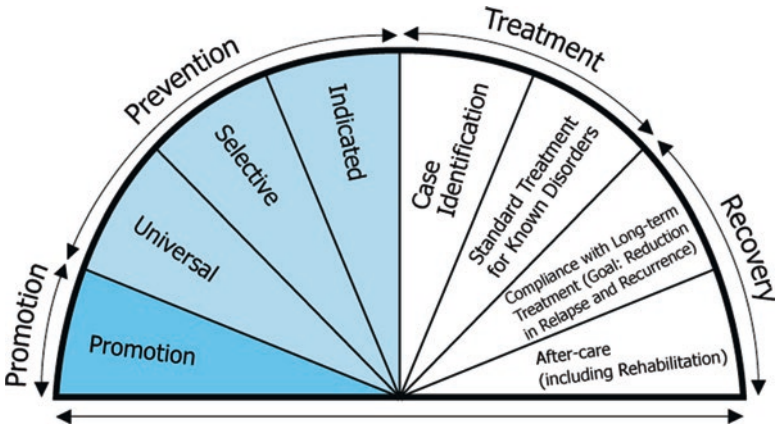

Fig. 1.9 The continuum of care protractor, courtesy of SAMHSA (2017a). Note that diagnosis occurs between prevention and treatment

mental health-care system on a new paradigm to reevaluate previous conceptualizations of continuums of care across the nation—this includes the criminal justice system as a starting point or referral point into health-care delivery systems.

1.5 Conclusion

With problems of awareness, in prevention, and with stigma, people will continue to suffer in their mental illness—particularly the vulnerable. Unfortunately, this can magnify the risk of contact by law enforcement and lead to the involvement in the criminal justice system. Further complicating the problem, mental health resources are scarce in most segments of the criminal justice system—whether it being federal or state prison, in local jails, or within community corrections. These institutions lack funding for programming and staff to fully attend to the needs of mental health inmates. Substance abuse often can further complicate mental health symptoms, creating an endless cycle of negative experiences for a vulnerable population.

This population was first brought into the public consciousness by Dorothea Dix. She brought compassion to a suffering class of people and sought to bring about the moral treatment of individuals with mental illness. While her efforts shifted people with mental illness from jails and prisons to state hospitals, most of these institutions ended up devolving into prisons themselves—with often "patient" treatment being worse than inmate life. This system continued until the abuses of the new system were brought to light by a new and powerful media. At the same time, psychiatric medicine (or psychopharmacology) experienced its most important breakthrough in the development of antipsychotic drugs. This enabled symptoms to be treated in what would be known as the least restrictive setting—often this means treatment in the community setting. From this moment through today, the ideal goal

for the majority of special interests and advocacy groups alike was to enhance American communities to build the capacity to address mental health by setting up full systems of care. Thus, a trend sets in to divest from state mental hospitals with hopes of setting up a comprehensive network of community mental health treatment services. After many decades of development, many gaps continued to exist to effectively treat many of those in need. At first, the most vulnerable have ended up homeless and, at times, in jail; and then, after the significant criminal justice policy shifts in the 1980s, an exponential increase of individuals with mental illness has occurred in jails and prisons. This has caused a notable strain on the criminal justice system, further complicating the overall system of care.

One solution is to develop a comprehensive continuum of care that involved both the public behavioral health and criminal justice systems. Professionals working to seek this change use data and evaluation methods to examine points in the system can be the most successful in intervening in mental health episodes or crises. This can be an encounter with a law enforcement officer, upon intake into a jail, at the emergency room, at a community clinic, and even can begin with a call to 911, crisis hotlines, or resource lines. This solution does not try to eliminate the criminal justice system as earlier advocates have pioneered; it includes it as one segment of many intervention points. In a perfect world, it would be the point of the last resort. In many circumstances, justice intervention can be a very salient one, however. As researchers and professionals acknowledge this, it can lead to stronger partnerships and better outcomes for the vulnerable.

Finances and investment will continue to be an impendent toward progress, especially in dire fiscal times. Both behavioral health and criminal justice services take higher priorities for lawmakers when they consider budget cuts. It is important to note that this trend is no longer absolute. With the 21st Century Cures Act, legislators have signaled an impetus for change. It dedicates resources, gives direction, and provides a template for progress. This progress may be incomplete without comprehensive criminal justice reform; however, *progress will still occur without it*, albeit at a slower pace and in fewer places across the country.

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