# Meeting the Needs of Those Persons With Serious Mental Illness Who Are Most Likely to Become Criminalized

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Persons with serious mental illness are a heterogeneous group. A large majority recognize that they are mentally ill, and they are treatment adherent, often able to work, and do not have major problems with substance abuse and violence. However, a substantial minority exists who receive little attention in the literature. They may not believe that they are mentally ill (the possible result of anosognosia), are nonadherent to psychiatric treatment, may have acute psychotic symptoms and serious substance abuse problems, may become violent when stressed, and may show less potential for recovery. This minority is at most risk for criminalization. High degrees of structure may help reduce this risk. They need a range of outpatient and inpatient treatment, including assertive community treatment, intensive case management, assisted outpatient treatment, structured housing, co-occurring substance abuse treatment, pre- and postbooking diversion, and available hospital beds. The mental health system can reduce criminalization by taking greater responsibility for these challenging persons.

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If we really want to help persons with serious mental illness who have been or are likely to become criminalized, then we need to understand their problems, how these problems manifest themselves, and what is needed to address them. The purpose of this article is to clarify these concerns.

For those who work directly with persons with serious mental illness in our jails and prisons, most of the contents of this article may seem like a simple statement of the facts. However, these are not the themes that most commonly make their way into the literature, and it is our hope that our article will bridge that gap.

Persons with serious mental illness (which we define as schizophrenic disorder, schizoaffective disorder, bipolar disorder, and major depressive disorder with psychotic features) are a heterogeneous group. On the one hand, a large percentage of persons with serious mental illness recognize that they are mentally ill and participate willingly in treatment. In most cases, they are able to live in the community, are often productive in terms of work, do not have a serious problem with substance abuse, are not violent, and show potential for recovery. As a result of the very visible success this group has had, much of the discussion in treating persons with serious mental illness has focused on such individuals.

On the other hand, there is a sizable minority of persons with serious mental illness who do not believe that they are mentally ill and, as a result, are generally resistant to psychiatric treatment (including medications). There is evidence that leads many persons to believe that this is anosognosia, a biologically determined inability to recognize that one is mentally ill, which is linked to frontal lobe dysfunction and abnormalities.[1,2] This minority of persons probably has overt psychotic symptoms, problems with substance abuse, great difficulty interacting appropriately with others, and a tendency to become

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violent when stressed. They are also likely to become involved with the criminal justice system.[3] For this group, recovery from the illness becomes difficult.

It must be stated that serious mental illness, in and of itself, is not a risk factor for violent behavior. However, it is the large number of persons with serious mental illness who have other factors associated with violence such as nonadherence to medications, acute psychotic symptoms, substance abuse, and a history of violence.[4] Clearly, these persons present a great challenge in treatment and rehabilitation and are among the most difficult to treat.

Currently, attention to the two groups varies significantly. The literature and practice tend to focus on the first group. There is less discussion of the second group, the sizeable minority of persons with serious mental illness who are characterized by chronic treatment nonadherence, anosognosia, psychotic symptoms, substance abuse, and a tendency to be violent. These are not the individuals who are usually thought of when developing the community treatment of persons with serious mental illness. Moreover, it is possible to overlook this group because so many of them, perhaps as many as 320,000 to 360,000,[5] reside in our jails and prisons, where many professionals in the mental health field do not go.

It should be noted that many persons with serious mental illness fall at various intermediate points between the two groups. There are those who may not have anosognosia and who are aware that they have a serious mental illness when they are in remission. Yet, they may discontinue treatment because of side effects or because they have not refilled their prescriptions and, as a result, become acutely psychotic. In this state they may not be able to recognize that they are mentally ill.[6]

The purpose of this article is to emphasize the existence and plight of those persons who are most difficult to treat and the need to direct much more attention toward them. Some of the concerns on which this discussion focuses will be these persons' tendency to be neglected by the community mental health system; the places where they are living, to a large extent in jails and prisons, and on the streets[7]; and ideally, how they should be treated.

## How We Got Here

With the advent of deinstitutionalization and the then new antipsychotic medications, many formerly hospitalized persons returned to live with their families or went to live in board-and-care homes or other similar facilities where they received some treatment, which consisted usually of medications and varying degrees of staff supervision. Other persons were placed in halfway houses and supervised apartments; while some were able to live independently. Some persons were involved in day treatment and were referred to vocational programs and various forms of social rehabilitation, such as clubhouse programs. While various combinations of these interventions were sufficient to maintain the majority of formerly hospitalized persons with serious mental illness in the community, it was not anticipated that such community treatment would prove to be inadequate for a large minority of persons (i.e., the difficult-to-treat group discussed herein), even when state and local mental health jurisdictions were willing and able to provide treatment.[8]

## The Need for Intensive, Structured Treatment

What is needed for those who do not respond successfully to community treatment? In our opinion, one of the most important deficiencies is insufficient structure for those who need it. One approach that has proven effective is intensive, structured treatment.[9] What constitutes structure? Structure is provided by such means as maintaining a high staff-to-patient ratio, as opposed to minimal staff supervision; by having staff dispense medications, as opposed to simply letting persons with serious mental illness take them on their own; by offering therapeutic activities that may add structure to most of their day; by staff being able and willing to set limits on inappropriate and violent behavior; and, for those who need it, by providing a locked therapeutic setting. Other ways of adding structure in the community include such modalities as treatment as a condition of probation or parole and assisted outpatient treatment. Some persons may need a high degree of external structure and control on an intermediate or long-term basis, such as placement in an intensive community program like Assertive Community Treatment (ACT), or possibly a locked intermediate care facility or a psychiatric hospital, particularly if the person refuses treatment. Adding involuntary treatment is another way of providing structure.

Some persons with long-term serious mental illness need little if any structure. Other persons, how-

ever, lack sufficient inner controls to cope even in supervised open settings, such as living with family or in a halfway house. If placed in the community in living arrangements without sufficient structure, they may quickly decompensate to an extent that results in hospitalization, living on the streets, or engaging in activities that lead to their arrest and incarceration.

Thus, sufficient support and structure have often been the missing ingredients for successful community treatment. With the shortage of intensive and effective community services, such as ACT and assisted outpatient treatment to provide structure, and the closure of so many state hospital nonforensic beds and local acute psychiatric inpatient beds, when such individuals commit a legal transgression, they are now more likely to be arrested.[10] Consequently, it has been left to the criminal justice system to provide or initiate the needed support and structure, as well as mental health treatment, for a large number of persons with serious mental illness.

These individuals who come to the attention of the criminal justice system are dealt with in various ways. In recent years, there have been efforts to divert persons with serious mental illness who have come to the attention of the criminal justice system, both before and after arrest, to treatment services in the mental health system. These efforts will be discussed later.

Generally, most are now placed either in forensic hospitals (e.g., as persons found incompetent to stand trial or not guilty by reason of insanity) or in correctional institutions, such as jails or prisons, where they receive their treatment. Despite many correctional officials' beliefs that these persons should not be their responsibility, correctional institutions have no choice but to provide treatment. It should be noted that the great majority of persons with serious mental illness who are involved in the criminal justice system remain in jails and prisons, while only a relatively few are committed to forensic hospitals for treatment. For example, in California in 2005, there were approximately 38,000 persons with serious mental illness in local jails and state prisons[11,12] compared with approximately 4,500 persons in state forensic hospitals.[13]

Another important point is that very few state hospital beds have been reserved for nonforensic patients.[14] For instance, in California there are approximately 5,000 persons in state hospitals, with about 4,500 identified as forensic patients (e.g., insanity acquittees, persons found incompetent to stand trial, sexually violent predators, and mentally disordered offenders). Thus, just 500 beds, or only one-tenth of the state hospital beds that now exist are available for persons in the civil system who need psychiatric hospitalization.

Looking at this in terms of number of beds made available for this population, the 5,000 state hospital beds comprise only 14 beds per 100,000 population in California. With respect to the 500 beds used for nonforensic patients, there are fewer than 1.5 state hospital beds available per 100,000 population. This number hardly begins to meet the need.[15] With so few beds allocated for nonforensic patients, the mental health system has much less capability of treating persons with serious mental illness who need a highly structured environment. Thus, it is left to the criminal justice system to provide this level of care when it is needed.

## Barriers to Treating the Seriously Mentally Ill

Problems of access create impediments to treating persons who do not recognize that they are mentally ill and who need more structure than they are receiving.[16] These problems include a shortage of mental health resources and funding generally; belief on the part of many persons both within and outside of the mental health system that hospital admission and involuntary treatment are seldom necessary; an insufficient amount of structured community housing resources; and the high cost of treatment modalities such as psychiatric hospitalization.[17,18]

Another barrier to treating this segment of the population is a preference on the part of most treatment staff to work with persons who are treatment adherent and who do not tend to be violent.[19] This preference is understandable.

While there is a subgroup of persons with serious mental illness who are violent, it must also be acknowledged that an even larger group of persons with serious mental illness are themselves subject to violence. For example, in a review of studies of violent victimization, 35 percent of persons with serious mental illness were victims of violence within the past year. Their victimization by violence tends to receive less public attention than the violence that is perpetrated by them.[20]

## The Locus of Acute Psychiatric Inpatient Treatment

It is noteworthy that, while in some jurisdictions acute community inpatient facilities have experienced a critical shortage of beds, the number of persons in jail receiving acute psychiatric inpatient treatment, or its equivalent, can be extremely high, as found in one study, in which 76 percent of the persons in jail with serious mental illness received such treatment during the instant incarceration.[5] It is likely that if there were enough inpatient beds in that mental health jurisdiction, many acutely psychotic persons might not have come to the attention of law enforcement officers, or if they did, could have been transported and admitted to acute psychiatric facilities rather than arrested, particularly if the transgressions were minor. Acute psychiatric treatment in a correctional setting is less desirable than such treatment in the mental health system. Jails and prisons have been established to protect society and to mete out punishment. Correctional facilities place a heavy emphasis on maintaining security and are generally not characterized as a therapeutic milieu.[21] Their primary mission and goals are not to provide mental health treatment.[19] Consequently, unless a person is suspected of or has been convicted of a serious offense, it could be argued that acute psychiatric inpatient treatment should be the responsibility of the mental health system and should be provided in noncorrectional settings.[22] To make this possible, acute inpatient beds must be a high priority in community mental health, and lengths of stay should be long enough to provide stabilization. Yet, just the opposite occurs: acute inpatient beds continue to be closed.

## Who Becomes Criminalized?

What are the characteristics of persons with serious mental illness who have been criminalized? A recent study in a county jail found that more than 90 percent of the inmates with serious mental illness had a history of nonadherence to medications before this arrest, 95 percent had prior arrests, more than 70 percent had prior arrests for violent crimes against persons, and more than 75 percent were known to have a history of substance abuse.[5] Another study conducted on individuals who had a serious mental illness and were transferred from jail to a psychiatric inpatient unit found that 75 percent had a history of physical assault, 72 percent engaged in substance abuse, and 78 percent were generally nonadherent to medications. Findings revealed that poor insight into illness and nonadherence to medications were associated independently with violence toward others.[23] These findings of a history of nonadherence to treatment, serious substance abuse, lack of insight into illness, and violence, as well as a current need for acute inpatient care, characterize a group of individuals who would be difficult to treat in any setting.

## Conclusions

We believe that the following steps should be taken to successfully address the needs of those persons with serious mental illness who are the most difficult to help and to reduce the extent to which they are or may become criminalized.

Society, and in particular the mental health field, must understand that persons with serious mental illness are a heterogeneous group. A large percentage of these individuals are aware that they are mentally ill and participate willingly in treatment. On the other hand, a sizeable minority do not believe they are mentally ill and are resistant to psychiatric treatment, including medications. Many of these individuals need acute hospitalization and may become violent when stressed. In addition, a large proportion has serious substance abuse problems.

With the very large and increasing number of persons with serious mental illness found in jails and prisons, there have been widespread efforts to divert these persons from the criminal justice system to the mental health system. Diversion before the person is actually booked into jail, or prebooking diversion, is exemplified by large-scale efforts to create mobile crisis teams of specially trained police officers or mental health professionals, or both. Diversion after booking includes mental health courts,[24] which hear specialized cases involving defendants with mental illness; use a nonadversarial team of professionals (e.g., judge, attorneys, and mental health clinicians); are linked to the mental health system that will provide treatment; and use some form of adherence monitoring that may involve sanctions by the court.

Persons who need but are resistant to treatment may require high degrees of structure, and have the potential for violence. Thus, a range of outpatient treatment interventions suitable to their needs is indicated. These interventions include assertive community treatment; intensive case management with

staff who are willing and able to treat these persons; a greatly increased number of crisis services; appropriate community living situations with staff who can monitor for medication adherence and signs of decompensation; various forms of involuntary treatment, such as assisted outpatient treatment, especially when combined with assertive community treatment; and increased access to appropriately structured housing.[15,25,26]

In addition, to address the acute needs of these difficult-to-treat persons and to either prevent or reduce the risk of their entry into the criminal justice system, there should be an adequate number of additional community crisis and acute inpatient psychiatric beds.[5] These crisis and acute inpatient facilities must, at discharge, have access to, and a close liaison with wrap-around services, assertive community treatment (ACT), supportive and structured housing, the ability to work with and support family members,[27] and effective co-occurring serious mental and substance use disorders treatment, including ongoing testing for substance abuse.[28]

It should be acknowledged that many of these persons need inpatient care that is not simply crisis oriented and acute. Many cannot respond in a short time and need structured, 24-hour care for various lengths of time. These persons need asylum, a place of refuge, from the pressures of the world.[29] Therefore, there is a need for many more facilities that can provide intermediate-term and long-term care. We believe this care should be in the mental health system and should not be in our jails and prisons, as so much of it is today.

Generally, Departments of Mental Health have tended not to provide many of these modalities. For instance, psychiatric beds continue to be closed, despite the clear need for them. In addition, there is often resistance to setting up assisted outpatient treatment in the community, even though assisted outpatient treatment has been shown to be effective when there is a requirement that it be accompanied by an intensive and proven form of community treatment (such as assertive community treatment) as well as meaningful sanctions for noncompliance.[26] There is also, in our experience, an understandable reluctance to treat persons who may become violent.

As noted earlier, there is a tendency for most of the states to convert their acute, intermediate, and long-term psychiatric beds to forensic beds. This trend has resulted in inpatient care being made available primarily to persons who commit an offense and are involved with the criminal justice system. This trend must be reversed.

Those who are already in the criminal justice system tend to be treatment resistant, violent, and in need of a high degree of support and structure.[30] Such individuals may also require legal leverage, when necessary, derived from the court and criminal justice system, to address nonadherence with treatment.[30] It is essential that staff be comfortable working with this population and providing the interventions that they need.[31,32] Sufficient security should be assured so that staff feel safe in their work environment.[33] Staff also must be aware of and capable of handling the challenges they will face with this population. Finally, if mental health staff are to increase their sense of job satisfaction and efficacy, it is critical that they know that the necessary treatment resources are available.

There should be both increased funding and a willingness on the part of the mental health system to restore beds for nonforensic patients and to institute more voluntary and involuntary treatment, both inpatient and outpatient. Some of this increased funding could come from the diversion of criminal justice system monies used for these patients in jails and prisons.[34]

Finally, we believe that there is a clear possibility that if many persons with serious mental illness in jails and prisons had received community mental health treatment appropriate to their needs, they would not have been arrested in the first place. The mental health system should stem the tide of criminalization by taking back the responsibility of caring for persons with serious mental illness who are the most disabled and difficult to treat and by not relinquishing their time-honored obligation to treat this population, ideally before such individuals engage in serious criminal conduct.

## References


1. Pia L, Tamietto M: Unawareness in schizophrenia: neuropsychological and neuroanatomical findings. Psychiatry Clin Neurosci 60:531–7, 2006
2. Amador X, David A: Insight and Psychosis: Awareness of Illness in Schizophrenia and Related Disorders (ed 2). New York: Oxford University Press, 2004
3. Elbogen EB, Mustillo S, Van Dorn R, *et al*: The impact of perceived need for treatment on risk of arrest and violence among people with severe mental illness. Crim Just Behav 34:197–210, 2007
4. Elbogen EB, Johnson SC: The intricate link between violence and mental disorder. Arch Gen Psychiatry 66:152–61, 2009

5. Lamb HR, Weinberger LE, Marsh JS, *et al*: Treatment prospects for persons with severe mental illness in an urban county jail. Psychiatr Serv 58:782–6, 2007
6. Hofer A, Kemmler G, Eder U, *et al*: Attitudes toward antipsychotics among outpatient clinic attendees with schizophrenia. J Clin Psychiatry 63:49–53, 2002
7. Greenberg GA, Rosenheck RA: Jail incarceration, homelessness, and mental health: a national study. Psychiatr Serv 59:170–7, 2008
8. Lamb HR, Bachrach LL: Some perspectives on deinstitutionalization. Psychiatric Serv 52:1039–45, 2001
9. Lamberti JS, Weisman RL, Faden DI: Forensic assertive community treatment: preventing incarceration of adults with severe mental illness. Psychiatr Serv 55:1285–93, 2004
10. Markowitz FE: Psychiatric hospital capacity, homelessness, and crime and arrest rates. Criminology 44:45–72, 2006
11. Harrison PM, Beck AJ: Prison and jail inmates at midyear 2005. Washington, DC: U.S Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Bulletin, 2006
12. National Commission on Correctional Health Care. Prevalence of communicable disease, chronic disease, and mental illness among the inmate population. The Health Status of Soon-to-Be-Released Inmates: A Report to Congress. Washington, DC: National Commission on Correctional Health Care, 2002
13. California Department of Mental Health: Weekly report of state hospitals serving the mentally ill. Sacramento, CA: December 21, 2005
14. Morris DR, Parker GF: Jackson's Indiana: state hospital competence restoration in Indiana. J Am Acad Psychiatry Law 36:522–34, 2008
15. Torrey EF, Entsminger K, Geller J, *et al*: The shortage of public hospital beds for mentally ill persons. Arlington, VA: Treatment Advocacy Center, 2008
16. Wilper AP, Woolhandler S, Boyd JW, *et al*: The health and health care of US prisoners: results of a nationwide survey. Am J Public Health 99:666–72, 2009
17. Council of State Governments: Criminal justice/mental health consensus project. Available at http://www.consensusproject.org/downloads/Entire_report.pdf. Accessed November 18, 2010
18. Lamb HR, Weinberger LE: The shift of psychiatric inpatient care from hospitals to jails and prisons. J Am Acad Psychiatry Law 33:529–34, 2005
19. Slate RN, Johnson WW: Criminalization of Mental Illness. Durham, NC: Carolina Academic Press, 2008
20. Choe JY, Teplin LA, Abram KM: Perpetration of violence, violent victimization, and severe mental illness: balancing public health concerns. Psychiatr Serv 59:153–64, 2008
21. Adams K, Ferrandino J: Managing mentally ill inmates in prisons. Crim Just Behav 35:913–27, 2008
22. Steadman HJ, Osher FC, Robbins PC, *et al*: Prevalence of serious mental illness among jail inmates. Psychiatr Serv 60:761–5, 2009
23. Alia-Klein N, O'Rourke TM, Goldstein RZ, *et al*: Insight into illness and adherence to psychotropic medications are separately associated with violence severity in a forensic sample. Aggress Behav 33:86–96, 2007
24. Baillargeon J, Binswanger IA, Penn JV, *et al*: Psychiatric disorders and repeat incarcerations: the revolving prison door. Am J Psychiatry 166:103–9, 2009
25. Munetz MR, Griffin PA: Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. Psychiatr Serv 57:544–9, 2006
26. Swartz MS, Wilder CM, Swanson JW, *et al*: Assessing outcomes for consumers in New York's assisted outpatient treatment program. Psychiatr Serv 61:976–81, 2010
27. Nordström A, Kullgren G, Dahlgren L: Schizophrenia and violent crime: the experience of parents. Int J Law Psychiatry 29:57–67, 2006
28. Drake RE, O'Neal EL, Wallach MA: A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. J Substance Abuse Treat 34:123–38, 2008
29. Sacks O: The Lost Virtues of the Asylum. The New York Review of Books 56:50–2, 2009
30. Lamberti JS: Understanding and preventing criminal recidivism among adults with psychotic disorders. Psychiatr Serv 58:773–81, 2007
31. Heilbrun K, Griffin PA: Community-based forensic treatment, in Treatment of Offenders With Mental Disorders. Edited by Wettstein RM. New York: Guilford Press, 1998, pp 168–210
32. Lamb HR, Weinberger LE, Gross BH: Community treatment of severely mentally ill offenders under the jurisdiction of the criminal justice system: a review. Psychiatr Servi 50:907–13, 1999
33. Arnetz JE, Arnetz BB: Violence towards health care staff and possible effects on the quality of patient care. Soc Sci Med 52: 417–27, 2001
34. Quanbeck C, Frye M, Altshuler L: Mania and the law in California: understanding the criminalization of the mentally ill. Am J Psychiatry 160:1245–50, 2003