

Preface

The information gathered for this book began as a project for the local Broward County, Florida Sheriff, who wanted to know what the literature stated were the best practices for mentally ill persons who were arrested and held in the County Jail. At the time, he was thinking about the possibility of building a mental health facility given the expanding number of detainees with mental health problems. As we began to survey the literature, it became clear that most of the research was about programs for justice—involved people in the prisons, not the jails and detention centers, where the movement in and out is constant and unpredictable. Therefore, the information in this book is an integration of the literature we found and adapted to jails, integrating it with interviews we conducted with the jail, courtroom, and community staff and stakeholders. The questions we asked and surveys we distributed are in the Appendix. The resultant data were analyzed using a qualitative method (conventional content analysis) in order to identify themes and patterns to develop a map for best practices. This book integrates the best practice as defined in the literature, our knowledge about clinical treatment of the mentally ill, together with our interview findings from the community to develop what we believe is the current Best Practices Model (BPM). We cannot provide a blueprint for all jurisdictions here; however, we do attempt to share the integration of the literature and practice with our readers. This is presented in Chap. 1.

Most important was our finding that the best practice is to keep the mentally ill out of jail. Therefore, we also reviewed the training for police in Chap. 2 so that they are able to recognize those whose crimes are committed due to their mental illness and refer them for treatment rather than criminalize their behavior. Sometimes, it is necessary to make the arrest, but then, there are ways to defer the person to one of the specialty courts, if available. We review the most common of these “problem-solving” courts in Chap. 3; the Mental Health Court, the Drug Court, and the Domestic Violence Court. Many of those who are mentally ill have substance abuse and domestic violence issues. Consequently, availability of dual diagnosis treatment and trauma treatment is important both in the jail and in the community. Those who have been adjudicated as incompetent to proceed to trial because of mental illness or disability are usually sent for “competency restoration”

and the best practices for these programs are reviewed in Chap. 4. Although the BPM suggests treatment for the mentally ill should be in the community with supervision by the courts, when they are in jail, there needs to be treatment available with seamless reintegration back to the community. This means coordination between the mental health and corrections systems. Successful programs are presented in Chap. 5.

It is clear that the challenges presented by the mentally ill involved with the judicial system suggest policies are in need of revision as indicated by a recent Department of Justice report illustrating that over 50 % of people in jails and prisons across the nation have been treated for a mental illness and/or substance abuse problem at some point prior to their being detained (James and Glaze 2006). It is estimated that at any time, approximately 20 % of all inmates will have a diagnosable mental illness that needs treatment during the time they are held in jail or prison. If the numbers of substance abusers are added to this group, the need for services would be greater than the ability to effectively provide them. This is also true if those who have suffered from trauma, especially child abuse or intimate partner violence, are also provided services to eliminate their Post Traumatic Stress (PTS) symptoms. Some suggest that our jails and prisons have, to some degree, become the mental hospitals of yesterday.

We used the local jail in our community administered by the Broward Sheriff's Office (BSO) in Broward County, Florida, as a resource in studying the issues that arise when trying to develop a BPM as this jail seemed to be similar to others reported in the literature that provide some services to the mentally ill. The number of people under the supervision of BSO at any time is estimated at 14,500 with approximately 5500 housed in its jails and 9000 placed under community control. If 50 % of this population required mental health treatment programs, the BSO psychology staff would have to serve 7250 people who have some form of a mental illness. Moreover, national studies indicate that approximately 70 % of the mentally ill in jails across the country have a co-occurring substance abuse disorder (National GAINS Center 2002). To better understand the scope of the problem, our research group reviewed some of the statistics available from BSO, Florida Department of Children and Families (DCF), and by Broward County Human Services Department regional office of the U.S. Department of Health and Human Services (HHS) as these are the major agencies responsible for the care and treatment of citizens in or out of jail in our community. In addition to adults, there are approximately 60 youth who are incarcerated in the BSO adult jail at any point in time, as they have been arrested for committing serious felonies and were waived into adult court by prosecutors. Most of these youth need intensive mental health services according to interviews conducted with attorneys who represent them, and current jail personnel and former Juvenile Detention Center staff who previously served them prior to waiver.

For the past 25 years, Broward County, like many other places in the U.S., has attempted to deal with this problem, taking a number of steps including activating several community-wide Mental Health Task Forces within the judicial and mental health systems to determine appropriate system coordination for those individuals who have both mental illness and substance abuse problems, called dual diagnosis

in the literature. Most recently, the state has required all agencies to become trauma-sensitive, understanding that the service recipients often have experienced trauma and still suffer from its effects. It is important to note that these task forces have found that it is often the same mentally ill individual who needs these additional services whether they are in jail or in the community, as they often develop co-occurring disorders such as substance abuse, domestic violence, sexual assault and harassment, cognitive impairment, and the like.

Since 2000, when then President William Clinton signed into law the first Federal legislation to establish 100 mental health courts, there has been a spotlight on the plight of the mentally ill in jails as well as prisons. Broward County actually established the first misdemeanor Mental Health Court in the United States in 1997, and it has become a model for subsequent programs including a felony mental health court and mental health probation. Judge Ginger Lerner-Wren, who has conducted the misdemeanor mental health court for the past 15 years, has served on President Bush's New Freedom Commission on Mental Health (2003). Several national centers (i.e., www.gainscenter.samhsa.gov, www.consensusproject.org) have been created to assist communities in the development of programs ranging from training police to avoid arresting the mentally ill where ever possible, deferring the mentally ill who commit nonviolent crimes into community treatment programs with intensive case management, developing treatment programs for those mentally ill defendants being held in jail, and moving those people found not competent to stand trial more expeditiously into hospital or community-based restoration centers. Despite these and other strategies for better responding to the needs of the mentally ill, there are still many places where the efforts are simply insufficient to stem the flow of the mentally ill in and out of the jails, which frequently do not have adequate resources to meet their needs.

Our research group identified various stakeholders who are responsible for meeting the mental health needs of adults in most jurisdictions. This is an important first step in designing a BPM for the community. These include the local courts and attorneys representing the people, advocate groups, regional offices of state and federal agencies such as the Department of Health and Human Services (DHHS), the Department of Children and Families (DCF), and the Department of Corrections (DOC), many of whom have contracted with not-for-profit agencies to provide the services for their recipients. Other stakeholders include the Broward County Hospital Districts and various independent community health agencies and mental health providers who also deliver services to the mentally ill. Our academic center, Nova Southeastern University (NSU), is the primary training institution in Broward County for medical and mental health personnel and provides services to the mentally ill through its training clinics. As a private not-for-profit educational institution, NSU works closely with all these governmental groups. When looking at developing a BPM, it is important that there be coordination of all of these governmental entities together with other agencies and universities for the success of any project undertaken by any one or a combination of these groups.

It is estimated that the population of the mentally ill will continue to increase as a local community grows and the mental health services are unable to keep up with

their needs. Furthermore, most states have faced fiscal crises with serious budget cuts in all areas of human services. Although the Affordable Care Act requires a team-based service model for health care beginning in 2014, there is no guarantee that the mentally ill will be provided with adequate services either in the community or in the criminal justice system. Therefore, it is not expected that there will be any major growth in the community in providing services to the mentally ill within the near future commensurate with service needs.

The term ‘best practices’ is one that has gained popularity in recent years to signify what is sometimes called ‘evidence-supported practice’ or simply a consensus in the literature of the most effective way to meet specified goals. The term has gained popularity in medicine and is utilized in the mental health services arena to denote practice that is supported by research and clinically based studies. A majority of BPM in any area suggest that communication and coordination among agencies is essential for a program to be successful. Dvoskin (2007) suggested that an integrated model combining intensive case management including housing needs upon release, competency restoration when needed, dual diagnosis programs (including mental health components into substance abuse treatment programs or vice versa), domestic violence intervention for batterers, and specialized treatment for women. Our findings in this study support Dvoskin’s recommendations for best practices and include emphasis on a seamless continuity of care as so many of the mentally ill people regularly move in and out of jail and community.

Therefore, several elements in the BPM we propose should be in place to ensure that all mentally ill individuals are recognized and receive appropriate care, including:

1. Pre-arrest diversion by law enforcement into community treatment facilities.
2. Diversion out of the criminal justice system after arrest into treatment or problem-solving courts.
3. Problem-solving court supervision with case management and monitoring in the community.
4. Mental health treatment while in jail.
5. Competency restoration programs in hospitals and in the community.
6. Mental health probation when released from jail or prison.
7. Long-term mental health treatment in the community with seamless continuity of care.

Although this book discusses the various options for assisting the mentally ill while in the criminal justice system, in fact our study indicated that the best option for the mentally ill is to treat them in the community.

Do not criminalize the mentally ill could be our mantra.

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