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Understanding Offenders with Serious Mental Illness in the Criminal Justice System

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UNDERSTANDING OFFENDERS WITH SERIOUS MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

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I. INTRODUCTION

Individuals with serious mental illnesses such as schizophrenia, bipolar disorder, and depression are overrepresented in the criminal justice system.[1] This overrepresentation has become a growing concern nationally among mental health workers, corrections departments, lawyers, public policy makers, and human rights advocates.[2] Although estimates vary widely, approximately 14 to 16% of people in the criminal justice system have a serious or persistent mental illness.[3] This translates to over one million people.[4]

The Los Angeles County jail system is one of the largest mental health treatment facilities in the country, treating over 3,000 inmates every day.[5] Though jails and prisons treat hundreds of thousands of inmates each year, they are not adequate treatment centers.[6] The purpose of these jails and prisons is to punish, not to control mental health symptoms, and they are not funded for that task.[7] Due to the lack of consistent mental health resources, minimal mental health treatment staff, and the stressful nature of a corrections setting, people with serious mental illness rarely receive

1. Seena Fazel & John Danesh, *Serious Mental Disorder in 23,000 Prisoners: A Systematic Review of 62 Surveys*, 359 LANCET 545, 548 (2002); Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVS. 761, 761 (2009); Linda Teplin, *The Prevalence of Severe Mental Disorder Among Urban Male Jail Detainees: Comparison with the Epidemiologic Catchment Area Program*, 80 AM. J. PUB. HEALTH 663, 665 (1990).

2. *See* Steadman et al., *supra* note 1, at 765.

3. *See, e.g.*, Fazel & Danesh *supra* note 1, at 543 (finding a 14% prevalence rate of serious mental illness among surveyed detainees); Steadman et al., *supra* note 1, at 764 (finding, of the detainees surveyed, a 15% prevalence rate of serious mental illness among males and 31% prevalence rate among females); Teplin, *supra* note 1, at 665–66 (estimating 9% lifetime prevalence of serious mental illness among surveyed detainees).

4. The Bureau of Justice Statistics reports the current adult correctional population in the United States is approximately 6.8 million people. DANIELLE KAEBLE, LAUREN GLAZE, ANASTASIOS TSOUTIS, & TODD MINTON, BUREAU OF JUSTICE STATISTICS, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 2014, at 1 (2016), http://www.bjs.gov/content/pub/pdf/cpus14.pdf.

5. James Swartz & Arthur Lurigio, *Serious Mental Illness and Arrest: The Generalized Mediating Effect of Substance Use*, 53 CRIME & DELINQ. 581, 582 (2007).

6. *Id.*

7. Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCHIATRY & L. 104, 105 (2010).

the treatment that they need in jail and prison.[8] Instead, they often end up getting punished for breaking the rules, which can result in longer prison stays and even solitary confinement.[9]

In addition to having trouble in prison, offenders with serious mental illness have a difficult time when they are released back into the community.[10] In fact, people with mental illness are significantly more likely to fail the terms of their probation and parole.[11] Studies have found that offenders with mental illness are around twice as likely to have their parole suspended than offenders without mental illness.[12] This results in a return to custody, often within a year,[13] further perpetuating the overrepresentation of individuals with mental illness behind bars.

This article examines why people with serious mental illness are overrepresented in jails and prisons, and what can be done to prevent criminal justice involvement among this high-risk population. In order to develop effective and efficient prevention and intervention strategies, it is critical to understand the role of mental health symptoms in causing and perpetuating criminal activity.

II. PUBLIC PERCEPTION OF OFFENDERS WITH MENTAL ILLNESS

Media accounts of violence often reinforce a link in the public's mind between serious mental illnesses and dangerousness.[14] Many people believe that the reason for the high prevalence rates of people with mental illness in prison is that

8. *See, e.g.*, Michael Winerip & Michael Schwartz, *Rikers: Where Mental Illness Meets Brutality in Jail*, N.Y. TIMES (July 14, 2014), http://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html?_r=1.

9. *See, e.g.*, Metzner & Fellner, *supra* note 7; Winerip & Schwartz, *supra* note 8.

10. Nina Messina et al., *One Year Return to Custody Rates Among Co-Disordered Offenders*, 22 BEHAV. SCI. & L. 503, 515 (2004); Frank J. Porporino & Laurence L. Motiuk, *The Prison Careers of Mentally Disordered Offenders*, 18 INT'L J.L. & PSYCHIATRY 29, 42 (1995).

11. *See generally* Messina et al., *supra* note 10 (finding higher rates of return to custody among mentally ill offenders).

12. *Id.*

13. *Id.*

14. Julie Turkewitz, *James Holmes Gets 12 Life Sentences in Aurora Shootings*, N.Y. TIMES (Aug. 26, 2015), http://www.nytimes.com/2015/08/27/us/james-holmes-gets-12-life-sentences-in-aurora-shootings.html?_r=0.

people with mental illness are violent.[15] This perception has been particularly perpetuated by the media coverage of mass shootings over the past decade. For example, Adam Lanza shot twenty children and six adults at Sandy Hook Elementary School in Newton, Connecticut before shooting and killing himself in 2012.[16] He had a diagnosis of an autism spectrum disorder.[17] Earlier that year, James Holmes walked into a packed movie theater in Aurora, Colorado and killed twelve people and injured an additional seventy.[18] The coverage of his murder trial, in which he pled not guilty by reason of insanity, focused on his mental health.[19] In 2011 in Tucson, Arizona, Jared Loughner killed six people and wounded twelve others, including U.S. Representative Gabrielle Giffords.[20] Much of the media coverage focused on Loughner's mental health history and the extent to which the murders could be attributed to psychosis.[21] A few years earlier, Seung-Hui Cho shot and killed thirty-three people at Virginia Tech University in Blacksburg, Virginia, before shooting and killing himself.[22] His history of psychosis prompted such headlines as, "Help the Ill Before They Kill."[23]

When people with serious mental illness make headlines for violence, it is often for irrational and unpredictable acts of mass

15. *See, e.g.*, Bruce Link et al., *Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance*, 89 AM. J. PUB. HEALTH 1328 *passim* (Sept. 1999).

16. Marc Santora, *Sandy Hook Gunman's Father Says He Wishes His Son Had Never Been Born*, N.Y. TIMES (Mar. 10, 2014), http://www.nytimes.com/2014/03/11/nyregion/adam-lanzas-father-in-first-public-comments-says-you-cant-get-any-more-evil.html.

17. *Id.*

18. Turkewitz, *supra* note 14.

19. Maria L. La Ganga, *James Holmes Painted as a Cunning Killer, or a Victim of Schizophrenia*, L.A. TIMES (Apr. 27, 2015, 6:32 PM), http://www.latimes.com/nation/la-na-james-holmes-trial-20150427-story.html.

20. Michael Muskal, *Jared Laughner Sentenced to Life in Tuscon Mass Shooting*, L.A. TIMES (Nov. 8, 2012), http://articles.latimes.com/2012/nov/08/nation/la-na-nn-jared-loughner-life-in-prison-20121108.

21. PETER LANGMAN, WHY KIDS KILL: INSIDE THE MINDS OF SCHOOL SHOOTERS 5 (2009).

22. Christine Hauser & Anahad O'Connor, *Virginia Tech Shooting Leaves 33 Dead*, N.Y. TIMES (Apr. 16, 2007), http://www.nytimes.com/2007/04/16/us/16cnd-shooting.html?pagewanted=all.

23. E. Fuller Torrey, *Help the Ill Before They Kill*, N.Y. POST (Apr. 23, 2007, 9:00 AM), http://nypost.com/2007/04/23/help-the-ill-before-they-kill/.

violence that spark public fear.[24] This is why the belief that mental illness causes unpredictable violence is pervasive.[25] However, these acts of extreme violence account for a very small percentage of the criminal activity carried out by people with serious mental illness.[26] It is important to note that most people with mental illness are not violent.[27] In fact, large-scale studies have found that people with mental illness are actually *less* likely to be violent than similar individuals without mental illness.[28] For people with mental illness who do engage in criminal activity, many of their crimes are "survival crimes" (e.g., urinating in public), or reactive crimes (e.g., responding to aggression).[29]

III. THE INSANITY DEFENSE

When media-hyped crimes committed by offenders with mental illness go to trial, sometimes there is consideration of an insanity defense.[30] The insanity defense has existed since the 1500s.[31] It was designed to limit criminal culpability for those who were too mentally ill at the time of their crime to be considered guilty of the crime.[32] Despite the attention that the insanity defense receives in the media, it is used in less than 1% of cases, and it is only a successful defense in 25% of those cases.[33] The limited use of

24. Emma E. McGinty et al., *Effects of News Media Messages About Mass Shootings on Attitudes Toward Persons with Serious Mental Illness and Public Support for Gun Control Policies*, 170 AM. J. PSYCHIATRY 494, 495 (2013).

25. Fred E. Markowitz, *Mental Illness, Crime, and Violence: Risk, Context, and Social Control*, 16 AGGRESSION & VIOLENT BEHAV. 36, 38–39 (2010).

26. Jillian Peterson et al., *Analyzing Offense Patterns as a Function of Mental Illness to Test the Criminalization Hypothesis*, 61 PSYCHIATRIC SERVS. 1217, 1219 (2010) [hereinafter *Offense Patterns*].

27. JOHN MONAHAN ET AL., RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL ILLNESS AND VIOLENCE 4–5 (2001).

28. *See id.*

29. *Offense Patterns*, *supra* note 26, at 1217–19.

30. *See, e.g.*, Julie Turkewitz, *Aurora Gunman Legally Insane, Psychiatrist Says*, N.Y. TIMES (July 8, 2015), http://www.nytimes.com/2015/07/09/us/aurora-gunman-james-holmes-legally-insane-psychiatrist-says.html.

31. NIGEL WALKER, CRIME AND INSANITY IN ENGLAND 16–17, 25–26 (1968) (indicating that some claim the defense to date back to 1200s and 1300s, however the cases are distinguishable from the insanity defense).

32. Richard J. Bonnie, *The Moral Basis of the Insanity Defense*, 69 A.B.A. J. 194, 194 (1983).

33. Patricia A. Zapf et al., *Insanity in the Courtroom: Issues of Criminal Responsibility and Competency to Stand Trial*, *in* 2 PSYCHOLOGICAL EXPERTISE IN COURT

the insanity defense is partially due to public opinion.[34] One study found that 66% of people do not think the insanity defense should "be allowed as a complete criminal defense."[35] Additionally, its minimal use may be due to the fact that, if an individual is found not guilty by reason of insanity, he or she will likely spend a longer time incarcerated (in a hospital) than a person who is convicted of similar offenses.[36]

In addition to being rarely used, the concept of insanity is difficult to define.[37] The definition has varied widely over time, and even varies from state to state.[38] For example, the "wild beast test" only considered a defendant to be insane if the defendant did not have his or her reason and senses at the time of the offense.[39] The *M'Naghten* Rule, currently used by twenty-five states, defines insanity as a "mental disease which prevents him from knowing the nature or quality of his act, or that it was wrong."[40] The American Law Institute's (ALI) definition is broader and utilized in twenty-one states. The ALI states that "[a] person is not responsible for criminal conduct if at the time of such conduct as a result of

79, 84 (Daniel A. Krauss & Joel D. Lieberman eds., 2009) [hereinafter *Insanity in the Courtroom*].

34. Patricia A. Zapf et al., *Criminal Responsibility and the Insanity Defense*, *in* 3 HANDBOOK FORENSIC PSYCHOL. 332, 355 (Irving B. Weiner & Allen K. Hess eds., 2006).

35. *Id.*

36. *See* Tarika Daftary-Kapur et al., *Jury Decision-Making Biases and Methods to Counter Them*, 15 LEGAL & CRIMINOLOGICAL PSYCHOL. 133 (2010).

37. *See, e.g.*, *Insanity in the Courtroom*, *supra* note 33, at 80–82.

38. *Id.* at 82.

39. *See* Rex v. Arnold, 16 How. St. Tr. 695, 764 (1724); *see also* Norman J. Finkel, *The Insanity Defense Reform Act of 1984: Much Ado About Nothing*, 7 BEHAV. SCI. & L. 403, 408 (1989); *Implementation and Clarification of the Durham Criterion of Criminal Irresponsibility*, 58 COLUM. L. REV. 1253, 1253 (1958) (explaining that, under the "wild beast test," courts were restrained "from imposing punishment if the accused, at the time of the commission of the act, were totally deprived of understanding and could no more know what he was doing than an infant, a brute, or a wild beast").

40. *See, e.g.*, Reese v. Wainwright, 600 F.2d 1085, 1090 (5th Cir. 1979) ("[T]o be legally insane [under the *M'Naghten* Rule] the defendant must have been unable to understand the nature of his act or its consequences, or incapable of distinguishing right from wrong."). The *M'Naghten* Rule maintains that a defendant should not be held accountable for her actions only if she did not: (1) know that her actions would be wrong or (2) understand the nature and quality of her actions. 18 U.S.C. § 17 (2014); *see, e.g.*, *Wainwright*, 600 F.2d at 1090; *see also* ARIZ. REV. STAT. ANN. § 13-502 (West, Westlaw through 2015).

mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of the law."[41] The *Durham v. United States* ruling in 1954 broadened the definition of insanity most of all, including crimes that are the "product of mental disease or mental defect."[42] The *Durham* definition is currently only used in New Hampshire.[43] Four states do not have the insanity defense.[44]

With these varying definitions, it is no wonder why the insanity defense is so widely misunderstood and rarely utilized. Criminal law exists to deal with people who commit acts that are wrong. Criminal law is based on culpability and assumes that people know the law and choose to disregard it.[45] However, this purpose becomes muddled when mental illness enters the picture. The insanity defense requires judges and juries to evaluate the degree to which a crime was committed by a direct result of symptoms of mental illness.[46] This question is important generally when examining the overrepresentation of people with serious mental illness in the criminal justice system—to what degree is their mental illness responsible for their criminal behavior?

41. MODEL PENAL CODE § 4.01 (AM. LAW INST. 2014); *see* Bradford H. Charles, *Pennsylvania's Definition of Insanity and Mental Illness: A Distinction with A Difference?*, 12 TEMP. POL. & CIV. RTS. L. REV. 265, 266 (2003).

42. Durham v. United States, 214 F.2d 862, 874–75 (D.C. Cir. 1954), *abrogated by* United States v. Brawner, 471 F.2d 696 (D.C. Cir. 1972). The *Durham* court went on to clarify the new rule, stating that "disease" means "a condition which is considered capable of either improving or deteriorating" and "defect" means "a condition which is not considered capable of either improving or deteriorating and which may be either congenital, or the result of injury, or the residual effect of a physical or mental disease." *Id.* at 875.

43. Thomson Reuters, *The Insanity Defense Among the States*, FINDLAW, http://criminal.findlaw.com/criminal-procedure/the-insanity-defense-among-the-states.html (last visited Mar. 13, 2016).

44. Those states are Idaho, Kansas, Montana, and Utah. *Id.*

45. *See* United States v. Barker, 514 F.2d 208, 229 (D.C. Cir. 1975) (Bazelon, C.J., concurring) ("The law in its most demanding view of criminal responsibility establishes that if an individual specifically intends to commit an act and if that act is proscribed by law, therefore the individual freely chose to do wrong.").

46. Caton F. Roberts et al., *Implicit Theories of Criminal Responsibility: Decision Making and the Insanity Defense*, 11 L. & HUM. BEHAV. 207, 225 (1987).

IV. REASONS FOR THE OVERREPRESENTATION OF MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

A. Defining Mental Illness

To understand why people with serious mental illness are overrepresented in the criminal justice system, it is critical to examine how often symptoms of mental illness directly cause crime.[47] People with mental illness can commit crimes as a direct response to their symptoms, such as attacking a stranger due to one's paranoid delusions.[48] Or people with mental illness can commit crimes unrelated to their symptoms, such as burglarizing a house when one is not experiencing any symptoms.[49] The first step to understanding this high risk population is to define which mental illnesses are usually tracked in the criminal justice system and which symptoms of those illnesses can lead to crime.

The definition of serious mental illness varies between states, but the list often includes schizophrenia (and schizophrenia spectrum disorders such as schizophreniform or schizoaffective disorders), bipolar disorder, and major depression.[50] Many other mental illnesses are not considered in measuring and defining serious mental illness in the criminal justice system; for example, many anxiety disorders, autism spectrum disorders, fetal alcohol syndrome, and most personality disorders.[51]

The primary focus of treatment and research has been on the role of schizophrenia in causing crime and violence.[52] Psychosis can

47. *See generally* Jillian K. Peterson et al., *How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior Among Offenders with Mental Illness?*, 38 L. & HUM. BEHAV. 439 (2014) [hereinafter *Criminal Behavior*] (synthesizing and discussing data examining the purported direct correlation between symptoms of mental illness and subsequent criminal behavior).

48. *See id.* at 443.

49. *See id.*

50. *Id.* at 440 (indicating some jurisdictions also include Post-Traumatic Stress Disorder and Borderline Personality Disorder (i.e., the Hennepin County Mental Health Court)).

51. Arthur J. Lurigio & James A. Swartz, *Changing the Contours of the Criminal Justice System to Meet the Needs of Persons with Serious Mental Illness*, *in* CRIMINAL JUSTICE 2000: POLICIES, PROCESSES, AND DECISIONS OF THE CRIMINAL JUSTICE SYSTEM 45, 48 (2000).

52. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 99–105 (5th ed. 2013).

directly lead to violence.[53] In particular, command hallucinations are visual or auditory hallucinations that give specific orders.[54] Individuals may act on these hallucinations and inflict violence as a result.[55] Delusions that involve being persecuted (i.e., followed or watched) can also result in violence if individuals act on these delusional belief systems aggressively.[56] A review of nearly 9000 insanity pleas from the early 1980s found that defendants were diagnosed with schizophrenia 43% of the time.[57] Among the cases where the insanity defense was successful, 67.9% of defendants were diagnosed with schizophrenia.[58]

However, it is possible for other mental illnesses to cause crime as well. Some scholars have argued that depression can cause criminal activity when an individual enters a "depressive rage," (i.e., intense anger during a depressive episode).[59] Suicidality and hopelessness could also conceivably lead to crime if an individual has limited concern about the consequences of their behavior and what happens to them in the future.[60] Similarly, Post-Traumatic Stress Disorder (PTSD) can lead to crime due to the symptom of hyper-arousal (elevated threat response), which can cause aggression.[61] Bipolar disorder can also directly cause crime because impulsivity is a key symptom of mania.[62] Impulsivity, which is a

53. *See* Dale E. McNiel et al., *The Relationship Between Command Hallucinations and Violence*, 51 PSYCHIATRIC SERVS. 1288, 1288 (2000) ("Clinical experience suggests that some patients who have hallucinations commanding them to engage in violent behavior do engage in such behavior.").

54. *See id.* at 1290.

55. *See id.* ("Twenty-three patients (22.3 percent) said they had complied with voices telling them to hurt other people—five said they had complied often, nine sometimes, and nine almost never.").

56. *See* Peter Cheung et al., *Violence in Schizophrenia: Role of Hallucinations and Delusions*, 26 SCHIZOPHRENIA RES. 181, 187–88 (1997).

57. Lisa A. Callahan et al., *The Volume and Characteristics of Insanity Defense Pleas: An Eight-State Study*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 331, 336 tbl.2 (1991).

58. *See id.*

59. *See* Andrew Carroll & Andrew Forrester, *Depressive Rage and Criminal Responsibility*, 12 PSYCHIATRY PSYCHOL. & L. 36, 38 (2005).

60. *See* John Crichton, *Mental Disorder and Crime: Coincidence, Correlation and Cause*, 10 J. FORENSIC PSYCHIATRY 659, 660–61 (1999).

61. *See* Emma L. Barrett et al., *Associations Between Substance Use, Post-Traumatic Stress Disorder and the Perpetration of Violence: A Longitudinal Investigation*, 39 ADDICTIVE BEHAV. 1075, 1078–79 (2014).

62. AM. PSYCHIATRIC ASS'N, *supra* note 52, at 124.

known risk factor for criminal involvement,[63] is much higher among people with bipolar disorder than the general public.[64]

B. Mental Illness Directly Causes Crime

Although symptoms of schizophrenia, depression, PTSD, and bipolar disorder can directly cause criminal behavior, it is also possible for someone to have these diagnoses and commit crimes for other reasons. In order to understand the role of mental health symptoms in causing crime, whether or not symptoms were present at the time a crime was committed needs to be assessed first.[65] Additionally, the degree to which these symptoms truly motivated the crime needs to be understood (i.e., was the individual responding to a hallucination or delusion when the crime was committed?). Understanding the role of symptoms can be accomplished by interviewing offenders directly, interviewing police officers or witnesses, or by reviewing arrest records.[66] A handful of psychological researchers have attempted to study the degree to which offenders are motivated by their mental illness, using a variety of techniques and populations. For example, a group of scholars studied 113 people with serious mental illness who were arrested and sent to a program that sends individuals with mental illness to treatment rather than jail.[67] Participants were interviewed about their recent offense to examine the influence of psychosis and other symptoms at the time the crime was committed.[68] Only 4% of participants reported that symptoms directly caused their crime, and 4% indicated that their symptoms indirectly caused their offense.[69]

Another study of 112 parolees with serious mental illness (compared with 109 parolees without mental illness) found similar

63. *See* Robert Krueger et al., *Linking Antisocial Behavior, Substance Use, and Personality: An Integrative Quantitative Model of the Adult Externalizing Spectrum*, 116 J. ABNORMAL PSYCHOL. 645, 646–47, 654 (2007).

64. *See* Esther Jiménez et al., *Impulsivity and Functional Impairment in Bipolar Disorder*, 136 J. AFFECTIVE DISORDERS 491, 492 (2012).

65. *See Criminal Behavior*, *supra* note 47, at 440.

66. *See id.* at 442–43.

67. John Junginger et al., *Effects of Serious Mental Illness and Substance Use on Criminal Offense*, 57 PSYCHIATRIC SERVS. 879, 880 (2006).

68. *See id.*

69. *See id.* at 881.

results.[70] Using interviews and records, participants were put into one of the following categories: psychotic symptom-based, poverty/survival-based, impulsive/reactive pattern, emotionally stable/instrumental pattern, and gang or drug-based.[71] Only 5% of participants commit crimes as a direct result of symptoms (i.e., the psychotic group).[72] The most common category was emotionally reactive, for both offenders with and without mental illness.[73] Toch and Adams also created a typology for offenders with mental illness after interviewing 495 offenders in New York.[74] The category of offenders responding directly to symptoms (i.e., acute disturbed exploders) held 10.3% of offenders.[75]

A more recent analysis of 1000 psychiatric patients with repeated incidents of violence over a year (part of the MacArthur Violence Study) showed that psychosis preceded violence for 12% of violent incidents.[76] Finally, a study involving in-depth interviews with 143 probationers about their criminal activity throughout their lifespan found that only 7% of crimes were directly motivated by symptoms of mental illness, with an additional 11% that were "mostly" directly related to symptoms.[77]

These various studies utilize different methodologies, definitions, and populations of offenders. However, they are all consistent in finding that symptoms of mental illness only cause crime in a small minority of cases—between 4% and 12% of cases.[78] This means that 88% to 96% of the time, crimes committed by people with serious mental illness are unrelated to their mental health symptoms.[79] Some researchers have wondered if there is a

70. *Offense Patterns*, *supra* note 26, at 1219–20.

71. *Id.* at 1218.

72. *Id.* at 1221.

73. *Id.*

74. HANS TOCH & KENNETH ADAMS, THE DISTURBED VIOLENT OFFENDER 81, 82 tbl.4.1 (1989).

75. *See id.*

76. Jennifer Skeem et al., *Psychosis Uncommonly and Inconsistently Precedes Violence Among High Risk Individuals*, ASS'N PSYCHOL. SCI. 1, 1, 7 (2015) [hereinafter *Psychosis*].

77. *See Criminal Behavior*, *supra* note 47, at 444.

78. *See* TOCH & ADAMS, *supra* note 74, at 82 tbl.4.1; Junginger et al., *supra* note 67, at 879–82; *Criminal Behavior*, *supra* note 47, at 446–47; *Offense Patterns*, *supra* note 26, at 1217–22; *Psychosis*, *supra* note 76, at 7.

79. *Psychosis*, *supra* note 76, at 7; *see, e.g.*, *Criminal Behavior*, *supra* note 47, at 446.

small group of people who commit crimes consistently related to their symptoms and for whom psychiatric care would prevent their criminal involvement; and another, larger group for whom mental health care would have little impact on criminal activity.[80]

The question was explored directly in the above-referenced study of 143 probationers with mental illness.[81] Criminal activity throughout the lifespan was examined to understand whether symptoms influenced criminal activity consistently over time.[82] The results demonstrated that two thirds of offenders who committed a crime directly motivated by symptoms later committed an additional crime that was unrelated to their symptoms, demonstrating inconsistency over time.[83] Psychiatric patients in the MacArthur violence study were "fairly" consistent in whether or not they committed violence that was immediately preceded by psychotic symptoms over a one-year period.[84]

C. The Criminalization Hypothesis

Although the public assumes that serious mental illness causes violence, empirical studies have consistently found that people with mental illness rarely and inconsistently commit crimes as a direct result of their symptoms.[85] Why, then, are people with serious mental illness so overrepresented in the criminal justice system? One possible explanation is the "criminalization" of mental illness.[86] According to the criminalization hypothesis, people with serious mental illness become involved in the criminal justice system because they do not have access to the mental health care that they need.[87]

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80. *See* Jennifer L. Skeem et al., *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism*, 35 L. & HUM. BEHAV. 110, 121 (2011).

81. *Criminal Behavior*, *supra* note 47, at 440–47.

82. *Id.* at 441.

83. *Id.* at 446.

84. *Psychosis*, *supra* note 76, at 6.

85. *See* TOCH & ADAMS, *supra* note 74, at 55–57; Junginger et al., *supra* note 67, at 882; *Criminal Behavior*, *supra* note 47, at 445–46; *Offense Patterns*, *supra* note 26, at 1221–22; *Psychosis*, *supra* note 76, at 8.

86. Marc F. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 HOSP. & COMMUNITY PSYCHIATRY 101, 103–04 (1972).

87. *Id.* at 104.

The criminalization of mental illness is largely blamed on the deinstitutionalization of mental health hospitals in the 1960s and 1970s.[88] Deinstitutionalization resulted after the invention of psychiatric medications, after several legal cases gave people with mental illness more rights,[89] and after new legislation passed that was designed to create community mental health centers.[90] Consequently, psychiatric hospital stays dropped from an average of 421 days to 189 days during this period of deinstitutionalization, and many institutions eventually closed.[91]

Although people were spending less time in the hospital during this period of time, they could not access the care that they needed in their community.[92] According to the criminalization hypothesis, instead of staying in hospitals, people with serious mental illness ended up in jails and prisons.[93] Jail booking for minor crimes can be used by police officers as a way to secure treatment for people that need it.[94] Therefore, the criminalization hypothesis asserts that people with serious mental illness are arrested for minor crimes and funneled through the criminal justice system as a way to access psychiatric care.[95]

However, there is little empirical evidence showing that the criminalization hypothesis adequately explains the overrepresentation of people with mental illness in jails and prisons. One study of psychiatric hospitals and prisons between 1969 and 1978 did not find that the prevalence of mental illness in prisons increased during this time frame.[96] In fact, in three states

88. *Id.*; *see also* Charles A. Kiesler et al., *Federal Mental Health Policymaking: An Assessment of Deinstitutionalization*, 38 AM. PSYCHOL. 1292, 1293 (1983).

89. *See* Addington v. Texas, 441 U.S. 418, 426 (1979); O'Connor v. Donaldson, 422 U.S. 563, 575 (1975); Lessard v. Schmidt, 421 U.S. 957, 957 (1975).

90. Abramson, *supra* note 86, at 105.

91. Charles Kiesler, *Public and Professional Myths About Mental Hospitalization: An Empirical Reassessment of Policy Related Beliefs,* 37 AM. PSYCHOL. 1323, 1331 (1982).

92. *See* Abramson, *supra* note 86, at 104.

93. Edwin F. Torrey, Editorial, *Jails and Prisons: America's New Mental Hospitals*, 85 AM. J. PUB. HEALTH 1611, 1612 (1995).

94. William C. Torrey et al., *The Challenge of Implementing and Sustaining Integrated Dual Disorders Treatment Programs*, 38 COMMUNITY MENTAL HEALTH J. 507, 516–17 (2002); *see also* H. Richard Lamb & Linda E. Weinberger, *Severely Mentally Ill Persons in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVS. 483, 484 (1998).

95. Torrey, *supra* note 93, at 1612.

96. Henry J. Steadman et al., *The Impact of State Mental Health Hospital Deinstitutionalization on United States Prison Populations, 1968–1978*, 75 J. CRIM. L. &

there was more mental illness in prisons in 1969 than in 1978, calling into question the criminalization hypothesis during this period of deinstitutionalization.[97] So although a lack of mental health resources and treatment options in the community may be a partial explanation of the overrepresentation of mental illness in the justice system, it is not the complete story.[98]

D. Difficulty Navigating the Criminal Justice System

In addition to the direct cause model and the criminalization hypothesis, another explanation for overrepresentation is that once offenders with mental illness enter the criminal justice system, they have a harder time navigating their way through it.[99] For example, offenders with serious mental illness are likely to be poor, meaning they cannot afford to hire their own attorney.[100] People with serious mental illness may have trouble understanding police interrogations and may even be more likely to make false confessions.[101] They may have more difficulty assisting their attorney in their own defense or fully understanding court procedures or plea deals.[102]

Once people with mental illness enter the prison system, they often have a harder time navigating the prison environment than their non-mentally ill counterparts, making it difficult to access

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CRIMINOLOGY 474, 487 (1984).

97. *Id.* at 485.

98. *See generally* HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS (2003), http://www.hrw.org/reports/2003/usa1003/usa1003.pdf (discussing the challenges and failures of providing mental health services in prisons).

99. *See* William H. Fisher et al., *Beyond Criminalization: Toward a Criminologically Informed Framework for Mental Healthy Policy and Services Research*, 33 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RES. 544, 546 (2006).

100. *See id.* at 553–54.

101. *See* Allison D. Redlich, *Law & Psychiatry: Mental Illness, Police Interrogations, and the Potential for False Confessions*, 55 PSYCHIATRIC SERVS. 19, 19–20 (2004).

102. *See* Andrew D. Reisner et al., *Competency to Stand Trial and Defendants Who Lack Insight into Their Mental Illness*, 41 J. AM. ACAD. PSYCHIATRY & L. 85, 86–87 (2013). *See generally* Victoria Harris & Christos Dagadakis, *Length of Incarceration: Was There Parity for Mentally Ill Offenders?*, 27 INT'L J.L. & PSYCHIATRY 387, 391–92 (2004) (discussing evidence of longer sentences for mentally ill offenders than for non-mentally ill offenders); Amy Watson et al., *Mental Health Courts and the Complex Issue of Mentally Ill Offenders*, 52 PSYCHIATRIC SERVS. 477, 478 (2001) (indicating that there is also some evidence that mentally ill offenders are typically sentenced to longer prison terms than non-mentally ill offenders).

needed treatment and resources.[103] Stress exacerbates mental health symptoms, and the stress of being in prison is certainly no exception.[104] A study of over 16,000 federal and state inmates found that offenders experiencing psychosis and major depression were more likely to receive infractions involving aggression while incarcerated.[105] In general, they were more likely to break the rules and less likely to receive early parole for good behavior, which resulted in longer sentences.[106] Elaine Lord posits that women with mental illness have a particularly difficult time in prison.[107] Female offenders with mental illness are more likely to break the rules, more likely to act aggressively, and more likely to end up in segregation.[108] Estimates of mental health diagnoses for women in prison vary widely, but some studies have found prevalence rates as high as 75%.[109]

Additionally, offenders with mental illness have a particularly difficult time when they leave prison and are twice as likely to fail their terms of probation and parole.[110] There are a number of reasons why supervision failure can occur, including committing a new offense or a technical violation (e.g., not showing up for a parole appointment or not consistently taking one's medication).[111] Qualitative interviews were conducted with forty-three offenders with mental illness and twenty-five treatment providers to examine the difficulties of transitioning back into the community after prison.[112] When returning to the community, offenders highlighted the difficulty of finding stable housing, often resulting in a return

103. *See* Leah Gogel Pope et al., *Transitioning Between Systems of Care: Missed Opportunities for Engaging Adults with Serious Mental Illness and Criminal Justice Involvement*, 31 BEHAV. SCI. & L. 444, 450 (2013).

104. *Id.* at 449.

105. Richard B. Felson et al., *Mental Disorder and Offending in Prison*, 39 CRIM. JUST. & BEHAV. 125, 131–37, 140 (2012).

106. *Id.*

107. Elaine A. Lord, *The Challenges of Mentally Ill Female Offenders in Prison*, 35 CRIM. JUST. & BEHAV. 928, 928–31 (2008).

108. *Id.* at 932–35.

109. *E.g.*, DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT: MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 4 (2006), http://www.bjs.gov/content/pub/pdf/mhppji.pdf.

110. *See* Jennifer L. Skeem & Jennifer Eno Louden, *Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment*, 57 PSYCHIATRIC SERVS. 333, 333 (2006).

111. *Id.* at 334–36.

112. Pope et al., *supra* note 103, at 446–47.

to substance use and failure to attend treatment.[113] Treatment providers often stressed the difficulties in coordinating mental health and criminal justice services since the two systems rarely overlap.[114] Case managers have been found to return people with serious mental illness to custody after a technical violation as a means of securing mental health treatment for them.[115]

E. Offenders with Mental Illness Are Similar to Other Offenders

Another theory that has gained support in recent years is based on the idea that offenders with mental illness are not very different from offenders without mental illness when it comes to criminal risk factors.[116] For example, offenders with mental illness are likely to come from poor neighborhoods and have negative life experiences in their background.[117] These factors place individuals at a higher risk for use of violence, regardless of the fact that they have a mental illness.[118]

In general, the most salient risk factors for criminal behavior, often referred to as the "central eight" include the following: (1) a history of antisocial behavior, (2) antisocial personality pattern, (3) antisocial cognition, (4) antisocial associates, (5) troubled family and marital relationships, (6) problems with school and/or work, (7) leisure and/or recreation problems, and (8) substance abuse.[119] In a recent analysis of over two hundred parolees, researchers used the Level of Service Inventory/Case Management Inventory to determine that offenders with a mental illness demonstrated

113. *Id.* at 451.

114. *Id.* at 451–52.

115. *See* Jeffrey Draine & Phyllis Solomon, *Jail Recidivism in a Forensic Case Management Program*, 20 HEALTH & SOC. WORK 167, 170 (1995).

116. *See* Skeem et al., *supra* note 80, at 117; *see also Offense Patterns*, *supra* note 26, at 1218.

117. *See* Eric Silver, *Understanding the Relationship Between Mental Disorder and Violence: The Need for a Criminological Perspective*, 30 L. & HUM. BEHAV. 685, 691–92 (2006).

118. *See id.* at 691 ("[T]heir likelihood of associating with individuals whose beliefs support the use of violence as a means of conflict resolution is heightened."); *id.* at 692, ("Of the many different types of criminal behavior that have been studied over the past decade, stressful life events and the negative emotions associated with them have shown their strongest effects on the occurrence of interpersonal violence.").

119. D.A. Andrews et al., *The Recent Past and Near Future of Risk and/or Need Assessment*, 52 CRIME & DELINQ. 7, 11 tbl.1 (2006).

significantly more of these central eight general risk factors than similar offenders who did not have a mental illness.[120]

One strong predictor of criminal activity is antisocial cognition, also referred to as criminogenic beliefs, which describes moral reasoning and thinking patterns that "rationalize and perpetuate criminal activity."[121] A recent study compared criminal thinking among ninety-four people with serious mental illness in prison with ninety-four people with serious mental illness in a psychiatric hospital.[122] People without past criminal justice involvement had lower levels of criminal thinking than people with a history of criminal justice involvement (whether in prison or the hospital).[123] Another recent study found that offenders with mental illness demonstrated high levels of criminal thinking, similar to offenders without mental illness.[124]

General risk factors have been found to predict criminal activity even among individuals with serious mental illness found not guilty by reason of insanity.[125] Nearly six hundred people found not guilty by reason of insanity were examined in a study that lasted for at least five years after their release from the psychiatric hospital.[126] Approximately 30% of people had their conditional

120. *See* Jennifer L. Skeem et al., *Offenders with Mental Illness Have Criminogenic Needs Too: Toward Recidivism Reduction*, 38 L. & HUM. BEHAV. 212, 220–21 (2014); *see also* MHS PUB. SAFETY, LEVEL OF SERVICE/CASE MANAGEMENT INVENTORY: AN OFFENDER ASSESSMENT SYSTEM (2004); Andrews et al., *supra* note 119, at 14 ("[T]he major predictors of violence . . . were not mental health variables but the risk factors already well established in general corrections and the psychology of criminal conduct.").

121. *See* June Price Tangney et al., *Working at the Social-Clinical-Community-Criminology Interface: The George Mason University Inmate Study*, 26 J. SOC. & CLINICAL PSYCHOL. 1, 5 (2007).

122. Nicole R. Gross & Robert D. Morgan, *Understanding Persons with Mental Illness Who Are and Are Not Criminal Justice Involved: A Comparison of Criminal Thinking and Psychiatric Symptoms*, 37 L. & HUM. BEHAV. 175, 177 (2013).

123. *Id.* at 182.

124. Robert D. Morgan et al., *Prevalence of Criminal Thinking Among State Prison Inmates with Serious Mental Illness*, 34 L. & HUM. BEHAV. 324, 332 (2010) ("[T]he results of this study indicated that mentally ill inmates presented with . . . criminal thinking comparable to non-mentally ill inmates.").

125. *See* Lisa A. Callahan & Eric Silver, *Revocation of Conditional Release: A Comparison of Individual and Program Characteristics Across Four U.S. States*, 21 INT'L J.L. & PSYCHIATRY 177, 184 (1998) (discussing how the revocation of conditional release from civil commitment "is influenced by . . . individual-level characteristics" such as employment and marriage).

126. *Id.* at 180.

release revoked during the study period.[127] The factors that predicted recidivism were substance abuse and unemployment (similar to offenders without mental illness), not mental health symptoms.[128] In another study that reviewed records of 125 people found not guilty by reason of insanity, researchers found that substance abuse diagnosis and prior criminal history predicted recidivism, rather than any mental health factors.[129]

F. Mental Illness Indirectly Causes Crime

Although offenders with mental illness have many of the same risk factors for criminal activity as offenders without mental illness, it does not mean that mental illness had nothing to do with the pathway to crime.[130] Mental illness exerts an influence over one's life, which may indirectly contribute to criminal activity.[131] Mental illness causes certain risk factors for criminal activity, which in turn causes criminal behavior.[132] Psychosis typically develops during late adolescence and early adulthood.[133] This is the period of time when young people are forming their identity, starting college and careers, and exploring relationships.[134] As one's symptoms progress, risk factors such as unemployment, relationship problems, and negative peer groups develop, which can then lead to criminal activity.[135]

G. Poverty

One possible indirect pathway from symptoms to crime is poverty. Some scholars argue that "persons with mental illness sometimes engage in offending and other forms of deviant

127. *Id.* at 181.

128. *Id.* at 185.

129. Candice M. Monson et al., *Stopping (or Slowing) the Revolving Door: Factors Related to NGRI Acquittees' Maintenance of a Conditional Release*, 25 L. & HUM. BEHAV. 257, 259, 264 (2001).

130. *Id.* at 264–65.

131. Skeem et al., *supra* note 80, at 117–18.

132. *Id.*

133. Kevin D. Tessner et al., *Longitudinal Study of Stressful Life Events and Daily Stressors Among Adolescents at High Risk for Psychotic Disorders*, 37 SCHIZOPHRENIA BULL. 432, 433 (2011).

134. Skeem et al., *supra* note 80, at 116.

135. *See id.*; *see also* Elaine F. Walker & Donald Diforio, *Schizophrenia: A Neutral Diathesis-Stress Model*, 104 PSYCHOL. REV. 667, 668 (1997).

behavior not because they have a mental disorder but because they are poor."[136] Serious mental illness makes it harder to finish one's education or establish and maintain a job.[137] Untreated mental illness also strains relationships with friends and family, which can result in fewer financial resources.[138] With fewer resources and options, poverty can lead to criminal activity.[139] In this model, mental illness leads to poverty, which leads to criminal activity.[140] While symptoms may not directly cause crime, they create the conditions in which criminal activity is more likely to occur.[141]

H. Social Support

An additional possible pathway to criminal behavior is a lack of social bonds.[142] Strong social bonds protect one against criminal behavior.[143] Lack of social support is also a contributing factor to violence and criminal activity, particularly among people with mental illness.[144] When serious mental illness takes hold, it can result in the alienation of friends and family who may not understand or detect untreated symptoms.[145] A lack of social support means fewer resources to cope with stress, fewer resources to aid in finding employment or housing, and fewer community ties that protect against criminal activity such as church or community groups.[146] In this way, symptoms of mental illness can lead to impaired social support, which leads to criminal behavior.[147]

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136. Fisher et al., *supra* note 99, at 553.

137. *Id.*

138. Jeffrey Draine et al., *Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons with Serious Mental Illness*, 53 PSYCHIATRIC SERVS. 565, 570 (2002).

139. *Id.* at 566.

140. *See id.* at 570.

141. *See id.*

142. TRAVIS HIRSCHI, CAUSES OF DELINQUENCY 16 (1969); ROBERT J. SAMPSON & JOHN H. LAUB, CRIME IN THE MAKING: PATHWAYS AND TURNING POINTS THROUGH LIFE 140 (1993).

143. *See* HIRSCHI, *supra* note 142, at 12.

144. *See* Eric Silver & Brent Teasdale, *Mental Disorder and Violence: An Examination of Stressful Life Events and Impaired Social Support*, 52 SOC. PROBS. 62, 62–65 (2005).

145. *Id.* at 64.

146. *Id.*

147. *Id.* at 64–65.

I. Substance Abuse

An additional indirect pathway from symptoms to crime is through substance abuse.[148] According to Fisher and Drake, "poverty often forces [people with mental illness] to live in neighborhoods, housing projects, homeless shelters, and other settings that are rife with illicit substances."[149] Among psychiatric inpatients, the rate of a co-occurring substance use disorder is around 50%.[150] According to national surveys, the likelihood of having a substance abuse disorder is nearly two times higher among people with serious mental illness than in the general population.[151] People with serious mental illness often "self-medicate" with drugs or alcohol to dull the impact of untreated mental health symptoms,[152] which can ultimately lead to criminal justice involvement.

These indirect pathways are difficult to study since they need to be tracked over the lifespan, and causal direction and ordering are difficult to determine (i.e., people may self-medicate symptoms by using drugs or alcohol, but drugs and alcohol also trigger and exacerbate symptoms of mental illness).[153] One recent study attempted to measure these indirect pathways by focusing on poverty and substance abuse in a sample of 142 offenders with serious mental illness that were recruited through a community corrections department.[154] Each crime committed during a

148. *See, e.g.*, William H. Fisher & Robert E. Drake, *Forensic Mental Illness and Other Policy Misadventures. Commentary on "Extending Assertive Community Treatment to Criminal Justice Settings: Origins, Current Evidence, and Future Directions"*, 43 COMMUNITY MENTAL HEALTH J. 545, 546–47 (2007).

149. *Id.* at 546.

150. Anthony F. Lehman et al., *Prevalence and Patterns of "Dual Diagnosis" Among Psychiatric Inpatients*, 35 COMPREHENSIVE PSYCHIATRY 106, 106 (1994).

151. Darrel A. Regier et al., *Comorbidity of Mental Disorders with Alcohol and Other Drug Abuse: Results from the Epidemiological Catchment Area (ECA) Study*, 264 JAMA 2511, 2514 (1990).

152. Kathleen T. Brady & Rajita Sinha, *Co-occurring Mental and Substance Use Disorders: The Neurobiological Effects of Chronic Stress*, 162 AM. J. PSYCHIATRY 1483, 1484 (2005).

153. Marvin S. Swartz et al., *Violence and Severe Mental Illness: The Effects of Substance Abuse and Nonadherence to Medication,* 155 AM. J. PSYCHIATRY 226, 230 (1998).

154. *See* Jillian Peterson, Untangling Mental Illness and Criminal Behavior: Exploring Direct and Indirect Pathways Between Symptoms and Crime 91 (2012) (unpublished Ph.D. dissertation, University of California, Irvine) (on file with

participant's lifespan was coded according to the degree to which it was influenced by criminal risk factors such as poverty and substance abuse.[155] Approximately 60% of the total sample consistently committed crimes that were a result of poverty or substance abuse—24% committed crimes related to substance abuse only, 12% committed crimes related to poverty only, and 24% committed crimes related to both poverty and substance abuse.[156] This early evidence suggests mental illness is connected to crime, but the indirect pathway runs through substance abuse and poverty.[157]

V. REDUCING CRIME AMONG OFFENDERS WITH MENTAL ILLNESS

There are many reasons why people with mental illness are overrepresented in the criminal justice system. The direct cause model, where symptoms directly cause crime, only applies to a small number of crimes (4 to 12%).[158] For people committing direct crimes, the criminalization hypothesis may be an appropriate explanation.[159] If these crimes occurred because of untreated mental health symptoms, then increased community resources would likely help curb criminal activity in these cases.[160] Additional ways other offenders with mental illness may have more difficulty navigating the criminal justice system are their lack of ability to assist in their defense, follow the rules in prison, and follow the rules of probation and parole.[161] These difficulties result in longer

author).

155. *Id.* at 57.

156. *See id.* at 103.

157. *Id.* at 92–93.

158. TOCH & ADAMS, *supra* note 74, at 82; Junginger et al., *supra* note 67, at 881; *Criminal Behavior*, *supra* note 47, at 446–47; *Offense Patterns*, *supra* note 26, at 1220; *Psychosis*, *supra* note 76, at 7.

159. Abramson, *supra* note 86, at 104.

160. *Id.* at 101.

161. *See* Fisher et al., *supra* note 99, at 546–49; *see also* Harris & Dagadakis, *supra* note 102, at 387; Redlich, *supra* note 101, at 19 ("[T]he probability of arrest was 67 times greater for persons who demonstrate symptoms of mental illness compared with those without such symptoms."); Reisner et al., *supra* note 102, at 85 ("A defendant's lack of insight could bear significantly on his trial decision-making, including rejection of mental-state defenses or transfer to mental health court. These individuals may, because of mental illness, be unable to have a rational appreciation of the appropriateness of legal strategies that rely on mental illness determinations."); Watson et al., *supra* note 102, at 478 (indicating there is

prison stays and more returns to custody than occur for offenders without mental illness.[162] Additionally, many of the other risk factors for criminal activity are present in the lives of offenders with mental illness.[163] Mental illness may indirectly cause crime because the mentally ill often have risk factors for crime such as poverty, impaired social support, and substance abuse, which in turn causes criminal activity.[164]

A. Interventions that Reduce Recidivism

Since there is more than one reason that people with mental illness become entangled in the criminal justice system, it is unlikely that any one approach will consistently reduce recidivism and prevent criminal activity for this group. At this point, most prevention and intervention programs for offenders with mental illness focus on providing access to mental health treatment or psychiatric medications.[165] However, it is known that symptoms of mental illness cause crime rarely and inconsistently.[166] Mental health treatment may even be mandated as part of the sentence for people with mental illness,[167] which sets up more opportunities for technical violations of probation or parole due to increased mandatory appointments.

There are a number of innovative programs for people with mental illness that attempt to link the criminal justice system to the mental health system. For example, mental health courts try to divert individuals from the justice system, often after they have plead guilty, by having them enter mental health treatment instead.[168] Jail diversion programs have a similar purpose—linking

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also some limited evidence that offenders with mental illness may receive longer sentences for similar crimes than offenders without mental illness).

162. Pope et al., *supra* note 103, at 445; Skeem & Louden, *supra* note 110, at 333.

163. Silver & Teasdale, *supra* note 144, at 63–66; Skeem et al., *supra* note 80, at 116.

164. Skeem et al., *supra* note 80, at 117.

165. *Id.* at 112–14; Mindy J. Vanderloo & Robert P. Butters, *Treating Offenders with Mental Illness: A Review of the Literature* 26–28 (Utah Criminal Justice Ctr., Univ. of Utah, Working Paper Spring 2012).

166. *Criminal Behavior*, *supra* note 47, at 446–47.

167. *See* Jennifer L. Skeem & Jennifer E. Louden, Presentation at the American Psychology-Law Society Annual Meeting: Mandated Treatment as a Condition of Probation: Coercion or Contract? (Mar. 2008).

168. Roger A. Boothroyd et al., *Clinical Outcomes of Defendants in Mental Health*

people with mental health treatment—often before their case even goes to trial.[169] Some jurisdictions, such as Dallas, Texas, have implemented late-start jail diversion programs to divert offenders with mental illness to treatment programs rather than facing potential parole revocation.[170] Prison reentry programs try to link offenders with mental illness to treatment programs after their release.[171] And specialty parole and probation agencies help link offenders with mental illness directly to services in their communities.[172]

Unfortunately, there is little evidence that interventions that focus solely on treating symptoms are effective at reducing recidivism for offenders with mental illness.[173] One recent meta-analysis found that high-quality empirical studies of mental health treatment programs for offenders with mental illness demonstrated no significant improvement on criminal justice outcomes.[174] An additional meta-analysis of twenty-six empirical studies found no effect of mental health treatments on criminal recidivism among offenders with mental illness.[175] These programs improve clinical symptoms, which is an important step in the lives of individuals with mental illness, but that does not translate into a reduction in criminal activity.[176]

Court, 56 PSYCHIATRIC SERVS. 820, 829–30 (2005).

169. *See* Kathleen Hartford et al., *Pretrial Court Diversion of People with Mental Illness*, 34 J. BEHAV. HEALTH SERVS. & RES. 198, 198–99 (2007).

170. *See* Chelsea E. Fiduccia & Richard Rogers, *Final State Diversion: A Safety Net for Offenders with Mental Disorder*, 39 CRIM. JUST. & BEHAV. 571, 574 (2012).

171. Amy B. Wilson & Jeffrey Draine, *Collaborations Between Criminal Justice and Mental Health Systems for Prisoner Reentry*, 57 PSYCHIATRIC SERVS. 875, 875 (2006).

172. Sarah M. Manchak et al., *High-Fidelity Specialty Mental Health Probation Improves Officer Practices, Treatment Access, and Rule Compliance*, 38 L. & HUM. BEHAV. 450, 450 (2014).

173. *See generally* Skeem et al., *supra* note 80 (noting that a focus on psychiatric services alone may not reduce recidivism).

174. Michael S. Martin et al., *Stopping the Revolving Door: A Meta-analysis of the Effectiveness of Interventions for Criminally Involved Individuals with Major Mental Disorders*, 36 L. & HUM. BEHAV. 1, 4 (2012).

175. Robert D. Morgan et al., *Treating Offenders with Mental Illness: A Research Synthesis*, 36 L. & HUM. BEHAV. 37, 45 (2012).

176. *Id.* at 44–45; Martin et al., *supra* note 174, at 4, 9.

B. Comprehensive Intervention Programs

Since offenders with mental illness demonstrate many of the same risk factors for criminal activity as offenders without mental illness, it is likely that programs addressing indirect routes to crime such as poverty, employment, housing, social support, and substance abuse will be helpful.[177] Offenders with mental illness typically leave prison with a one to four week supply of medication and a phone number for community mental health care.[178] In order to stop the revolving door of criminal justice, involvement with reentry programs that help people successfully make the transition from prison back into the community may be promising.

There are a number of models for reentry programs that help offenders manage their community transition. Transition teams provide needs assessment, release planning, agency coordination (including health, substance abuse, probation, and parole), and help with applications for insurance, disability, and housing.[179] Transition teams begin meeting with offenders in prison and continue providing services in the community after release.[180] Community aftercare programs go further than transition teams by providing housing, programming, and resources for offenders following release from prison.[181] Rather than coordinating with other outside agencies, aftercare programs directly provide services that offenders need to ease their transition into the community.[182] Specialty parole can also be helpful: it involves specially trained parole agents with caseloads comprised primarily of parolees with mental illness.[183] A national survey of specialty probation agencies revealed five features: caseloads comprised only of parolees with mental illness, reduced caseload size, ongoing training of officers

177. Peterson, *supra* note 154, at 77.

178. HUMAN RIGHTS WATCH, *supra* note 98, at 194–95.

179. J. Steven Lamberti et al., *Forensic Assertive Community Treatment: Preventing Incarceration of Adults with Severe Mental Illness*, 55 PSYCHIATRIC SERVS. 1285, 1287–88 (2004).

180. *Id.*

181. Beth Angell et al., *Engagement Processes in Model Programs for Community Reentry from Prison for People with Serious Mental Illness*, 37 INT'L J.L. & PSYCHIATRY 490, 491–92 (2014).

182. *Id.*

183. Sarah M. Manchak et al., *Mentally Disordered Offenders Under Community Supervision*, *in* ENCYCLOPEDIA CRIMINOLOGY & CRIM. JUST., 3065, 3069–70 (Gerben Bruinsma & David Weisburd eds., 2014).

in mental health-relevant issues, integration of internal and external resources, and reliance on problem-solving supervision strategies.[184]

Unfortunately, little is known about whether or not these programs actually work. In order to research these programs, experimentally designed studies that use control groups or matched design and adequate follow-up data are needed. These studies are difficult to carry out and require funding and resources that criminal justice agencies often lack. In one of the only experimental evaluations of reentry programming for offenders with mental illness identified in the literature, researchers randomly assigned over 200 inmates with mental illness to a treatment or control condition.[185] Half of the people in the treatment group also chose to participate in aftercare in the community, which provided temporary housing in a twenty-bed facility.[186] One year after their release, returns to prison were significantly lower for the treatment plus aftercare group (5%) compared to the control group (33%).[187]

Successful re-entry programs like this one will likely need to include features such as vocational training and halfway houses,[188] as well as cognitive behavioral treatments that target the criminal thinking so often seen among offenders with mental illness.[189] Policies and programs that reflect risk, needs, and responsivity principles are likely to be effective for the majority of offenders with mental illness (i.e., match program intensity to the level of risk, target changeable risk factors, and match services to individuals).[190] Further studies highlight the need to address the

184. Jennifer L. Skeem et al., *Probation, Mental Health, and Mandated Treatment: A National Survey*, 33 CRIM. JUST. & BEHAV. 158, 169–72 (2006).

185. Stanley Sacks et al., *Randomized Trial of a Reentry Modified Therapeutic Community for Offenders with Co-occurring Disorders: Crime Outcomes,* 42 J. SUBSTANCE ABUSE TREATMENT 247, 249–52 (2012).

186. *Id.* at 249.

187. *Id.*

188. *See generally* Joan Petersilia, *What Works in Prisoner Reentry? Reviewing and Questioning the Evidence*, 68 FED. PROBATION 4 (2004) (analyzing how to improve the current effectiveness of prison reentry programs).

189. *See generally* Sacks et al., *supra* note 185 (analyzing through a national survey the effectiveness of specialty parole systems).

190. *See* USING SOCIAL SCIENCE TO REDUCE VIOLENT OFFENDING: A BRIEFING PAPER FOR PUBLIC POLICYMAKERS (Joel A. Dvoskin et al. eds., 2011), http://static1.1.sqspcdn.com/static/f/1013495/26048233/1426528574393

lack of education, unemployment, homelessness, substance abuse, and prosocial attachments seen among offenders with mental illnesses.[191]

VI. CONCLUSIONS

Successful programs for offenders with mental illnesses that effectively prevent or break the cycle of criminal justice involvement are possible, but these programs need to be comprehensive—addressing the holistic needs of this high-risk population, rather than a sole focus on mental health symptoms and treatment. Early programming may also be critical for intervention. Emerging adulthood is the key point at which both symptoms develop and criminal justice involvement usually begins.[192] Resources for high school students, such as mental health services and social workers, may help young adults manage this difficult period of time. Longitudinal experimental research is needed to know whether early intervention programs for at-risk adolescents result in reductions in future criminal activity.

It is unlikely that any one-size-fits-all program will work for this population. Instead, examining the individual needs among each offender (e.g., untreated symptoms, unemployment, homelessness, criminal peers, and drug or alcohol abuse) will be critical for preventing future criminal activity. Designing comprehensive programs involves cooperation among the criminal justice, social services, and medical systems. While these programs are expensive, they will ultimately save costs.[193] A study by the Urban Institute

/BriefingPaper.pdf?token=1A5yQWxySH4HbfDxGUsuTxneelk%3D. *See generally* Skeem et al., *supra* note 80 (exploring how effective current interventions have been in regard to combating recidivism in imitates with mental illness).

191. *See generally* Draine et al., *supra* note 138 (exploring how mental illness effects the social construct of crime, unemployment, and homelessness); Fisher et al., *supra* note 99 (examining the impact of poverty, inactivity, and more on mentally ill offenders).

192. *See generally* Stephanie W. Hartwell et al., *Emerging Adults with Psychiatric Disabilities Involved with the Criminal Justice System*, 54 INT'L OFFENDER THERAPY & COMP. CRIMINOLOGY 756, 756–68 (2010) (stating emerging adults, due to their vulnerability, need tailored community service treatments and services to prevent them from reoffending).

193. *See generally* JOHN ROMAN ET AL., IMPACT AND COST-BENEFIT ANALYSIS OF THE MARYLAND REENTRY PARTNERSHIP INITIATIVE 18 (Urban Inst. Justice Policy Ctr. ed., 2007) (stating the benefit from the Maryland reentry program outweighed the expenditure of $1.2 million spent in running the program).

found that a 5.6% drop in arrest rates resulted in a savings of $7.2 million for the state.[194] A cost-benefit analysis showed that the state received a return of $3 for every $1 spent on the program.[195] While comprehensive programs that cross system boundaries sound difficult to coordinate and implement, they are certainly worth the investment in terms of saving costs, preventing victims, reducing recidivism, and improving the lives of people with serious mental illnesses.

194. *Id.*
195. *Id.*