Sheriff

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Keeping Offenders with Mental Illnesses out of Jail

Breaking the Cycle, Together

By Ray Coleman

Jails have become the mental institution of last resort, and more recently the institution of the *first* resort.

We are overwhelmed by the tide of untreated mental illness in our jails. According to the Bureau of Justice Statistics, 16 percent of jail and prison inmates—or more than 300,000 people—have severe mental illnesses. That is more than four times the number of people in psychiatric hospitals.

This is not a new problem. Our nation faced a similar crisis in the mid-1800s when Dorothea Dix began imploring states to build psychiatric hospitals to care for inmates who had mental illnesses. By 1880, because of work by reformers like Dix, less than 1 percent of inmates were mentally ill. In place of prisons, a system of state psychiatric hospitals had been established to care for individuals who needed psychiatric treatment.

A century later, we've come full circle. More and more state psychiatric hospitals are being closed, and people with mental illnesses are again being shuffled into jails and prisons. In Ohio, for instance, there was a 43 percent increase in the state prison general population between 1990 and 1996, but a *285 percent* increase in inmates with mental illnesses in that same period. (*Cincinnati Post*, October 26, 1996.) Those of us in the corrections field are far too familiar with statistics such as these.

The dimensions of this problem are certain to increase as more psychiatric beds close. During the 1990s, twice as many hospitals were closed as in the previous two decades. In 2003, half of the states reported shortages in psychiatric beds as a result of hospital downsizing. And 28 states plan to close more hospital beds between 2003 and 2005.

The problem with coming full circle is that you end up where you started. While medical science was making progress all around us, those who work with the population facing these terrible diseases were left in the dust.

Those who refuse treatment while they are in jail present a particular dilemma from a jail-safety and jail-management perspective. Yet when I recently surveyed the audience of a workshop at the National Sheriffs' Association conference this past June, not a single hand went up when I asked who in the crowd had the legal authority in their jurisdictions to require inmates with mental illnesses to take medication. The members of the audience represented jails of all sizes from all over the country, yet all faced a similar problem: restrictive state laws limiting court-ordered treatment.

Not surprisingly, every member of the audience raised his or her hand when I asked how many of them manage people with serious mental illnesses in their county jail. But not a single hand was raised when I then asked how many believe jail is the best place to manage people with severe mental illnesses.

That is because corrections officers know too well the perils of incarcerating someone who is so ill. People with severe and untreated brain diseases such as schizophrenia and bipolar disorder are more often victimized by other prisoners, in part because of their sometimes-bizarre behavior brought on by the illogical thinking, delusions, auditory hallucinations and severe mood swings that can be characteristic of these diseases. People with untreated mental illnesses often land in solitary confinement, which can exacerbate symptoms. They are also highly likely to attempt suicide. A Los Angeles County Jail survey found that 71 percent of inmates who committed suicide had histories of mental illness or had been examined by mental health workers just before they killed themselves.

Housing so many severely mentally ill offenders also presents a fiscal challenge to most corrections facilities. Even many of the small- and medium-sized jails find it necessary to employ mental health professionals on staff. At the NSA conference, there was an overwhelming and obviously frustrated consensus in the audience at my session about the difficulty of managing psychiatric medications. This is reflected in media reports from around the country. The Los Angeles County Jail spends $10 million per year on psychiatric medications. (*Los Angeles Times*, November 20, 2001.) Fully half of those in Maine's Hancock County Jail are on some form of psychotropic medication. (*Portland Press Herald*, January 13, 2002.) And in Georgia, the cost of treating prisoners with severe mental illnesses is approximately $30 million—and is expected to rise to $70 million by 2007 (*The Atlanta Journal-Constitution*, April 4, 2004.)

There is finally broad recognition, both within the industry and from without, that people with severe mental illnesses are overrepresented in the criminal justice system. We regularly read local and regional news articles calling for reform to prevent the criminal justice system from being a dumping ground for the untreated mentally ill. And initiatives such as mental health courts and law enforcement crisis-intervention teams are ensuring that those who land in the system encounter people who are better informed about their diseases. Thanks to these kinds of initiatives, offenders with mental illnesses stand a much better chance of

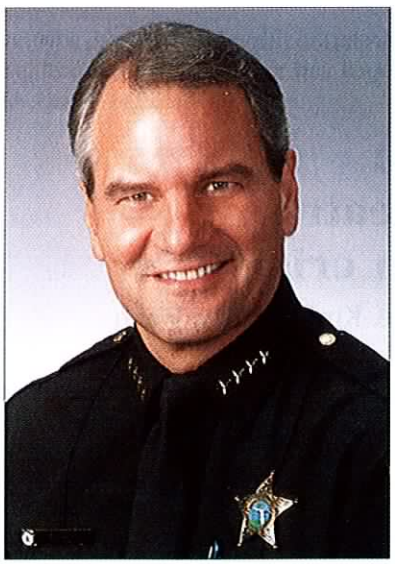
getting into treatment than ever before.

That surge of information in the criminal justice system is an important step to reform. Following are insightful perspectives on solutions from Sheriff Donald Eslinger from Seminole County in Florida, the Honorable James Cayce from Washington State and Mary Zdanowicz from a national group advocating for better treatment laws.Their visions and the recent collaborations I have seen give me hope that the decline I have observed over the course of my career will soon be corrected.

No matter how well managed or well funded, jails and prisons are terrible places for people with severe mental illnesses. No matter how well trained, law enforcement officers should not be the front-line responders for people in crisis. No matter how well run, mental health courts are a *post-arrest* diversion in a world where people need more help *pre-arrest*.

We need to work together to ensure that people can get the treatment they need well before they land on the doorstep of the criminal justice system. ✪

Ray Coleman is a respected consultant in the corrections field and is former director of the King County, Wash., Department of Adult Detention.



The Sheriff as Advocate:
Improving Mental Health Treatment Laws

By Donald F. Eslinger, Sheriff of Seminole County, Fla.

Sheriffs are not medical professionals. And yet, over the last few years my deputies have increasingly been called on to handle dangerous situations involving people with untreated severe mental illnesses. This situation has become a public safety concern for our officers and the citizens we are charged to protect.

The problem is growing increasingly worse, and it is not unique to Florida. Nationally, 1998 statistics showed that people with mental illnesses killed law enforcement officers at a rate 5.5 times greater than the rest of the population (the Treatment Advocacy Center. "Briefing Paper: Law Enforcement and People with Mental Illnesses," August 2004). Law enforcement officers were more likely to be killed by a person with a mental illness (13 percent) than by assailants who had a prior arrest for assaulting police or resisting arrest (11 percent). There is danger for everyone in these encounters, as borne out by newspaper headlines every day. In August and September 2004 alone, people with severe mental illnesses or law enforcement officers have been killed or seriously injured in tragic encounters in at least 14 states: Alabama, Arizona, California, Illinois, Indiana, Kentucky, Louisiana, Maryland, New York, Oklahoma, Oregon, Pennsylvania, Texas and Wisconsin.

In Florida, the law governing involuntary commitment for those with severe mental illnesses is called the Baker Act. Florida law enforcement officers initiate more than 100 "Baker Acts" every day. By comparison, we made an average of 104 aggravated assault arrests, 72 burglary arrests and 24 robbery arrests each day in 2003. Clearly, handling people in crisis because of mental illnesses has become one of our top law enforcement duties.

This issue became more personal for me six years ago when, in the course of a 13-hour standoff, Seminole County Sheriff's Deputy Gene Gregory and Alan Singletary, a man with untreated schizophrenia, were both killed and other deputies injured.

Reeling from this incredible loss, we were stunned by the primary reason: State law prohibited Alan's family from getting him the treatment he needed.

But what could we do?

Quickly it became clear: Law enforcement officers may not be medical professionals. But we are in a prime position to be formidable advocates on this issue.

An ad hoc group was formed to assess what actions we could take to ensure that people who needed treatment would get it. With support from an amazing alliance between Deputy Gregory's widow and Alan Singletary's sister, we pulled together a group to work for reform. The very first issue on which emerged a consensus from our group was that more resources should be dedicated to helping people with severe mental illnesses. But it was also readily apparent that resources alone were not enough. More money could not help the population that needed it the most, those refusing treatment not because of a dearth of services, but because they didn't believe that they were sick. This lack of insight into illness is a common symptom of severe brain diseases and keeps many from treatment. We realized we needed a strong law to allow the sickest people to be court-ordered into outpatient treatment, a practice referred to as "assisted outpatient treatment."

This was the crux of the problem in Florida: People were refusing treatment because they didn't think they were sick, and our outdated law gave judges no options for helping them, other than inpatient hospitalization. As a result, the same population of people kept revolving through the system without receiving any real benefit. Over a two-year period in Florida, 540 people each had eight or more Baker Act emergency examinations, averaging at least one every three months. This small group of people was using a dispro-

portionate share of mental health, criminal justice and court resources. Truly helping them would also help others and at the same time reduce the overall burden on the system.

The Florida Sheriffs' Association knew that if we wanted this change, we would have to take the lead. Some activists have succeeded in turning assisted outpatient treatment into a controversial topic, although the statistics on its successes are clear. This perception of controversy keeps obvious advocates—including some in the mental health community who understand the benefits of assisted outpatient treatment—from standing up for change.

But we as sheriffs can.

There are some clear benefits for sheriffs who do resolve to take a leadership role in mental health advocacy:

Improved public safety. The best benefit to advocacy is, of course, a better law to protect officers and citizens. New York implemented an assisted outpatient treatment law in 1999. Results from that law show that for people placed in assisted outpatient treatment for six months:

- 75 percent fewer were arrested
- 69 percent fewer were incarcerated
- 55 percent fewer experienced homelessness
- 63 percent fewer were hospitalized.

There were also significant reductions in harmful behaviors among participants, such as harm to self (45 percent reduction) and harm to others (44 percent reduction). We fought for this law in Florida in hopes of duplicating some of those results.

Strengthened community relationships. Mental health advocacy can lead to better developed and more positive relationships

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Mental Health Courts:
One form of assisted treatment
Guiding people through crisis

By Jim Cayce, Superior Court Judge, King County, Wash.

As a judge who has presided over a mental health court, I have seen many people facing agonizing circumstances.

One of those people was Rob.

Rob is a man with bipolar disorder who appeared in my court in an acutely manic and delusional state, screaming and cursing. He was clearly confused and distressed. I found that he was not competent to proceed and ordered that he be evaluated for treatment.

When Rob reappeared in my courtroom several weeks later, the difference was astonishing. After several weeks of treatment, the man who appeared before me was calm, soft-spoken and obviously very intelligent.

This past summer at the National Sheriffs' Association conference in Seattle, I played a tape of Rob's two courtroom appearances for a workshop at which I was presenting. The audience of law enforcement officials listened intently to the stark difference in this man's behavior in the two courtroom sessions. Then Rob himself joined us at the podium to answer questions. Rob was in the audience when I played the tape for the sheriffs in the workshop—it was the first time he had heard it. He told us that he didn't remember much of his first appearance—particularly the yelling. He did say that he clearly remembered walking down a long corridor on his way to the court, right behind President Bill Clinton. It was hard for the workshop audience to imagine that the man who was speaking to them so calmly about his delusions was the same man screaming profanities in the first recording.

Rob ended up in my courtroom after he had stopped taking his medication. As with many others with severe brain diseases, he simply did not think he needed it anymore. When police came to pick him up for trespassing, he wielded a pool cue in a threatening manner. The encounter could have ended in tragedy. Fortunately, the officer was able to contain the situation and brought Rob to jail and, eventually, to mental health court.

Mental health courts are a form of assisted treatment. To avoid being sentenced to jail, someone with a severe mental illness who finds him- or herself arrested can choose to instead participate in treatment that is intensively monitored by the mental health court. Mental health courts specialize in adjudicating defendants with mental illnesses, utilizing a collaborative team approach that includes a clinical specialist who links defendants to needed treatment. Mental health courts are potent tools in the battle to get treatment for those who genuinely need it, not jail time.

Offenders who appear before mental health courts typically receive:

- an immediate diagnosis and match to services
- case consolidation, when feasible
- all hearings with the same judge and legal/clinical team
- close, specialized monitoring and support during release
- up to two years of supervised treatment.

The mental health court in King County, Wash., was created in response to a specific preventable tragedy. In August 1997, retired Seattle fire captain Stanley Stevenson was murdered by a just-released misdemeanant defendant with mental illness. That event triggered the establishment later that year of the Mentally Ill

Offender Task Force, which was chaired by retired Supreme Court Justice Robert Utter. The task force assessed options to better serve the population of offenders with mental illnesses. Among the recommendations for change was a proposal to start a mental health court. At that time, there was only one other mental health court in operation, started by Judge Mark Speiser in Broward County, Fla. King County developed its mental health court using Broward County as a model. When King County's mental health court opened in February 1999, it was only the second such court in the nation.

A University of Washington evaluation of the King County mental health court found that 85 percent of participants had been diagnosed with a severe mental illness. For those who chose to "opt in" to the court, the evaluation found that they:

- were three times more likely to enroll in services
- received more treatment service hours
- experienced significant improvement in functioning
- spent fewer days in detention on average
- had a significant decrease in new jail bookings.

Washington State University (WSU) research findings from a study of the King County mental health court also demonstrated this diversion model's value. The court significantly reduced recidivism—there was a 75.9 percent decrease in the number of offenses committed, according to the WSU findings. WSU concluded that the King County mental health court successfully provides a means to significantly reduce the occurrence of violent criminal activity associated with participating defendants. There was an 87.9 percent decrease in violent offenses committed by its graduates, the study found.

Assisted treatment—whether in the form of mental health courts for offenders or preventative measures, such as assisted outpatient treatment—works to keep people *out* of jail and *in* mental health treatment. Mental health courts are one strong way to ensure that those who will agree to voluntarily participate in this mechanism can get the help they need.

Rob—the fellow I referred to earlier—is a prime example of that. He has been doing well since he left the court. He realizes now that he needs medication. If his condition were to deteriorate again, he says he would want to participate again in the mental health court.

More than anything else, Rob's story made me realize that we are not doing people any favors by letting them refuse treatment when they are actually too sick to make rational treatment decisions. Rob has a life today because he appeared in mental health court instead of being sent to jail. He is receiving treatment and is not resentful that I made him accept it.

I came to see that we could use the leverage of the court to get people into treatment—without them feeling that they had been coerced. We can make sure that they will get the help they need if they are treated with respect and dignity through the process—which is what the mental health court does. I am grateful that I had the opportunity to help so many people with severe mental illnesses in the King County Mental Health Court. ✪

An executive summary of the University of Washington evaluation can be found at www.metrokc.gov/kcdc/execsum.htm. An executive summary of the Washington State University evaluation can be found at www.metrokc.gov/kcdc/mhcsum32.pdf.

Collaboration vs. Consensus:
Sheriffs and the mental health community can work together without ignoring court-ordered treatment

By Mary T. Zdanowicz, Esq.

In recent years we have witnessed an unprecedented collaboration between criminal justice and mental health communities at both the local and national levels. These partnerships are paying off. In 2000, Congress passed *America's Law Enforcement and Mental Health Project [Public Law No: 106-515]*, which authorized funding for 100 pilot mental health courts. Stakeholder groups such as Florida's Partners in Crisis have successfully advocated for increased funding for services at the state level. The Criminal Justice/Mental Health Consensus Project, coordinated by the Council of State Governments, published a 430-page *Consensus Report* on the problem and some possible solutions.

The Consensus Report is a valuable resource, but it is also ironically emblematic of a significant problem that arises when trying to seek "consensus" in the mental health community. The report states:

"Agreement in the field dissolves... when stakeholders discuss where to turn when mental health treatment systems have failed to successfully engage an individual in treatment. Conflicting views on involuntary commitment illustrate this tension. Some see involuntary inpatient or outpatient treatment as the ultimate intrusion, a dehumanizing deprivation of rights to be avoided at all costs. Others hail involuntary treatments as necessary and lifesaving tools

that must be employed when an individual's judgment is impaired…

"The report takes into account the mental health system's values and largely steers away from making recommendations that would apply coercive measures to people with mental illness…"

It is at this vital crossroad that collaboration fails and the need to find consensus becomes a hindrance rather than help. For the last 30 years, the mental health system has systematically abandoned individuals with severe mental illnesses such as schizophrenia and bipolar disorder who do not seek treatment voluntarily—parroting the false belief that nothing can be done to get someone into treatment until he or she becomes dangerous. Of course, this is not only inaccurate but deadly, because by the time someone becomes dangerous, it is the criminal justice system, not the mental health system, that responds.

Severe mental illnesses, by their nature, make coerced care necessary in some cases. Nearly half of people with schizophrenia and bipolar illness have moderate to severely impaired awareness of their illness. This is caused by a neurological deficit called *anosognosia*, also found in other brain disorders such as Alzheimer's, which prevents the person from realizing he or she is ill—and prevents him or her from seeking treatment as a result.

There is no question that allowing people to refuse treatment has devastating consequences: homelessness, arrest, victimization, violence and suicide. But we now know that the benefits of mandating treatment far outweigh any detriments. Studies show that the majority of those who are compelled to take medication agree with the decision when they look back at it later. The studies also show that perceived coercion does not adversely affect future compliance with treatment.

Collaborative efforts to divert people with mental illnesses from the criminal justice system typically focus exclusively on voluntary measures. The *Consensus Report* promotes only solutions that steer clear of coercive measures. Because the mental health community cannot reach consensus on the issue of coercion, people who refuse treatment—those who are typically the sickest—end up becoming the sole responsibility of law enforcement and corrections personnel. Unintentionally, the criminal justice system ends up doing a kind of reverse triage, keeping the most medically needy in the criminal justice system and diverting those who are easy to treat to the mental health system for care.

Sheriffs play a significant leadership role in mental health/criminal justice collaborations in their communities. Sheriffs therefore must push representatives of the local mental health system to detail what happens to people who refuse treatment. Too often, the response is that nothing can be done until someone becomes dangerous, and then the only recourse is hospitalization. In most states, that answer is incorrect, based on a misunderstanding of the law. Except in eight states that still desperately need legal reform (Connecticut, Maine, Maryland, Massachusetts, Nevada, New Jersey, New Mexico and Tennessee), the mental health community can indeed help those who refuse treatment—and thereby ensure that these individuals won't be encountering deputies instead of doctors. Assisted outpatient treatment (AOT), a legal option in 42 states, allows the mental health system via a court order to treat those who are too sick to realize they need help. Studies show that AOT reduces violence, arrests, homelessness, victimization and acts of violence.

Assisted outpatient treatment allows judges to court-order treatment in the community so that the mental health system can treat those who are too sick to realize they need help. Mental health courts are a proven and effective way to divert this population once they have been arrested, but that still means that these individuals have to deteriorate to the point of committing a crime. Similarly, CIT (crisis-intervention training) makes law enforcement officers more aware of what happens to someone when he or she "decompensates" and becomes symptomatic. These mechanisms, as powerful and positive as they are, work to help someone *after* his or her disease becomes unmanageable. When the system only intervenes after things are bleakest, tragedies remain inevitable.

Because of the deep divisions within the mental health system on this issue, the problem will not be solved unless law enforcement takes the lead for reform. Sheriff Donald F. Eslinger did that recently in Florida, which just became the 42nd state to allow assisted outpatient treatment.

This reform effort may not be a "consensus project," but neither will it be a solo effort on the part of law enforcement. In my experience, about half of those in the mental health community understand the benefit and necessity of coercive measures. And many more are seeing the light as the studies on AOT repeatedly prove its success in helping those who could not be helped before.

In New York, Kendra's Law was adopted in 1999 to address those who refuse treatment and have a history of recidivism. According to the New York Office of Mental Health, people in the program are twice as likely to have had prior contact with the criminal justice system when compared with a similar population of mental health service recipients. This significance is incredibly important to law enforcement executives because it demonstrates that AOT does what the traditional mental health system cannot or will not do: It provides treatment for individuals susceptible to criminalization before they become criminals. In fact, individuals in the program experienced 75 percent fewer arrests.

Criminal justice/mental health collaborations are essential to developing the advocacy and systems necessary to provide treatment for individuals with severe mental illnesses who otherwise end up in jail or in a deadly encounter with law enforcement. But law enforcement executives must also pursue an agenda to accomplish what consensus cannot—enabling the mental health system to care for individuals who are too ill to recognize they need voluntary services. Sheriffs are in a unique position to advocate a more rational triage for the care of most severely mentally ill persons—one that diverts those who are too ill to accept treatment away from deputies on the streets, away from jails, and back to the mental health system that is best equipped to provide the care they need. ✪

Mary T. Zdanowicz is executive director of the Treatment Advocacy Center, a national nonprofit dedicated to removing barriers to treatment of severe mental illnesses. For more information, go to www.psychlaws.org.

The Sheriff as Advocate:
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with members of the community, including members of the mental health community and the government agencies responsible for human services.

Strengthened programs. The closer relationships and improved communication channels make other programs for people with mental illnesses—such as diversion programs, crisis-intervention training, mental health courts and service programs—all the more effective.

Better informed policymakers. In Florida, legislators heard a great deal from us about the impact of mental health issues on law enforcement resources. They heard our message that ineffective treatment laws meant higher rates of incarceration, more arrests, more interventions with the homeless community, more calls for someone to be transported for evaluation and more need for crisis intervention. When sheriffs around the country bring attention to these issues, issues that legislators might not have previously considered, it could very well pay off in budget allocations and priorities in human services and criminal justice committees.

Increased publicity. The Florida Sheriffs' Association made Baker Act reform its top legislative priority for three years in a row. The overwhelming media support brought the issues—as well as the sheriffs advocating those issues—into the media spotlight. In Florida, 30 supportive newspaper editorials, countless opinion pieces, letters to the editor and news stories helped get our message out to an estimated 14 million people. That kind of positive publicity can help your department at budget time or when you need public opinion on your side.

Even with extensive crisis-intervention training and other important diversion tools, law enforcement officers do not want to be in a confrontational situation with someone who is delusional and psychotic. The job of caring for our most ill, and often most vulnerable, citizens is better left to those with the training and expertise to handle such health-care crises. And the job of promoting public safety by lobbying for stronger treatment laws is perhaps best placed in the hands of those who are facing people in crisis every day. ✪

Sheriff Eslinger is legislative chair and former president of the Florida Sheriffs' Association, whose Baker Act reform bill was signed into law June 30, 2004 and will go into effect January 1, 2005.