BEHAVIORAL HEALTH IN THE JUSTICE SYSTEM

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Mitigation Specialist &
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AGENDA

- Current data regarding prevalence of mental illness in community and incarcerated populations
- Review of symptoms of mental illness that can lead to criminalization
- Historical overview of social and political trends that have impacted the criminalization of mental illness
- The impact experienced by those incarcerated and mentally ill
- Trauma
- Principles of re-traumatization
- Current mental health correctional practices
- Aspirational practices

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- Background working in:
  - Jails, prison, state psychiatric hospitals, sex assault crisis, child welfare, re-entry, and community settings.
- Serving special populations:
  - Sex offenders (adult/juvenile), personality disorder, severely mentally ill (SMI), high-risk/high-acuity, survivors of domestic and sexual violence, high incidence of trauma.
- Currently working has a mitigation specialist while maintaining my own private practice.

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INTRODUCTION

- There is a clear intersection between individuals with mental illness, including substance use disorders, and the criminal justice system.
- As community facilities have closed, correctional facilities have been tasked with caring for increasing proportions of people struggling with their mental health.
- Untreated, or poorly treated, mental health concerns can lead to increased problems while incarcerated and pose a barrier to rehabilitation and successful re-entry.

What topics come to mind when you hear "*criminalization of mental illness*"?

MENTAL HEALTH BY THE NUMBERS

- Generally, **nearly one in five** individuals have a diagnosable mental illness over the span of a year.
- Approximately 5.2% have a serious mental illness.*
- The rate of **severe** mental illness in jails and prisons is estimated to fall between 16% and 24%.
- By contrast, the rate of **severe** mental illness in the general community falls between 3.9% and 5.0%.
- **Individuals with mental illnesses are significantly more likely to come into contact with the criminal justice system.**

Severe (serious) mental illness (SMI):

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder
- Major depression with psychotic features

	Community population	State prison	Federal prison	Local jail
Major depressive disorder	12% MDD (18% of those with psychotic ft.)	23.5%	16.0%	29.7%
Bipolar disorder	4.4% (82.9% of cases being severe)	43.2%	35.1%	54.5%
Psychotic disorder	Schizophrenia: 0.25 to 0.64% Schizoaffective: 0.3%	15.4%	10.2%	23.9%

Other common mental health concerns:

- Substance use disorders/addiction
- Depression
- Anxiety
- Grief/loss
- Trauma (e.g., PTSD, C-PTSD)
- Developmental disorders (e.g., Autism)
- Personality disorders
- General stress, coping, life changes

Bureau of Justice Statistics, 2006

Schizophrenia	Schizoaffective	Bipolar	Major Depression w/ Psychotic Features
Severe disorder of thought & perception, with accompanying disturbance in mood & behavior characterized by a loss of touch with reality:	Characterized by sx's of schizophrenia & sx's of a mood disorder, such as mania or depression.	Mood disorder characterized by extreme mood swings (emotional highs and lows) that affect sleep, energy, activity, judgment, behavior, and the ability to think clearly.	Mood disturbance accompanied by either delusions, hallucinations, or both.
• Hallucinations *(false sensory perceptions)* • Delusions *(fixed beliefs not amenable to change)* • Cognitive disorganization *(signs of internal confusion; speech, thought)* • "Negative" symptoms (*absence of experiences*) • Anosognosia *(lack of insight/inability to recognize own sx's).*	• A period during which there is a major mood disorder that occurs at the same time sx's of schizophrenia are present. • Delusions or hallucinations for 2+ weeks in the absence of a major mood episode • Symptoms that meet criteria for a major mood episode are present for most of the total duration of the illness	Mania (hypomania): • Abnormally upbeat, jumpy, wired • Increased activity, energy, agitation • Exaggerated sense of well-being and self-confidence • Decreased need for sleep • Unusual talkativeness • Racing thoughts • Distractibility • Poor decision making (buying sprees, hypersexuality, high-risk bx's)	• Depressed mood (sad, empty, hopeless, tearful) • Marked loss of interest or feeling no pleasure in all (or almost all) activities • Changes in appetite • Sleep disturbances • Restlessness or slowed bx • Fatigue or loss of energy • Feelings of worthless or excessive or inappropriate guilt • Decreased ability to think or concentrate; indecisiveness • Thinking about, planning, or attempting suicide
Typically diagnosed in late teens - early 30s. Tends to emerge earlier in males (late teens – early 20s) than females (early 20s – 30s)	Typically diagnosed between 25 – 35 years old. Tends to emerge earlier in men.	Typically diagnosed in teenage years, early 20s.	Typically diagnosed in older adults and/or later in life.

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WHAT IS BEING CRIMINALIZED?

Symptoms of Psychosis	Symptoms of Mood Disorder
• Hallucinations • Delusions • Confusing, disorganized thought processes • Confusing, disorganized speech • Social withdrawal • Inappropriate social behavior • Poor basic hygiene • Flat, restricted emotions • Lack of insight or inability to recognize one's symptoms, even when pointed out.	• Extreme happiness, excitement, or irritability • Excessive energy • Little need for sleep • Inability to concentrate • Racing thoughts • Rapid speech • Hypersexuality • High-risk/dangerousness behavior (shopping sprees, gambling, driving fast) • Grandiosity • Extreme sadness, anxiety, or irritability • Loss of energy; fatigue • Changes in appetite (eating too much or too little) • Changes in sleep (over/under sleeping) • Feelings of hopelessness, worthless • Thoughts, intentions, or plans of suicide

Cook County Jail

Population:
~4,689 in jail
~1,751 EM

25-30% with mental illness
(~1,610 – 1,932)

Rikers Island

Population:
~6,182

20% with SMI

Half have some kind of mental health diagnosis.

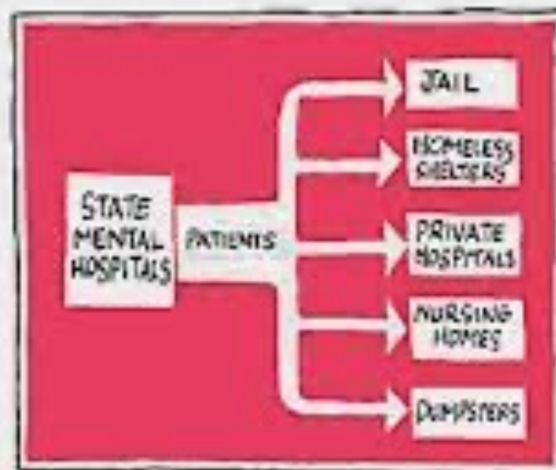
Los Angeles County Jail

Population:
~13,871

41% have mental health problems

Each individually houses more persons with mental illnesses than any psychiatric institution in the United States.

WE HAVE A PLAN THAT WILL SAVE EVEN MORE MONEY!


STATE MENTAL HOSPITALS
PATIENTS
JAIL
HOMELESS SHELTERS
PRIVATE HOSPITALS
NURSING HOMES
DUMPSTERS

1955

The number of mentally ill people in public psychiatric hospitals peaks at 560,000

1963

President JFK signs the Community Mental Health Act – federal funding for community-based care and treatment facilities

1965

Passage of Medicaid - states are incentivized to move patients out of hospitals because the program did not cover people in "institutions for mental diseases."

1971

Nixon declares a "War on Drugs"

1976

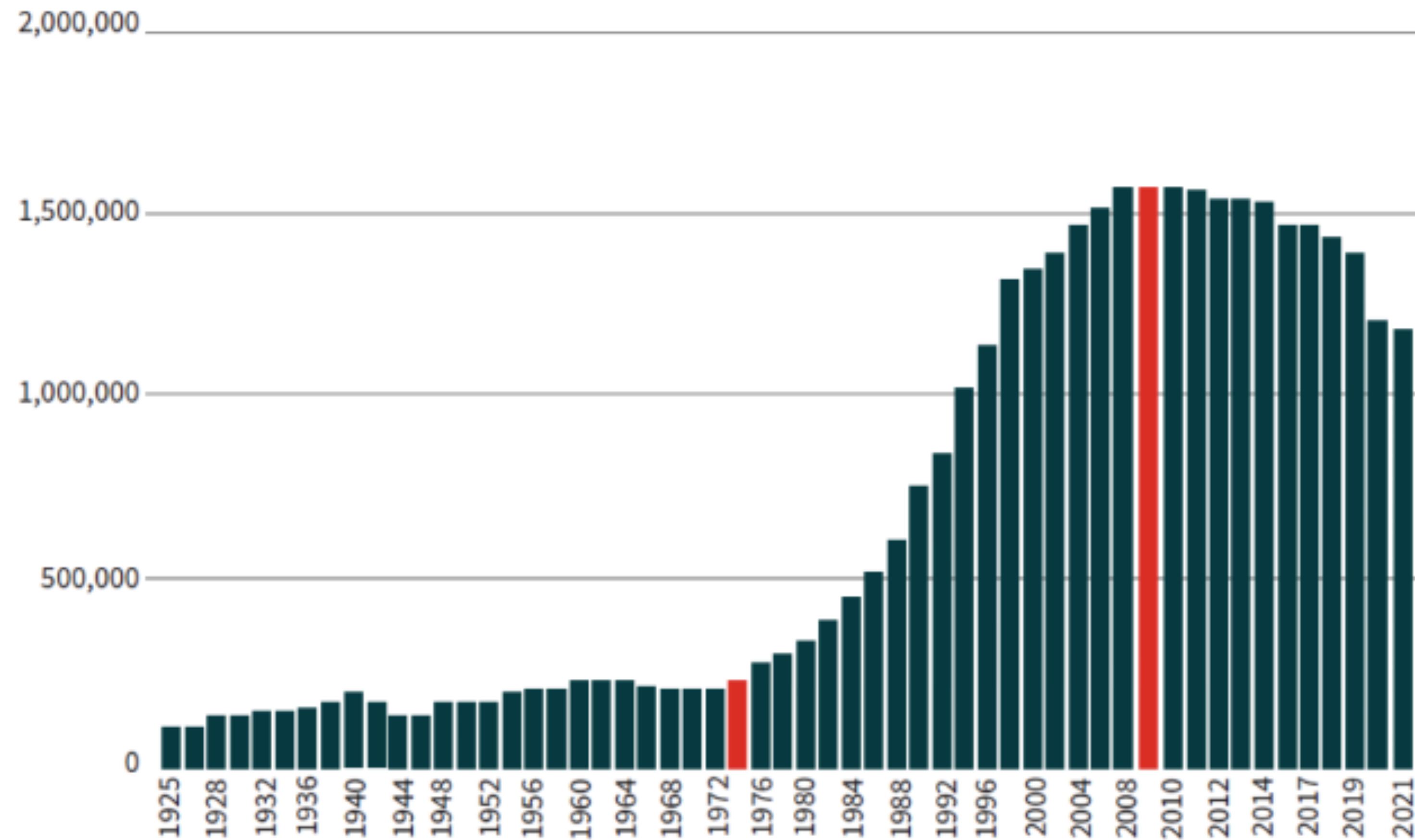
The U.S. Supreme Court, in *Lessard v. Schmidt*, tightened criteria for involuntary hospitalizations.

Estelle v. Gamble established that the deliberate failure of prisons to address medical needs of inmates constituted "cruel and unusual punishment."

1981

President Reagan repeals community health legislation and federal funding for mental health decreases by 30%.

Figure 1. U.S. State and Federal Prison Population, 1925-2021



Red bars = Start and peak years for the surge of mass incarceration

THE REMAINING NEED FOR INPATIENT, PSYCHIATRIC TREATMENT

- Despite the theory behind deinstitutionalization, there remains a small subset of people with serious, chronic mental illness who need inpatient hospitalization.
- Many of these people are incapable of seeking treatment voluntarily or paying for it privately and tend to only receive treatment when they decompensate enough to be civilly committed..
- Unfortunately, more and more hospital beds are being used by forensic patients.
  - In 2010, 33% of all public psychiatric beds went to forensic patients.
  - In some states, this was as high as 92%.
- As hospitals downsized, thousands of seriously mentally ill individuals who meet criteria for civil commitment are either:
  - Released from custody because there are no state psychiatric beds available, and/or
  - The emergency custody order expires before an order for a full evaluation can be obtained from the court

INCARCERATION AS FIRST FORM OF TREATMENT & INTERVENTION

- In a sample of low-income, predominantly African American patients hospitalized for first-episode psychosis, 57% reported a history of incarceration (mean = 2.9 +/- 3.4).
- Another study showed that 12% of adult psychiatric patients receiving treatment in the San Diego County health system had prior incarcerations, while 28% of Connecticut residents treated for schizophrenia and bipolar had been arrested or detained.
- During the period of 1993 – 2001, approximately 23.6% of individuals with serious mental illness had been arrested one or more times, mostly for non-violent crimes. Here, only 3% were diverted for community services in lieu of incarceration.
- Many individuals lack health insurance prior to incarceration, and Medicaid coverage is either suspended or terminated upon incarceration. Consequently, 90% of people released from jail lack coverage and thus, access to most health services.
- In 1976, the U.S. Supreme Court ruled in *Estelle v. Gamble* that failure to provide basic health care in correctional facilities violated the constitutional prohibition against cruel and unusual punishment. As a result, correctional facilities are mandated to provide adequate medical treatment.
  - This ruling occurred alongside other social and political movements that simultaneously limited the availability of mental health treatment and significantly increased the incarcerated population (i.e., War on Drugs, de-institutionalization & lack of funding for community mental health, Three Strike Laws, mandatory minimums and harsh sentencing revisions).
- By 1975, there were only 675 funded community mental health centers with 800 unfunded community mental health centers remaining.

$5 - 8x$

IMPACT

- Individuals with mental illnesses tend to remain in custody for longer periods of time that those brought in on similar charges who are not mentally ill.
- There are about 10x more individuals with SMI in jails and state prisons than in the remaining state hospitals.
- Mentally ill prisoners have higher than average disciplinary rates and are at increased risk of physical/sexual victimization, suicide, and placement in segregation or solitary confinement.
- Mental illness can impact an individual’s chance of parole and/or successful re-entry.

THE RISK OF UNTREATED MENTAL ILLNESS: DISCIPLINARY INCIDENTS

Formerly charged with disciplinary violations		
	With mental illness	Without mental illness
State inmates	58%	43%
Federal inmates	40%	28%

Fighting infractions		
	With mental illness	Without mental illness
State inmates	36%	25%
Federal inmates	21%	9%

James & Glaze (2006)
Ditton (1999)

THE RISK OF UNTREATED MENTAL ILLNESS: VICTIMIZATION

Rates of victimization by another inmate		
	With mental illness (male inmates with either schizophrenia or bipolar dx)	Without mental illness
Physically victimized	31%	18%
Sexually assaulted	10%	3%

Rates of victimization by staff		
	With mental illness	Without mental illness
Physically victimized	27%	24%
Sexually assaulted	9%	7%

Blitz, Wolff, & Shi, 2008
Blitz, Wolff, & Shi, 2007

THE RISK OF UNTREATED MENTAL ILLNESS: SELF-HARM & SUICIDE

30% of inmates engage in self-injurious behavior.

Self-harm most often occurs in maximum-security lockdown units.

Often minimized as attention-seeking or manipulative.

340 persons in state & federal prisons died by suicide in 2019.

Suicides accounted for 30% of deaths in local jails and 8% of deaths in state and federal prisons

It's estimated that about 50% of individuals who committed suicide had a serious mental illness.

Appelbaum et al. 2011
U.S. Dept. of Justice, 2021

THE RISK OF UNTREATED MENTAL ILLNESS: SOLITARY CONFINEMENT & SEGREGATION

- Inmates in crisis, who are persistent management problems or who may pose a danger to themselves or others, are often segregated from the general population.
- Being on lockdown for up to 23 hours a day can produce or aggravate mental health problems.
- Solitary confinement and segregation can have long-lasting effects on an individual's mental and physical health.
- A national survey of wardens indicated unanimous support for supermax-type facilities.

Haney (2003)
Mears & Castro (2006)

MENTAL HEALTH & PAROLE DECISION MAKING

- Research has been somewhat inconsistent on the extent to which mental health has a negative impact (or no/limited impact) on parole decision-making.
- A 1994 study found that inmates with previous psychiatric hospitalizations were 30x less likely to be released for parole compared to those who never had a psychiatric hospitalization, even controlling for race, prison infractions, and the violence of the current offense.
- A separate study found that the presence of psychological problems was associated with a smaller chance of being parole.
- This is an understudied area where attitudes of parole board members can vary depending on geography, appointment, and other factors.
- Compassionate release: incarceration shortens life expectancy due to years of trauma and inadequate access to medical and mental health care.

Mental Health Risk Factors and Parole Decisions: Does Inmate Mental Health Status Affect Who Gets Released (2019)

Table 10

REASONS GIVEN BY SENTENCING COURTS FOR FOR GRANTED MOTIONS[1]
Fiscal Year 2023, 3rd Quarter

REASONS	N	%
Rehabilitation[2]	76	14.0
Serious physical or medical condition (USSG §1B1.13, Note 1(A)(ii))	68	12.5
COVID-19/pandemic	46	8.5
Missing/no reason provided	46	8.5
Other mandatory minimum penalties/long sentence	35	6.4
Terminal illness (USSG §1B1.13, Note 1(A)(i))	34	6.3
Career Offender issues	32	5.9
Multiple 18 U.S.C. § 924(c) penalties	30	5.5
21 U.S.C. § 851 enhanced drug penalties	28	5.2
Nearly meets requirements of USSG §1B1.13, Notes (1)(A)-(C)	20	3.7
BOP failure to provide treatment	15	2.8
Family circumstance - care for minor child (USSG §1B1.13, Note 1(C))	14	2.6
Age 65 and deteriorating health and served 10 years/75% (USSG §1B1.13, Note 1(B))	11	2.0
Deteriorating physical or mental health due to aging process (USSG §1B1.13, Note 1(A)	10	1.8
Conviction/sentencing errors	10	1.8
Extraordinary and compelling (not specified)	8	1.5
Mandatory nature of guideline at sentencing	6	1.1
Guideline amendment	5	0.9
Safety Valve disqualification	4	0.7
Family circumstance - care for spouse or registered partner (USSG §1B1.13, Note 1(C))	3	0.6
Serious functional or cognitive impairment (USSG §1B1.13, Note 1(A)(ii))	2	0.4
ACCA issues	1	0.2
Other	39	7.2
TOTAL	**543**	**100.0**

"Mentally ill prisoners can find themselves in a vicious circle. Mental illness leads to discipline or victimization problems, which leads to solitary confinement and decompensation. This worsens mental illness and results in further discipline or victimization with further segregation. Mentally ill prisoners suffer these harms for longer periods of time because they serve, on average, fifteen months longer for the same crimes than do the non-mentally ill. Since their illnesses often prevent them from engaging in prison programming that results in the acquisition of 'good time' credits, the mentally ill prisoners also tend to serve a greater percentage of their sentences."

Ball, W.D. (2007). Mentally ill prisoners in California Department of Corrections and Rehabilitation: Strategies for improving treatment and reducing recidivism. *Journal of Contemporary Health Law & Policy, 24* (1), 1 – 42.

CO-OCCURRING DISORDERS: MENTAL HEALTH & SUBSTANCE USE

- Substance use disorders often occur simultaneously in individuals with mental illness, usually to cope with overwhelming, uncomfortable, or painful symptoms.
- In 2020, an estimated 17 million U.S. adults experienced both mental illness and a substance use disorder.
- Some research suggests that as many as 85% of individuals incarcerated in state prisons have an active substance use disorder or were incarcerated for a crime involving drugs or drug use.
- There is a strong link between trauma exposure and substance use problems.
- The best treatment is integrated intervention, when a person receives care for both their diagnosed mental illness and substance use disorder.

TRAUMA:
IT IS UNIVERSAL

- Adverse Childhood Experience (“ACE”) Study
- Between 1995 and 1997, Kaiser Permanente conducted a large-scale study to investigate the impact of childhood abuse and neglect, along with other household challenges, on later-life health and well-being.
- All responses refer to participants’ experiences during their first 18 years of life.
- ACEs are categorized into three groups: abuse, neglect, and household challenges, with additional subgroups.

ACEs are **common** across all populations.

66% reported at least one ACE

20% reported three or more ACEs

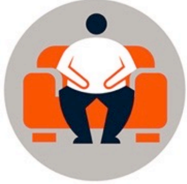
"America's health crisis."

Close relationship between ACEs and negative health and well-being outcomes.

Some populations are more vulnerable to experiencing ACEs because of social & economic factors.

Trauma rarely happens alone: If there is one ACE, there's an 87% chance there are others.

BEHAVIOR


Lack of physical activity

Smoking

Alcoholism

Drug use

Missed work

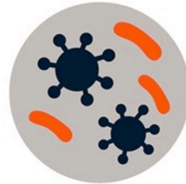
PHYSICAL & MENTAL HEALTH

Severe obesity

Diabetes

Depression

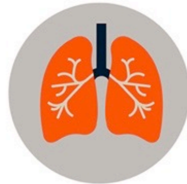
Suicide attempts


STDs

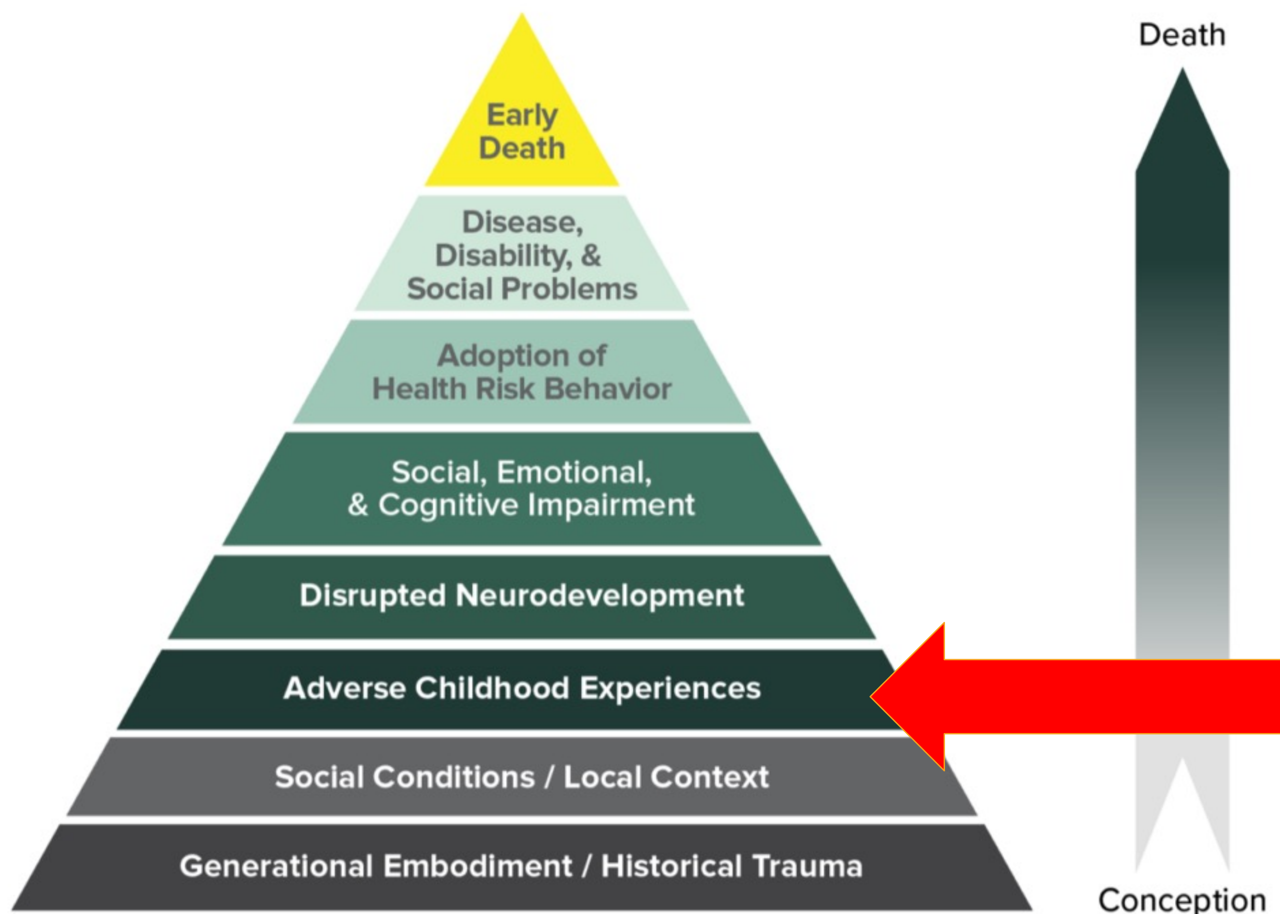
Heart disease

Cancer

Stroke


COPD

Broken bones



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

CORTEX

Creativity, "thinking," language, values, time, hope

LIMBIC

Reward, memory, bonding, emotions

DIENCEPHALON

Arousal, sleep, appetite, movement

BRAINSTEM

Temperature, respiration, cardiac

Perry, B. & Winfrey, O. (2020). What happened to you? Pg. 27

TRAUMA

- In community samples, PTSD is associated with poor social and family relationships, absenteeism from work, lower income, and lower educational and occupational success.
- Even before entering jail or prison, incarcerated people are more likely than those in the community to have experienced abuse and trauma.
- PTSD is more prevalent among women than men across the life span.

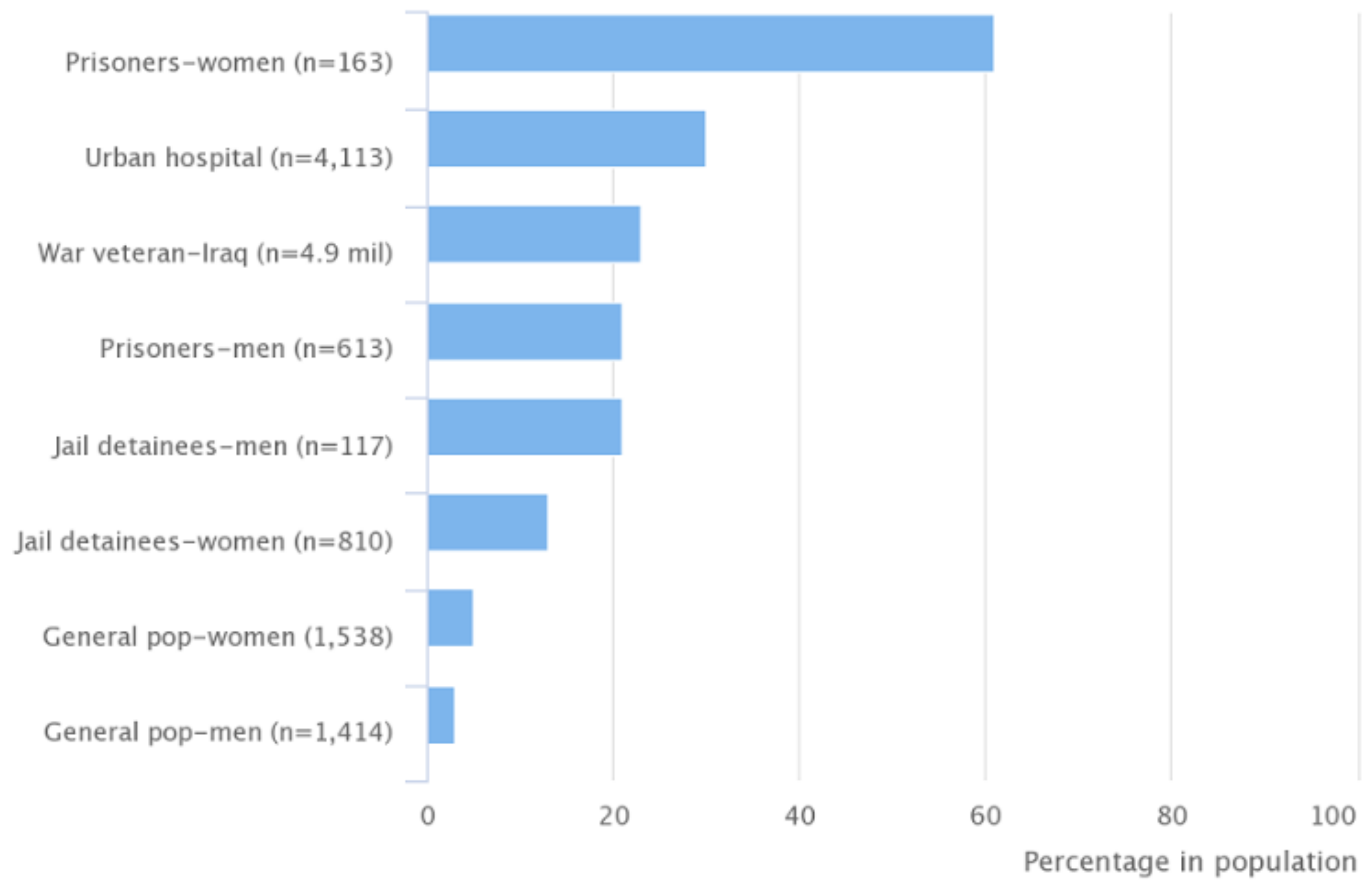


FIGURE 1
PREVALENCE OF PTSD BY POPULATION
Prisoners–women (n=163)
Urban hospital (n=4,113)
War veteran–Iraq (n=4.9 mil)
Prisoners–men (n=613)
Jail detainees–men (n=117)
Jail detainees–women (n=810)
General pop–women (1,538)
General pop–men (n=1,414)
0
20
40
60
80
100
Percentage in population

SYMPTOMS OF TRAUMA

Recurrent, involuntary, or intrusive memories	Reliving or reexperiencing (flashbacks)	Trying to avoid thinking or talking about the event	Negative thoughts about yourself, other people, or the world	Hopelessness about the future	Memory problems, including not remembering aspects of event
Severe emotional distress or physical reactions to reminders	Upsetting dreams or nightmares	Avoiding people, places, or activities that remind you	Difficulty maintaining close relationships	Feeling detached from family and friends	Lack of interest in activities you once enjoyed
Difficulty expressing positive emotions	Feeling emotionally numb	Trouble sleeping	Trouble concentrating	Overwhelming guilt or shame	Thoughts of self-harm, suicide
Being easily startled or frightened	Always being on guard for danger (hypervigilance	Self-destructive behavior	Irritability, angry outbursts, or aggression	Persistent thoughts about the cause or consequences; blame	Feeling detached from reality

WHAT IS CRIMINALIZED?

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What are components of incarceration that may lead to re-traumatization?

CARCERAL RE-TRAUMATIZATION

- Constant surveillance
- Use of isolation
- Noise
- Searches, restraints
- Discipline
- Threats of violence and abuse
- Lack of trust in staff, people, surroundings
- Limited opportunities for personal care/healthy coping
- Limited access to treatment (or removal from treatment as a 'consequence')
- Barriers to meaningful connection with family, friends, and other supports
- Policies based on security and control.
- Poor medical care
- Few meaningful employment or educational opportunities

What happens when individuals with untreated (and/or exacerbated) trauma re-enter the community?

TRAUMA & RE-ENTRY

- Research suggests that many individuals continue to experience trauma after release.
  - In one study, 47% of participants experienced at least one traumatic event within 8 months after their release from incarceration.
- Incarceration tends to worsen mental health symptoms.
- Stress due to employment, stable housing, positive social supports
- Barriers to accessing medical/mental health services.
- "Post incarceration syndrome"
- Distrust of others, difficulty in relationships, difficulty problem-solving and decision-making, sensory disorientation, social & temporal alienation (not feeling like you belong in social situation).

TRAUMA & ADDICTION

- Traumatic experiences change the brain.
- Trauma makes the brain more prone to addictive behaviors because:
  - The impact of trauma on brain circuitry and neurochemistry: the brain desires addictive substances to feel better.
  - Trauma is incredibly painful, and all addictions are attempts to escape from pain.
- Traumatized people are more likely than others of similar backgrounds to abuse alcohol both before and after being diagnosed with PTSD.
  - Men and women reporting sexual abuse have higher rates of alcohol and drug use disorders than other men and women.
  - Up to 80% of Vietnam veterans seeking PTSD treatment have alcohol use disorders.
  - Adolescents with PTSD are 4x more likely than adolescents without PTSD to experience alcohol use/dependence, 6x more likely to experience marijuana use/dependence, and 9x more likely to experience hard drug abuse/dependence.

International Society for Traumatic Stress Studies, Traumatic Stress and Substance Abuse Problems

MENTAL HEALTH SERVICES IN CORRECTIONAL SETTINGS

- *Ruiz v. Estelle* (1980) established the fundamental components of a mental health treatment plan for inmates, which remain in effect today.
  - Screening and evaluation; suicide prevention; availability of trained mental health professionals; treatment, not just segregations or supervision; appropriate use of psychiatric medications; proper maintenance of confidential records of treatment.
- Americans with Disabilities Act (ADA) mandates reasonable accommodations for all disabled, including inmates.
- Unfortunately, the goal of most correctional health systems is to merely stabilize and to facilitate the maintenance of the individual in general population, minimizing the need for limited and specialized services.
- Issues such as understaffing, poor screening and tracking of mentally ill offenders, misdiagnoses, long waitlists for programming, and concerns related to proper medication and adequate access to care remain.
- The physical and social environments run counter to the promotion of coping/life skills appropriate for life after release.
- Services are often diluted and manualized with access barriers (e.g., literacy, ability) and often occur in group settings.
- Difficult to find appropriate medication regimen (trial and error, significant side effects)

HOPES & DREAMS FOR TREATMENT

- Mental health treatment ought to resemble community-based treatment.
- Clinicians with proper training and caseload availability for short- and long-term therapy.
- Diversification of available treatment modalities, including opportunities for trauma treatment.
- More opportunities for remote access to care (i.e., telehealth).
- Trauma-informed revision of policies, practices.
- Opportunities to practice and apply, realistically, skills and insight that more closely resemble life post-release.

SOURCES

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- Cook County Sheriff's Department
- Los Angeles Almanac: Los Angeles County Jail System By The Numbers
- Bureau of Justice Statistics, Special Report, Mental Health Problems of Prison and Jail Inmates (2006)
- From Handcuffs to Hallucinations: Prevalence and Psychosocial Correlates of Prior Incarcerations in an Urban, Predominantly African American Sample of Hospitalized Patients with First-Episode Psychosis, National Institute of Health, 2011.
- Trauma-Informed and Evidence-Based Practices and Programs to Address Trauma in Correctional Settings, Illinois Criminal Justice Information Authority
- International Society for Traumatic Stress, Traumatic Stress and Substance Abuse Problems
- Brain reward circuitry: The overlapping neurobiology of trauma and substance use disorders (2021)
- *Brad H. v. City of New York,* 2000. This article includes a link to the settlement agreement. Settlement had to be extended several times, now through 2025.
- *Wakefield v. Thompson* (1999). The Ninth Circuit held that prison officials must provide a supply of medications to prisoners requiring medication when they are released from prison.
- The Sentencing Project: Mass Incarceration Trends
- Mental Health Risk Factors and Parole Decisions: Does Inmate Mental Health Status Affect Who Gets Release (2019). National Library of Medicine.
- Mental and Physical Health Problems as Conditions of Ex-Prisoner Re-Entry (2021)
- The Criminalization of Mental Illness: Crisis and Opportunity for the Justice System (2021), Third Edition
- The Rise and Demise of America's Psychiatric Hospitals (2019).
- How Solitary Confinement Contributes to the Mental Health Crisis (2023), National Alliance on Mental Illness (NAMI)
- Preliminary FY 2023 Compassionate Release Data (through 3rd Quarter), U.S. Sentencing Commission

RESOURCES FOR FURTHER SELF-STUDY

Videos:

- How childhood trauma affects health across a lifetime.
- Learn the signs and symptoms of PTSD.
- How the body keeps the score on trauma.
- Anderson Cooper tries a schizophrenia simulator.
- TEDx Talk: My journey through schizophrenia and homelessness.
- TEDx Talk: The Criminalization of the Mentally Ill

Books:

- The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma by Bessel van der Kolk
- What Happened to You? Conversations on Trauma, Resilience, and Healing by Oprah Winfrey and Bruce Perry
- In the Realm of Hungry Ghosts: Close Encounters with Addiction by Gabor Mate
- Insane: America's Criminal Treatment of Mental Illness by Alisa Roth

Other Resources:

- The National Child Traumatic Stress Network
- Trauma-Informed Care Implementation Resource Center
- American Bar Association's book on Trauma-Informed Lawyering
- The Trauma-Informed Lawyer Podcast

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