UCR School of Public Policy
ROBERT PRESLEY CENTER OF CRIME & JUSTICE STUDIES

Bulletin

Volume 2, Issue 2 June 2021

PROFILING THE PREVALENCE OF MENTAL HEALTH ISSUES in the CRIMINAL JUSTICE SYSTEM

United States

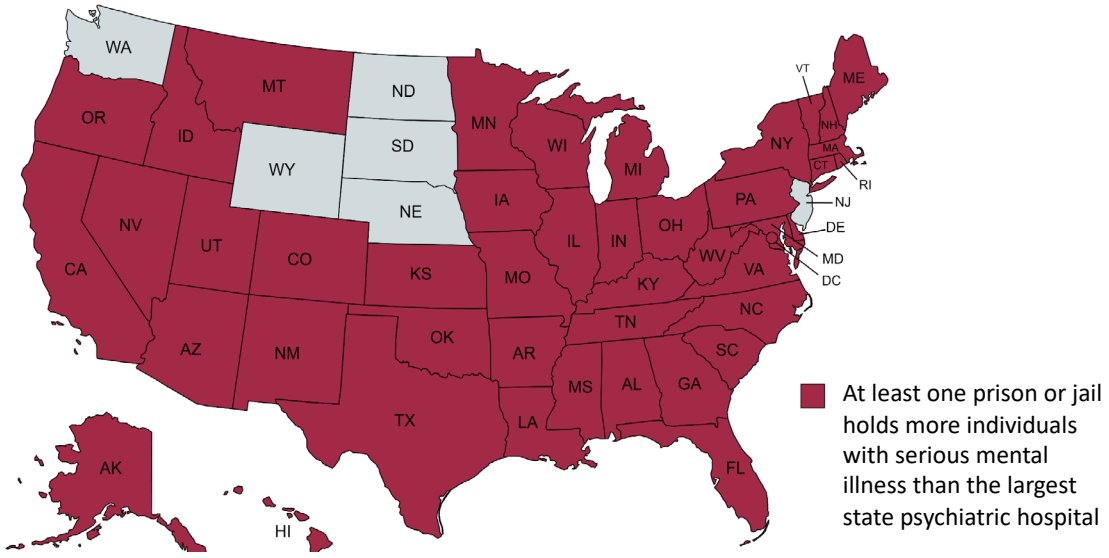
The proliferation of psychotropic medications, a reduction in government spending on mental health, and changing norms emphasizing the treatment of mental illness over indefinitely housing the mentally ill, contributed to the deinstitutionalization of mental health services over the latter half of the 20th century. America's prisons and jails are the "new asylums", with forty-four states having at least one prison or jail that houses more individuals with serious mental illness than the largest psychiatric hospital operated by the state (see Figure 1). In some parts of the United States, psychiatric treatment is more accessible in jail than in the community. [1]

That is not to say prisons or jails are necessarily well-equipped to house or treat those with mental illness. In 2018, the Treatment Advocacy Center sought to systematically evaluate the services and programs provided to individuals who are incarcerated and experiencing mental health issues. State efforts were evaluated based on ten best-practice criteria, including the extent to which the state's corrections system prioritized mental health by having an adequate number of psychiatric beds, adequate psychiatric treatment, and community release treatment teams. Together, these programs and services are rooted in evidence-based practice and known to decrease the likelihood of re-arrest among those with mental illness (see Figure 2).

State is making an excellent effort and has most components of a model program.	No state received an A grade
State is making a commendable effort and has many components of a model program.	B+: HI, ME, MO, OR B: CA, CT, LA, OH, TN, WA, WI B-: CO, GA, MN, NY, VA
State is making a modest effort and has some components of a model program	C+: MI, OK C: AZ, AR, IL, KY, MD, SC C-: NV, NH, RI, UT, WV
State is making a small effort and has few components of a model Program	D+: DE, KS, ND D: AL, FL, NE, NJ, PA, SD, VT D-: IA, MT, NC
State is making almost no effort	F: AK, ID, IN, MA, MS, NM, TX, WY

Adapted from https://www.treatmentadvocacycenter.org/grading-the-states

Figure 2



Adapted from https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf

Figure 1

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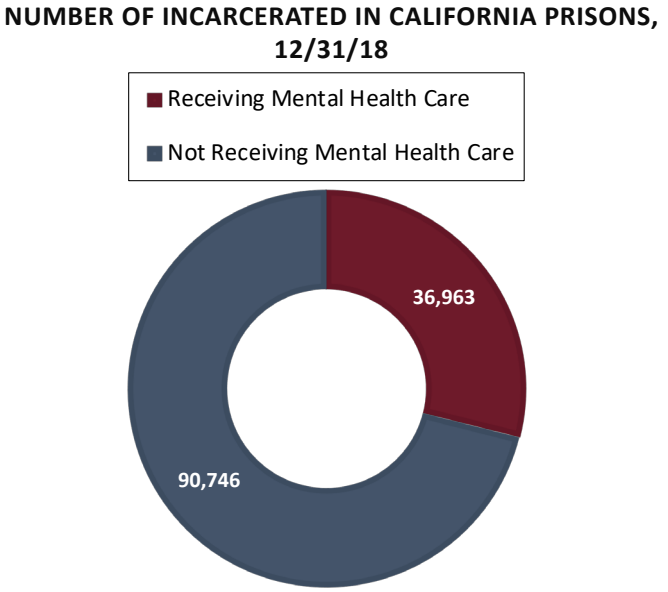


Adapted from: https://calbudgetcenter.org/resources
Figure 3

Only nineteen of the forty states that responded to the survey received a grade of 'C' or better. Notably, California earned a 'B' and is credited with, "making a commendable effort [that] has many components of a model program."[2] However, having the components of a model program does not necessarily translate into successful outcomes overall and the efficacy of some of these programs are profiled in subsequent sections.

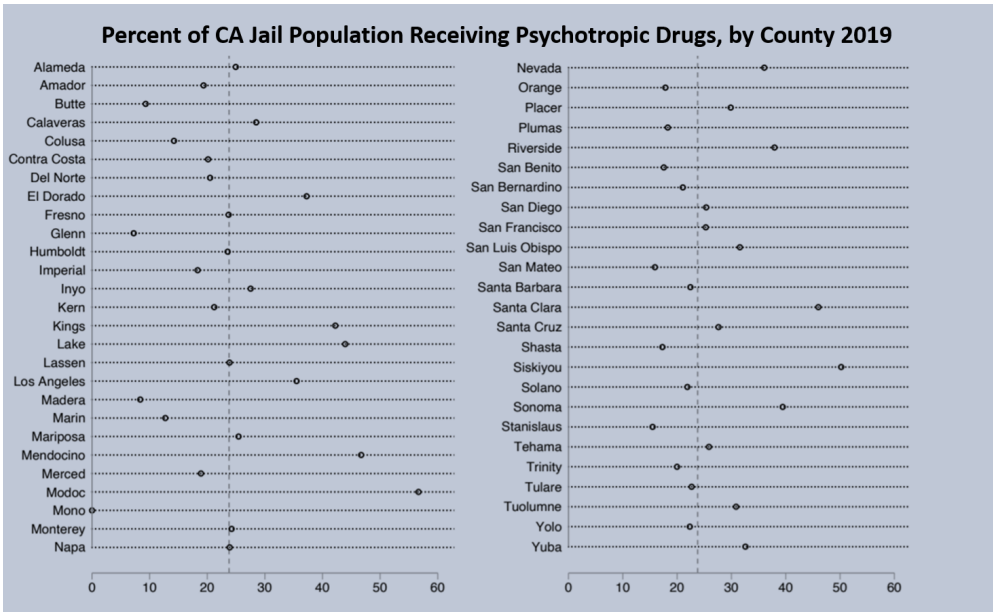
California & Our Region

More than one in four people incarcerated in California's prisons receive mental health care (see Figure 3). In 2019, the Los Angeles County jail system identified more than 5,000 of its 15,000 inmates as having mental illness, making it the single largest mental illness treatment center in the nation.[3] Roughly 20% of offenders in San Bernardino County and 35% in Riverside County are prescribed psychotropic medication while in jail, compared with 23% across all counties in California (see Figure 4). Nearly 40% of Riverside County's average daily jail population are classified as having an active mental health case.

THE PUZZLE

The predominant model of dealing with issues of mental health within the criminal justice system relies heavily on incarceration, is expensive, and largely ineffective at preventing re-arrests. In 2019, the average cost of keeping someone in prison in California was over $81,000[4] and offenders diagnosed mental illness are more likely than their counterparts to recidivate, regardless of the severity of their diagnosis.[5]

The overwhelming number of system-impacted individuals with mental illness begs the question: what can be done to reduce reliance on incarceration as a mental health solution and improve outcomes for those with mental illness? For alternatives, we look to states and counties that have piloted programs at each stage of the justice system – law enforcement, the courts, the correctional system, and upon re-entry.



Adapted from: https://calhps.com/wp-content/uploads/2020/02/Jail_MentalHealth_JPSReport_02-03-2020.pdf
Figure 4

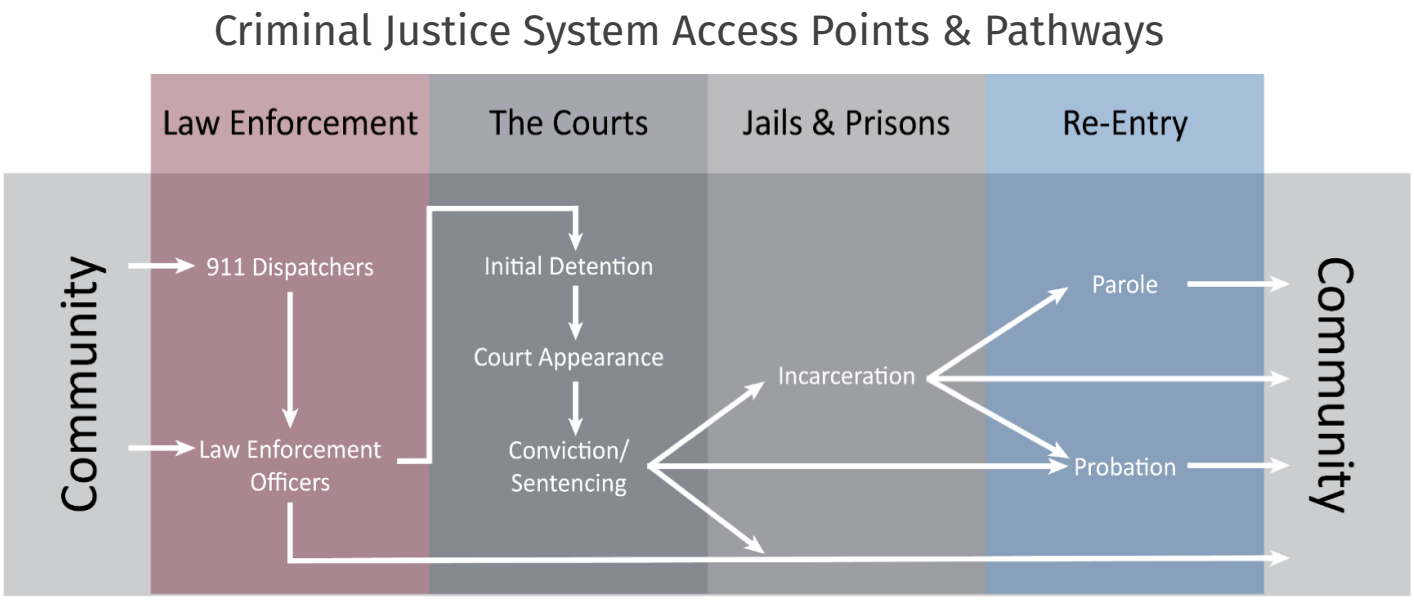


Figure 5

RESEARCH TESTED INTERVENTIONS

Without a large-scale or system-wide solution, individual states, counties, cities, and criminal justice agencies have developed their own response to the deinstitutionalization of mental health care. These solutions are typically locally-led, implemented across the life cycle of an individual's involvement with the criminal justice system, and are best understood through the lens of the different 'access points' or phases of the system (see Figure 5). In the sections below, some of the most common responses and accommodations for those with mental illness who are system-impacted are profiled alongside research that speaks to the effectiveness of these interventions.

Law Enforcement

Without adequate funding for mental health services, law enforcement has stepped into the role of frontline medical interventionists when responding to disturbances involving someone with mental health issues. When a 911 call is made regarding a situation involving someone with mental illness, police officers are the first to respond and de-escalate the situation.

The Crisis Intervention Team (CIT) model, also known as the "Memphis Model" was first piloted in Tennessee after a man with a history of mental illness and substance abuse was fatally shot by an officer. The officer acted in accordance with his training, which at the time did not include any special consideration for those with mental illness.[6] As a response, the CIT model provides specialized training to officers so they are able to recognize and de-escalate situations involving mental health concerns and refer individuals to treatment or make a transfer to a psychiatric emergency department if the situation is dire. It also requires the cooperation of the community, an accessible crisis system, training for behavioral staff to understand law enforcement's unique challenges, and community education. To-date, over 1,000 CIT programs have been adopted internationally and the additional education they provide is widely accepted to be a positive addition to officer training.[7]

Research on the success of the CIT model in diverting mentally ill offenders from entering the criminal justice system and protecting officer safety is mixed.

Studies that ask officers about their experience using CIT report overwhelmingly positive findings. Officers who participate in CIT training report feeling better equipped to respond to calls involving someone with mental illness and are better able to identify those cases upon arrival than their non-CIT peers.[8] Notably, officers with CIT training also report a better understanding of local mental health

teams, a reduction in the perceived stigma associated with mental illness, and are more likely than their non-CIT colleagues to say they will consider diversion instead of discretionary arrest.[9] Officers self-report similar findings when applying their CIT training in juvenile populations.[10]

These positive self-reports reflect officers' opinions and suggest CIT training is working, but studies that test the causal relationship between CIT and decreased arrest rates for those with mental illness find less support. A comprehensive review of rigorous evaluations of CIT models in Ohio, Kentucky, Florida, Indiana, Illinois, and Georgia found no effect of CIT on arrest rates for those with mental illness and no effect of CIT on actual officer safety.[11] These mixed findings may be due to the variation between CIT programs and contextual differences. For example, a critical component of the CIT model is the availability of psychiatric emergency drop-off services with no refusal policies, so officers know they can transport someone and return to policing in a timely manner. However, only ~30% of CIT programs have formal agreements with emergency psychiatric facilities that actually allow officers to quickly transport an individual and return to policing.[12] In the absence of an accessible drop-off, officers may feel inclined to arrest even if they would prefer to divert someone with mental illness to treatment simply because they do not have the time to contact multiple facilities and find placement.[13]

While there has not been enough conclusive research on CIT for it to receive the gold stamp of being an 'evidence-based practice,'[14] it is a promising practice in that the training makes officers feel more assured when responding to mental health calls, encourages collaboration with mental health practitioners, and opens the door to diversion as an alternative to incarceration. Additional research is necessary to identify why CIT helps in some cities, but not in others.

Other localities have developed crisis treatment models that attempt to avoid law enforcement involvement when possible. Oregon's Crisis Assistance Helping Out on the Streets (CAHOOTS) is a community policing model that dispatches a medic and crisis interventionist to respond to non-violent 911 calls involving mental health issues. For over thirty years, CAHOOTS has safely responded to 911 calls, diverted individuals into treatment, and worked with police if situations turn into an emergent public safety threat. By providing a means of circumventing law enforcement, CAHOOTS is also cost-effective and saves taxpayers in Eugene and Springfield roughly nine million dollars per year. Many cities and states have solicited information from CAHOOTS amid recent calls for police reform, but CAHOOTS has made it clear they believe their model can only be successful if there are supportive mental health and treatment resources that individuals can be referred to in the area.

During recent calls for police reform, some advocates argue there should be a complete decoupling of mental health intervention from law enforcement. This position includes de-funding the police and diverting those resources into outreach interventionists, improved treatment programs, and related supportive services, regardless of the efficacy of models like CIT and CAHOOTS.

Law Enforcement in the Inland Empire

Riverside and San Bernardino counties have similar approaches in that both provide training to officers, but they also go a step further by having crisis intervention teams of clinical therapists, behavioral health specialists, and peer support specialists that respond with officers on the frontlines. The goal of these programs is to provide supportive care for those with mental health issues, while decreasing the need for inpatient hospitalizations and the amount of time law enforcement officers must dedicate to individuals in psychiatric crisis.

The Courts

Mental health courts (MHCs) are an alternative to traditional courts that are available in some localities for defendants whose mental illness contributed to the crime they committed. An individual must agree to have their case heard in a MHC and the primary goal is to support the individual's quality of life and successful re-entry through supportive services and treatment, while balancing concerns for public safety. MHCs are similar to the CIT model in that they are intended to be highly collaborative with actors outside of the criminal justice system and bring treatment options directly to the individual experiencing mental health issues.

Of the three large studies to comprehensively review the effect of MHCs, two found that having a case heard in a MHC, as opposed to a traditional court, was correlated with a slight decrease in the likelihood of re-arrest.[15] The third found mixed evidence for a decrease in re-arrest, but noted MHCs' success is in decreasing the severity of the final charges brought against the individual with mental illness and the length of time they are incarcerated.[16]

Disregarding the somewhat mixed finding on recidivism, it is promising that MHCs decrease the length of incarceration without an apparent effect on public safety as incarceration is widely documented to adversely affect mental health, particularly among those predisposed to mental illness.[17] Sentencing someone with mental illness to prolonged incarceration – particularly when there are diversion programs available – stands to further destabilize their mental health and may make them more likely to interact with the criminal justice system in the future.

The Courts in the Inland Empire

Riverside and San Bernardino counties have established MHCs that bring members of the justice system, mental health providers, and other supportive service providers under the coordination of a MHC judge. Both counties also have Homeless and Veteran courts, which provide a similar approach for special populations and are often used by those with mental illness given the higher rates of mental illness among our homeless and veteran populations. to interact with the criminal justice system in the future.

Jails & Prisons

Jails and prisons are able to provide psychiatric treatment to varying degrees, but research has found these resources are often delayed, resulting in a lapse in treatment for chronic mental illness, or are reserved for the most seriously and obviously mentally ill. For example, a nationally representative study of prisoners in the United States found that of those who reported taking medication for mental health issues at the time of their admission to prison, less than 50% were provided continuing medication once incarcerated. Those most likely to continue to receive their medication were those with serious and outward mental illness (e.g. schizophrenia), while conditions like depression went untreated.[18] Alternative mental health treatments (e.g. psychotherapy, etc.) are much less available in jails and prisons than pharmacotherapy.[19]

Recognizing time and resource constraints may preclude intensive alternative therapies, most research suggests better screening tools be developed to reliably assess an inmate's mental health status upon admission and throughout their incarceration. Such evaluation would decrease lapses in treatment and help ensure all inmates are receiving continued support for their mental health while incarcerated.

Prisons in California

Over the past twenty-five years, California has been taken to task over how it treats and houses those with mental illness within the state prison system. In *Brown v. Plata* (2010), the Supreme Court ruled California's prison overcrowding deprived inmates of adequate mental health care that violated the 8th Amendment's protection against cruel and unusual punishment. The 9th Circuit's decision in *Coleman v. Newsom* (2020) offered additional specific insight, noting the California state prison system violated the 8th Amendment and needed to take remedial action in the areas of screening, treatment programs, staffing, record keeping, medication distribution, and suicide prevention. The California Department of Corrections and Rehabilitation's (CDCR) Mental Health Program is now charged with ensuring all patients have access to mental health services in the least restrictive environment possible. This includes the CDCR's operation of two standalone psychiatric hospitals for those who require intensive, inpatient treatment.

Re-Entry

Roughly 600,000 offenders are released from jails and prisons in the United States every year. There are many well-documented barriers to successful community re-entry and an individual's mental health issues often complicate this transition. Because those with mental illness often also experience substance abuse issues, the likelihood of them being homeless or hospitalized quickly upon discharge is much greater than for the general population.[20] Moreover, those who transition from one 'system of care' to another and have mental illness, self-report high levels of strain as they attempt to navigate re-entry.[21]

Community re-entry approaches vary substantially across counties and states, but there is broad agreement that mentally ill offenders require additional supportive services to aid in their re-entry and decrease the likelihood of them recidivating.

For those processed through the federal re-entry court, criminogenic cognitive behavioral therapy is often prescribed as a post-release condition.[22] Other systems assign peer re-entry specialists to ease the burden of community re-entry by lending their shared, lived experience and by helping them in daily tasks, including providing transportation, assisting with job interviews, and serving as an accountability partner in treatment programs. Peer specialists have been found to be effective at improving re-entry outcomes among men and women. Day reporting centers and other 'one stop shop' models that offer housing, treatment, employment, and other rehabilitative services under one roof are yet another method of supporting re-entry. Two studies that evaluated day reporting centers' impact on participants with mental illness found completion of the day reporting center program was associated with a 40% decrease in the likelihood of reoffending, with the caveat that older offenders and offenders with strong histories of substance abuse were less likely to enjoy the benefits of the program. [23]

Re-Entry in California & the Inland Empire

The State has invested in 29 day reporting centers that provide non-medical supportive services, including counseling, during community re-entry. Riverside and San Bernardino counties also have day reporting centers that allow probationers to volun-tarily take advantage of wrap-around services, some of which support mental health.

THE SOLUTION

There is no easy or singular solution to the complex issues of mental health and the criminal justice system. Over the past thirty years, community-based treatments – like crisis response teams, specialized courts, and supportive re-entry services – have shown great promise in establishing humane, cost-effective alternatives to incarceration. The mixed research findings should not be taken as evidence of the failure of these programs; rather, these studies highlight the unique needs of each community and the importance of locally-tailored solutions. The criminal justice system can work toward tested, evidence-based practice in this area if piloting and evaluating programs in different contexts is prioritized. ■

To learn more about emergency mental health services available in Riverside and San Bernardino counties, please visit the websites below.

Riverside
https://www.rcdmh.org/Crisis-Resources/County-Mental-Health-Triage-Services

San Bernardino
https://wp.sbcounty.gov/dbh/crisis-services/

A LOOK BACK AT PRIOR ISSUES

Volume 2, Issue I: Bail Reform | Volume 2, Issue 1 of the Presley Center Bulletin focused on Proposition 25 (2020), which sought to replace California's use of cash bail with pre-trial risk assessments that would allow defendants to be released under the least restrictive, non-monetary conditions. Proponents of the measure argued California's system disproportionately detained low-income and minority populations - not because they posed a greater risk to public safety, but because they were unable to afford their bail. On November 3rd, 55.4% of California voters cast their ballot to maintain the cash bail system.

Since the election, the California State Supreme Court issued a unanimous ruling in the case In re Humphrey that requires judges must consider an arrestee's ability to pay bail in an effort to ensure no one is held in jail solely because of their ability to pay. Justice Cuellar authored the opinion, noting "the common practice of conditioning freedom solely on whether an arrestee can afford bail is unconstitutional,". The decision stops short of eliminating cash bail altogether, as Prop 25 could have, but requires judges to set reasonable bail based on whether the detained is (1) a threat to public safety and (2) a flight risk.

Volume 1, Issue II: COVID-19 & Public Safety | Volume 1, Issue II was published three months into the COVID-19 pandemic and summarized the most common strategies law enforcement was taking to protect against the spread of the virus, while balancing public safety concerns. These included measures like early release of offenders, a reduction in jail admissions, the elimination of medical co-pays, the prohibition of visitors, and the reduction of the costs of video and telephone calls. The Presley Center reviewed research on each measure and hypothesized these strategies were unlikely to increase crime if prior findings held under the new circumstances of the COVID-19 pandemic.

Now, enough time has passed that research is able to start unpacking the actual impact of the COVID-19 pandemic on public safety. A recent study compared forecasted crime rates with actual crime rates during the early months of the pandemic and found crimes like serious assaults in-public and commercial burglary remained about the same, while motor vehicle theft and residential burglary slightly decreased. Continued research in this area will allow for a more refined understanding of the impact of COVID-19-related changes within the criminal justice system on public safety.

Visit https://presleycenter.ucr.edu/bulletins for prior issues

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ROBERT PRESLEY CENTER
OF CRIME AND JUSTICE STUDIES
University of California, Riverside
School of Public Policy
Interdisicplinary North 4022
900 University Avenue
Riverside, CA 92521