

BEST PRACTICES IN TREATING MENTALLY ILL OFFENDERS
IN THE CRIMINAL JUSTICE SYSTEM

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BEST PRACTICES IN TREATING MENTALLY ILL OFFENDERS IN THE CRIMINAL
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Abstract

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Since the deinstitutionalization of the mentally ill, jails and prison systems have had a drastic increase in housing offenders with severe and persistent mental illness. Mentally ill offenders are more costly, and more time consuming for law enforcement officers and correctional staff. Offenders are often released from correctional facilities without the ability to navigate the mental health system. Due to obstacles in care, and reliance on often ill-equipped law enforcement agencies, many offenders are left with few survival options and frequently return to the confines of jail and prison, only to have the cycle resume.

This paper will provide a review of the best practices for law enforcement officers, court officials, and community corrections professionals in the treatment of mentally ill offenders. It will further provide a review of best practices in advocating for the ethical treatment of mentally ill offenders navigating the criminal justice and mental health system.

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Chapter One: Introduction

Law enforcement officers bear the brunt of decision-making in our normative culture. They decide what is criminal and make daily assessment for threats of dangerousness. As first responders trained in law, the ability to decipher the perception of dangerousness due to a psychiatric impairment often comes second to removing the perceived threat. With mental disease often comes behavior that may be deemed a nuisance. It is the discretion of an officer that makes the determination of law violations and dangerousness. In determining such, the question of why the behavior exists is not always a function of an officer. Policing agencies have come to the conclusion that responding to the needs of those with chronic mental illness is costly. Law enforcement agencies are deriving models of response to address the needs of community members with mental disease through training while also assuring best practices in officer safety and community policing. This is done by funneling cases into community mental health treatment, the court system, and community corrections (Thompson, Osher, & Tomasini-Jacobs, 2008).

Community mental health courts have become a means by which criminal cases are diverted from the criminal justice system into community mental health while also allowing provisions for ongoing mental health treatment. Each case is specified through the court with mandated treatment outlined in a case plan. While participating in mental health court, the participant is provided a case manager to assist with overseeing treatment need as well as an outlined treatment plan. The case manager also acts as an agent to the court providing community supervision and reporting the participant's progress to the assigned judge (Thompson et al, 2008).

While the participant is on a court order for treatment they may have a case manager (if involved in a mental health court), probation, or parole agent overseeing their community supervision. A person who is diagnosed with a persistent mental disease may have a variety of

needs while on community supervision. Assistance with mental health treatment, housing, gaining an income either through supportive employment or social security disability, payee services, medication monitoring are only a few of the specialty services that help reduce recidivism. Due to the multitude of needs, specialty trained case managers and agents typically handle these caseloads (Thompson et al, 2008).

Statement of the Problem

Historically, the United States has had numerous changes in the mental health system, and in treatment of people with mental health disease. In 1964, driven in part by fiscal reality, political realignment, philosophical shifts, and medical advancements, Congress passed the Community Mental Health Centers Act. Since then, the system has shifted its emphasis almost entirely from institutional care and segregation to providing community-based support for individuals with mental illnesses. In 1955, there were 339 state psychiatric beds for every 100,000 people in the population. By 2005, this number had dropped to 17 per 100,000. This process is referred to as “deinstitutionalization” (Reuland, Schwarzfeld & Draper, 2009).

Some observers suggest that deinstitutionalization is a main cause of the increased number of people with mental illnesses in contact with the criminal justice system. In fact, no study has definitively shown a transition of this population from mental health institutions to jails and prisons. Other trends in criminal justice and mental health policy—for example, higher arrest rates for drug offenses and under-funded community-based treatment—are likely to account for this population’s increasing contact with law enforcement, courts, and corrections (Reuland et al., 2009).

The significant reduction in the population of state mental hospitals during the past 40 years has corresponded to a steady rise in prison and jail populations. Some suggest that this

correlation represents a phenomenon of “trans-institutionalization,” implying that the very same people who were in mental health institutions are now incarcerated. While there is little doubt that deinstitutionalization—and the associated inadequate funding of community-based mental health services—has played a role in the overrepresentation of people with mental illnesses in the criminal justice system, the relationship is not as simple as many contend. In fact, no study has proven a transition of people with mental illnesses from state hospitals to jails and prisons. While the total number of people with mental illnesses incarcerated has increased along with the general rise in correctional populations, there is no evidence that the percentage of people in prison or jail who have a mental illness is any greater than it was when the Community Mental Health Centers Act was passed (Osher & Levine, 2005).

Method of Approach

This paper is a literature review of best practices in: the treatment of mentally ill offenders in the criminal justice system, the training of law enforcement personnel to recognize mental illness, the navigation of services in the community, and the design of diversion programs for those in the criminal justice system who have ongoing and persistent mental illness. All material for this paper has been provided as best practices model through a variety of publications published by the US Department of Justice, Council of State Government.

Chapter Two: Review of the Literature

Law Enforcement

Officers generally have broad discretion in how they address minor offenses, or calls when no crime has been committed but citizens or business owners want them to “do something” about an individual whose actions are causing concern. Officers handle a majority of these incidents informally by talking to the person at the scene without taking him or her into custody. These encounters provide officers an opportunity—sometimes missed—to link individuals to effective interventions, which may prevent subsequent law enforcement encounters (Reuland et al, 2009).

Officers’ encounters with people with mental illnesses are relatively infrequent, but they can be particularly challenging. These encounters:

- often take much more time than other calls for service,
 - require officers to have special training and skills,
 - may depend on the availability of community mental health resources for successful outcomes,
 - typically involve repeat contacts with the same individuals who have unresolved mental health needs,
 - are mostly in response to a person with mental illness committing a minor or “nuisance” offense,
 - occasionally involve volatile situations, risking the safety of all involved.
- (Reuland et al., 2009).

Due to officers often being the first responders to those that present with disruptive or unlawful behaviors resulting from mental illness, training officers in the special needs of mentally disturbed individuals has been made a priority for many law enforcement agencies. This is due in part to the amount of discretion that is often exercised by the officer and the hope that through training the ability to provide a diversion to incarceration will be considered as an alternative. There are a few exceptions, but in general most offenses in which officer involvement with a mentally disturbed subject is deemed necessary result in misdemeanor charges. The majority of law enforcement encounters with people with mental illnesses are with individuals suspected of committing low-level, misdemeanor crimes, or who are exhibiting nuisance behavior. Law enforcement may receive calls when a business owner or community member wants officers to “do something” about a person—whether or not a crime was committed. Law enforcement officers encounter people with mental illnesses at risk of harming themselves, the majority of law enforcement encounters with people with mental illness are individuals at risk of harming someone else is relatively infrequent (Reuland et al, 2009).

Assessed Risks with Mentally Ill Subjects

The stereotype that people with mental illness are more likely than the general population to be violent is not fully supported by the evidence. Several large-scale research projects found a weak statistical association between mental illness and violence. The association becomes stronger, however, when a person with a mental illness has a co-occurring substance use disorder and/or is not taking his or her medication. Still, it is important to note that research focusing solely on people with mental illnesses who were involuntarily committed to a psychiatric facility may distort the relationship between

violence and mental illness as these individuals represent only a small fraction—the most severely ill—of this group (Thompson et al., 2008).

Although data are scarce on the precise number of law enforcement field contacts with someone with a mental illness who is exhibiting violent or aggressive behavior, research shows that officers do respond to calls for service that involve people with mental illnesses whose violent behavior is at issue. For law enforcement policymakers, the critical question is not whether people with mental illnesses are dangerous, but how best to maintain safety when violent or dangerous behavior results in calls to law enforcement (Schwarzfeld, et al., 2008).

According to a review of literature by the Us Consensus Project, (cited by Reuland, et al., 2009) a 1996 literature review determined that available data on incidents in which individuals intend to end their own lives by engaging in criminal behavior to prompt a lethal response by law enforcement officers—known colloquially as “suicide-by-cop”—are too flawed by methodology to provide a reliable understanding of this phenomenon. However, when considered in its entirety, the body of research *does* suggest that a mental illness and history of substance abuse, coupled with substance use at the time of the incident, are relevant factors in these events (Reuland, et al., 2009).

For these reasons law enforcement agencies have taken special note to how best assess for risk to determine a best practices model for law enforcement responses to individuals with mental illness. Law Enforcement–based specialized responses can create positive changes for all individuals involved, including the following:

- *improving* officer safety,
- *increasing* access to mental health treatment, supports, and services,

- *decreasing* the frequency of these individuals' encounters with the criminal justice system,
- *reducing* certain costs incurred by law enforcement agencies (Reuland et al., 2009).

Officers continue to play a pivotal role in assuring that people with mental illness are treated as opposed to criminalized for their mental disease. While statistically mental illness is not in itself a threat to an officer, there are factors that contribute to dangerous outcomes if the nature of the illness is not understood by the officer, and precautions are not taken to de-escalate the behavior properly. While, to a clinician, agitation may be an obvious symptom of an illness, to an officer it may be perceived as a threat. Typical policing would dictate that the officer provide a verbal command which the subject is to follow. Or, if the officer continues with a continuum of force, advancing their measures of restraint and /or control. While this practice is efficient in policing, it may escalate a mentally ill subject and put the officer at higher risk of having a violent altercation (Thompson et al., 2008).

Officer discretion often can mean the difference between a person being charged criminally for an offense as opposed to being detained and placed on a court order for mental health treatment. While an officer may see a variety of misdemeanor offenses such as disorderly conduct, loitering, or soliciting, the behaviors may be a result of the client not having the ability to meet societal norms due to a mental illness. Upon further investigation, the officer may have the ability to determine past mental health treatment and substantiate the behavior as being a result of a mental health disorder. From a community policing model, the person is less likely to have ongoing police contact if there

is the ability to stabilize their behaviors (and gain proper mental health treatment), have a steady income, and have a home in which to reside. In effect, the policing agency would spend less time on calls involving mentally ill people and therefore the cost burden to the policing agency would be less.

Models of Response

The **CIT model** originated in the Memphis (Tenn.) Police Department and is therefore often called the Memphis Model. It was developed in response to a tragic incident in which a law enforcement officer used lethal force against a person with a mental illness. This model is designed to de-escalate tensions at the scene and to reduce the need for use of force during these types of encounters. To improve the likelihood of a safe and effective outcome, the CIT model includes training and deployment of self-selected officers to provide a first-response to the majority of incidents involving people with mental illnesses (Schwarzfeld, Reuland, & Plotkin, 2008).

The CIT model is a training model where the officer responds to incidents in which there are mentally ill subjects. The officer acts both as the law enforcer and as the crisis counselor. This model has grown in popularity due in part to the cost efficient nature of having a responder that is an officer and trained in crisis counseling. The specialty trained officer is then aware of the community mental health resources that are available and has relationships within the community agencies to assist in getting the subject transitioned into mental health treatment.

The **co-responder model** was developed in Los Angeles County and implemented soon after in San Diego (Calif.). Leaders in those jurisdictions were concerned that they

were unable to link people with mental illnesses to appropriate services or provide other effective and efficient responses. They identified limitations on officers' time and lack of awareness about both community mental health resources and the characteristics of individuals who need access to those services as major obstacles. They then developed an approach that pairs specially trained officers with mental health professionals to provide a joint secondary response to the scene (Schwarzfeld et al, 2008).

The co-responder model is efficient due to the subject having an on-scene assessment, as well as the ability to have the mental health worker take over the transition of the clients' care in mainstreaming into mental health services while the officer is then able to return to their duties as a patrol officer. While this model is efficient, the cost effectiveness in comparison to the Memphis Model remains in question.

Many communities also have developed teams of community mental health professionals, such as mobile crisis or assertive community treatment teams, to assist officers at the scene. While these models are undoubtedly a valuable resource for many communities and departments, they are not law-enforcement-based (Schwarzfeld et al, 2008).

Officer Training

Many times those who struggle with their mental illness lack insight into their behavior or illness and do not seek treatment voluntarily. It is the law enforcement officer who is the first to respond and make a determination of mental illness, with the criteria being a perceived mental disease and behaviors that create dangerousness either to self or others. Due to the nature of mental illness, the typical police response often can escalate the potential for further dangerousness because the subject may not process information normally. For this reason

specialty training has been essential in responding to calls involving emotionally unstable or mentally ill subjects.

Officers who provide the first response to people with mental illnesses require a broad understanding of relevant issues and a range of skills in order to perform the unique responsibilities of their assignment. Experts whom officers will find credible should teach this training. The following sections discuss the challenges that planners and coordinators often experience (Thompson et al, 2008).

When teaching law enforcement personnel the instructor should:

- discusses important approaches to teaching content related to mental illness that meet the unique needs of law enforcement personnel and is sensitive to the policing culture,
- involve experienced law enforcement personnel in many aspects of the training,
- connect non-law enforcement coordinators and trainers with patrol officers and other policing personnel to increase their awareness of the law enforcement culture, the current realities of policing at the street level, and the complexity of these encounters for officers,
- establish a shared commitment to addressing the problem,
- recognize and respect officers' safety concerns,
- use training techniques that engage officers (Thompson et al, 2008).

Use of Officer Language and Experience

It is further advised that when instructing law enforcement personnel, the overuse of clinical terms should be avoided. While mental health professionals use often more elaborate terms to describe the subject's behavior, officers often use more efficient language by referring to the subject as their committed offense, such as: "pedophile," "drug dealer," "burglar," etc. The trainer should speak efficiently and avoid clinical terminology that is wordy and extensive in detail. It is further advised that the trainer be familiar with the terminology of the officers in that particular area such as the code that is often used to refer to an emotionally disturbed subject (Thompson, et al, 2008).

To better understand the struggles of the area law enforcement agencies it is advised that a trainer call upon officers' practical experiences and knowledge. For example the trainer may ask:

- What types of calls frustrate you?
- Are there calls that have not been handled as well as they could have been?
- What types of calls have you dealt with that had poor outcomes?
- What calls have you handled in which you felt you needed better options?
- What are your success stories?
- What has gone well?

In addressing the officer's concerns, the trainer may want to ensure that trainers are familiar with community resources by providing trainers with a "community service inventory" that includes information about what mental health supports and services are available in the community, how and when law enforcement can access these services and

what treatments or supports they offer to which client groups. Coordinators can develop written materials that summarize this important background (Thompson et al, 2008).

Mental Health Court

The America's Law Enforcement and Mental Health Act (H.R. 2594), has provision to establish "Mental Health Courts" in order to direct nonviolent mentally ill offenders out of jail, into long term treatment. The courts are intended to protect rights of mentally ill patients. Mental health courts are uniquely effective at reducing the recidivism of seriously mentally ill offenders because they use the power of the criminal justice court to ensure that the defendants receive long-term mental health treatment (Strickland, 2000).

A mental health court is a specialized court docket for certain defendants with mental illnesses that substitutes a problem-solving model for traditional criminal court processing. Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. Incentives reward adherence to the treatment plan or other court conditions, non-adherence may be sanctioned, and success or graduation is defined according to predetermined criteria (Thompson, et al, 2008).

According to the publication, *Mental Health Courts: A Primer for Policymakers and Practitioners*, communities start mental health courts with the hope that effective treatment will prevent participants' future involvement in the criminal justice system and will better serve both the individual and the community than does traditional criminal case processing. Within this framework, mental health court planners and staff cite specific program goals, which usually fall into these categories:

- increased public safety for communities—by reducing criminal activity and lowering the high recidivism rates for people with mental illnesses who become involved in the criminal justice system,
- increased treatment engagement by participants—by brokering comprehensive services and supports, rewarding adherence to treatment plans, and sanctioning non-adherence,
- improved quality of life for participants—by ensuring that program participants are connected to needed community-based treatments, housing, and other services that encourage recovery,
- more effective use of resources for sponsoring jurisdictions—by reducing repeated contacts between people with mental illnesses and the criminal justice system and by providing treatment in the community when appropriate, where it is more effective and less costly than in correctional institutions (2008).

The article published by the Council of State Governments, *Mental Health Courts: A Primer for Policymakers and Practitioners*, advises that not all Mental Health Courts are created the same. While some systems model their court much like a drug court. A drug court is a diversion program that allows the offender to be in treatment and work on a court ordered treatment plan. If the plan is successfully completed the offender avoids the permanent charge on a criminal record as well as avoiding incarceration. There are some key differences. One is that mental illness is not a crime, whereas the consumption of illegal substances is in itself an illegal act. Furthermore in communities that have drug courts, there may be an overlap of those who are diagnosed with a mental disease who also have ongoing difficulties with addictions. The

publication advises that a mental health court serves a wider variety of mental illnesses whereas the drug court's concentration is on drug offenses. Case planning may need to accommodate a wider variety of service needs in the mental health court.

Because those who have a diagnosis of a serious and persistent mental illness often exhibit behaviors that can be difficult to manage without proper training of court officials the Counsel of State Governments, *Mental Health Courts: A Primer for Policymakers and Practitioners*, suggests that the court take into account the following special circumstances:

- delusions, hallucinations, severe depression, paranoia, or mania (i.e., hyperactivity and agitation) that is obvious to others, is disruptive to status hearings, or prevents constructive interaction with court staff,
- presence of suicidal thoughts or other dangerous behavior,
- inability to handle stress in group settings,
- impaired cognitive functioning (including difficulties in attention, concentration, memory, and abstract thinking that impair an individual's ability to communicate his needs),
- inability to interact effectively with court staff without excessive anxiety, agitation, or aggressive behavior (in some cases, anxiety and agitation can result from withdrawal from alcohol, cocaine, methamphetamine, or other drugs),
- history of failure to respond to or adhere to psychotropic medication,
- presence of a co-occurring personality disorder, for example, borderline personality disorders with associated suicidal and manipulative behaviors, and

antisocial personality disorders with associated features of sociopathy, such as callousness towards others and an inability to develop reciprocal interpersonal relationships.

Outcomes

In addition to describing mental health court operations generally, several studies have evaluated individual mental health courts and their impact on a range of participant and system outcomes. Their findings suggest the following:

- Mental health court participation resulted in comparatively fewer new bookings into jail and greater numbers of treatment episodes compared with the period prior to program participation.
- Participants were significantly less likely to incur new charges or be arrested than a comparison group of individuals with mental illnesses who did not enter the mental health court program.
- Participation increased the frequency of treatment services, as compared with involvement in traditional criminal court.
- Mental health court participants improved their independent functioning and decreased their substance use compared with individuals who received treatment through the traditional court process.
- Participants spent fewer days in jail than their counterparts in the traditional court system.
- Mental health court participants reported more favorable interactions with the judge and perceived that they were treated with greater fairness and

respect than in traditional court (Counsel of State Governments, *Mental Health Courts: A Primer for Policymakers and Practitioners*, 2008)

Fiscal Implications

Researchers have also begun to explore the fiscal impact of mental health courts. A recent study by the RAND Corporation assessed the Allegheny County Mental Health Court in Pennsylvania. The study found that the program did not result in substantial added costs, at least in the short term, over traditional court processing for individuals with serious mental illnesses. The findings also suggested that over the longer term, the mental health court may actually result in net savings for the government.

In assessing the impact of mental health courts, it is important to note that these findings draw on a handful of studies, many of which look at individual programs and so cannot be generalized. Furthermore, research has not yet explored how changes in a mental health court's program elements or procedures affect outcomes. A comparative study of outcomes across different mental health courts has yet to be completed (Counsel of State Governments, *Mental Health Courts: A Primer for Policymakers and Practitioners*, 2008).

Community Supervision

According to a 1999 study, an estimated 5% of people in the general population have a serious mental illness at any given time. The Bureau of Justice Statistics (BJS) reported in 1999 that an estimated 16% of people under community supervision were mentally ill. This figure was based on self-report data from a national survey. Research suggests that people with mental illness are overrepresented in probation and parole populations at estimated rates ranging from two to four times those in the general population (Prins & Draper 2009).

According to the Bureau of Justice, there are six evidence-based mental health treatments that have been shown to improve clinical outcomes for people with serious mental illness. However, the effectiveness of these practices has not been examined for people with mental illness under community corrections supervision. These include:

- Assertive Community Treatment (ACT), a service delivery model in which a multidisciplinary team of mental health professionals provides individualized treatment,
- Illness of self-management and recovery, in which people learn skills to monitor and control their own well-being,
- Integrated mental health and substance abuse use services, in which specific treatment strategies and therapeutic techniques are combined to address mental illness and substance use disorders in a single contact or series of contacts over time,
- Supported employment, in which people with mental illness are employed in competitive, integrated work setting with follow-along supports,
- Psychopharmacology, in which medications are used to treat mental illnesses,
- Family psycho-education, in which people with people with mental illnesses and their families learn about mental illnesses, symptom management and stress reduction (Schwarzfeld, Reuland, & Plotkin, 2008).

According to Prins and Draper (2009), there are a number of general officer strategies and techniques that show promise in reducing recidivism of people with mental illness under community corrections supervision. These include:

- “Firm but fair relationships between community corrections agents and the people under their supervision, that are characterized by caring, fairness, trust, and authoritative (not authoritarian) style. These types of relationships reduce supervisees’ risk or recidivism.
- Problem-solving strategies and positive pressure to encourage compliance with the terms of community supervision, which involve agents working with the people under their supervision to identify obstacles to compliance, resolve these problems, and agree on compliance plans. Using these strategies and avoiding threats of incarceration or other negative pressure reduces supervisees’ risk of recidivism.
- Boundary-spanning skills, in which agents actually coordinate and work on terms with treatment and service providers. Use of these skills increases supervisees’ use of services.

Two promising health treatment practices may improve clinical outcomes for people with mental illnesses and, though untested for people with mental illness under community supervision, are particularly relevant to the challenges this population faces:

- Supported housing, such as “Housing First,” in which people with mental illnesses gain quick access to housing in addition to case management and other supports.
- Trauma interventions, in which people with mental illness and extensive histories of trauma (especially among women) including physical and sexual abuse, receive targeted interventions (Prins & Draper 2009).

Integration of Treatment

A variety of programs models integrate, to varying degrees, community corrections supervision with mental health treatment. Preliminary evidence suggests that these programs may reduce the risk of arrest and revocation and improve linkages to treatment and other services. One of these models, specialized mental health probation caseloads, is a promising practice for improving clinical and legal outcomes for people with mental illness under probation supervision (Prins & Draper 2009).

Studies have also shown that in addition to clinical challenges, people with mental illnesses are more likely than those without mental illness to report prior traumatic experiences such as physical and sexual abuse. Victimization rates are especially high for women with mental illness who are under probation supervision (Prins & Draper 2009). Thus, treatment for such issues would be important to include.

Of people under probation supervision, 39% with mental illness, compared with 12% of people without mental illness, reported having being abused before their arrest. Thirty-one percent of men with mental illness on probation reported having being abused before their arrest compared with seven percent of men without mental illness. Fifty-nine percent of women with mental illness reported being abused before their arrest compared to seven percent without mental illness. Of those that reported being abused before their arrest, 28% of people with mental illnesses reported physical abuse compared with ten percent of people without mental illness. Twenty-one percent of men with mental illness reported physical abuse compared with five percent of men without mental illness. Forty-seven percent of women with mental illnesses reported physical abuse compared with 36% without mental illness (Prins & Draper 2009).

Of those who reported ever being abused before arrest, 22% of people with mental illness reported sexual abuse compared with six percent of people without mental illness. Fourteen percent of men with mental illness reported sexual abuse compared with two percent of men without mental illness. Forty-two percent of women with mental illnesses reported sexual abuse compared with twenty percent of women without mental illness (Prins & Draper 2009).

Chapter Three: Conclusions and Recommendations

Mentally ill people have borne the brunt of changes in funding and institutionalization practices. In generations past they would have likely been placed in state run asylums. Deinstitutionalization has attempted to provide for the rights of people with mental disease, but has resulted in a significant proportion of people with mental illness being treated (or simply housed) in correctional facilities across the United States. Police continue to act as first responders despite many policing agencies offering little to no training for their officers on how to detect mental disease. Many communities have no provisions in the court system for people with mental illness. Often the inability of the person with mental illness to conform to societal norms spirals into misdemeanor crimes; warrants due to nonpayment of citations; and a behaviors constituting a public nuisance, which mainstream America hardly wants to observe on their streets. The mentally ill are in effect left to get their needs met through a correctional system that is ill equipped to provide appropriate treatment.

There have been advances made in the areas of serving those with mental disease in the criminal justice system. And, through data collection and research by the US Department of Justice Council of State Government, best practices in the areas of response and treatment have been proven effective in parts of the United States. Through research, there have been a significant number of improvements to the way that law enforcement responds to calls concerning people who have a persistent mental disease. The process of diversion from the criminal justice system has been started by law enforcement agencies having the officer respond to the call with a mental health professional, and/or being trained him- or herself. The courts have made drastic improvements as well by providing a court diversion model for Mental Health Court to allow for the participant to get treatment and avoid a criminal charge. Even probation and parole and

community supervision programs in various regions of the United States have adopted a best practice for getting proper treatment of their mentally ill offenders while they are on supervision through ACT (Assertive Community Treatment) which provides of treatment services while the offender is in the community.

Unfortunately, despite all the advances in research and best practices, few communities have reaped the rewards of what has been deemed ideal humane treatment for this special needs population. Many times the complexities have made community treatment and diversion programs costly and there is little to no funding available to meet the demands. While there continues to be grant funding available for some programming, the data is still not clear on the cost-effectiveness of having a mental health court, CIT teams, or an ACT model for community treatment. What are best practices and ideal continues to come in last in comparison to what is cost effective. Until more research can provide for the cost effectiveness of these programs and community models, it is likely that the correctional system will continue to carry the burden of being the new institutional treatment of those that fail to meet societal norms resulting in criminal offenses.

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