Interaction of the Criminal Justice System and Psychiatric Professionals in which Civil Commitment Standards Are Prohibitive

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Three case studies are the basis for a discussion of the criminalization hypothesis as it may apply to psychiatric probationers and parolees in the criminal justice system. In each of these cases, the treating psychiatrist faced the problems of noncompliance with treatment and/or restrictive civil commitment standards. The patient's status as a probationer or parolee played a pivotal role in strategies for ensuring treatment through the criminal justice system as opposed to the mental health system or civil commitment process.

The incarceration of persons with serious and persistent mental illness is an issue of increasing concern and is receiving attention in the popular media and in scholarly publications.[1–9] The criminalization of persons with mental disorders refers to the diversion into the criminal justice system of persons with mental disorders who in an earlier time would have been in state or other psychiatric facilities.[10] The criminalization hypothesis[5, 10, 11] postulates that the employment of a narrow definition of dangerousness to self or to others that is used in civil commitment proceedings promotes the use of criminal arrest in lieu of psychiatric hospitalization as a management strategy for persons with mental illness. Arrest may then result in "criminal sentencing to jails or prisons, or criminal commitment to mental hospitals by a finding of 'incompetency to stand trial' or 'not guilty by reason of insanity'."[12]

The essence of the debate about criminalization seems to lie with the issue of

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whether there is a direct causal link between deinstitutionalization and the increasing incarceration of mentally ill persons. There are those who are of the opinion that the criminalization of mental illness occurred historically long before deinstitutionalization.[13] Teplin[10, 11] has intensively researched this issue and has concluded that the longitudinal data to support a causal relationship between criminalization and deinstitutionalization do not exist, which leaves the issue of causality an untested assumption. However, there is "evidence that the mentally ill are criminally processed when mental health alternatives would be preferable but are unavailable."[11] As previously noted, the concept of criminalization of persons with mental illness describes mechanisms of diversion into the criminal justice system. However, the concept does not address the treatment of persons with mental illness once they are diverted into the criminal justice system.

The present article will examine a criminal justice processing mechanism, the technical violations of probation and parole, that seems to serve the latent function of obtaining treatment and behavioral management for decompensated mentally ill persons who may resist treatment and who are already under judicial orders in the criminal system. Because of various circumstances, service providers and probation or parole officers may well not be able to obtain needed psychiatric treatment for decompensated individuals in the involuntary treatment system, even though the civil commitment system is usually thought of as the appropriate processing mechanism for the receipt of such treatment. In this case, the involvement of a community mental health patient in the criminal justice system may be seen as an opportunity to impose controls that otherwise could not be imposed by the civil system or by the mental health system. Thus this paper is concerned with the use of incarceration as a strategy for severely mentally disabled patients under court sanctions of probation and/or parole and not with the incarceration of mentally ill persons in general.

Attention should be paid to these mechanisms for several reasons. First, the jail system is being used for a purpose for which it was not intended, to provide psychiatric treatment to people who otherwise may not have returned to jail. Second, treatment received in jail may not be integrated into a community-based system of care. Thus the uses of these strategies are temporary measures at best. Third, the mechanisms of probation and parole represent coercive strategies for treating persons with mental illness. The effectiveness of such strategies for medication compliance and the reduction of psychotic symptoms or negative behaviors is questionable.[14]

The examination of these mechanisms has several policy implications. Community mental health professionals are using these strategies because they do not see involuntary commitment as a feasible alternative, but they do see a need for emergency psychiatric treatment. The use of strict involuntary commitment standards or the strict interpretation of those standards needs to be examined. Particular attention must be paid to the effect of incarceration on the most seriously ill persons

with mental illness (under sanctions of probation and/or parole) who might not meet the strictest standards of dangerousness but who are occasionally in dire need of treatment. For these patients, their need for treatment should indicate hospitalization with aftercare, not incarceration.

Technical Violations

Probation and parole are two types of conditional releases after a conviction.[15] These dispositions place probationers/parolees under supervision in the community in lieu of incarceration.[15] Offenders on probation or parole are released on the condition that they agree to the conditions of release and are aware that they are subject to incarceration should they violate these conditions. These conditions may include stipulations for compliance with specific psychiatric treatment such as counseling or therapy, psychopharmacological interventions, substance abuse treatment, and/or participation in structured housing programs. Failure to comply with these conditions of probation or parole is referred to as a violation. In simplest terms, committing a new offense results in a criminal violation, whereas noncompliance with the conditions of parole or probation results in a technical violation.[15] Technical violations are the consequence of illegal behavior in the context of an individual's status as a probationer or parolee.

Failure to comply with the stipulations of parole or probation can result in incarceration. Furthermore, psychiatric patients on parole or probation often receive intensive monitoring of their compliance with court-ordered stipulations, which may bring their socially unacceptable or noncompliant behavior under closer scrutiny than if they were under less intensive supervision. This close supervision increases the likelihood of incarceration.[16, 17] Because the nature of mental illness often makes it difficult for patients to comply with treatment recommendations, those mentally ill patients on probation or parole under this type of monitoring may thus face incarceration when their symptoms are exacerbated. This possibility is enhanced when a local jail system has a well developed mental health program within the confines of the jail, and the involuntary commitment procedures hold to a narrow definition of dangerousness. Under these circumstances, it is often easier to return offenders to jail for treatment when their symptoms are exacerbated than to hospitalize them in the community.

In addition, persons with mental illness and those with jail detention experience have a higher incidence of substance abuse than the general population does.[18, 19] Incarcerated individuals with substance abuse problems often come under the auspices of yet another service system for addictions and substance abuse treatment postrelease. This adds to the number of professionals involved in a patient's stipulated service and increases the surveillance capacity of the service system.[20] This additional monitoring heightens the chance that the patient will be observed violating probation or parole. Furthermore, a probationer/parolee who is involved in any use of illegal substances while under judicial sanctions increases the likelihood of incarcer-

ation, as this is grounds for a technical violation.

These factors raise the issue regarding the extent to which an increase in the intensity of the monitoring of patients by service providers in the community mental health system, specifically when augmented by the criminal sanction of probation or parole, increases the likelihood that probationers and parolees will return to jail. Patients are given a coercive choice between compliance with treatment and returning to jail. Although it reflects long-standing concerns about social control for persons with mental illness, this issue is to some extent a new one in the delivery of community mental health services for forensic patients since the initiation of deinstitutionalization. In the effort to provide benevolent community-based services for forensic patients with serious mental illness, coercive mechanisms have been introduced into the community mental health service delivery system,[21] when once they were reserved for the psychiatric hospital.

Setting

These issues are discussed in the context of the Philadelphia criminal justice and mental health systems. System characteristics and operating norms in other communities may differ to the extent that a discussion of technical violations may not seem relevant. The discussion of these mechanisms in this context, however, may serve to bring their use to light in other systems or may lead to the discovery of parallel mechanisms that serve a comparable function.

The following elements make the Philadelphia situation unique.

1. The city contracts to provide mental health services within the jail system. The jail mental health program includes a 49-bed acute inpatient unit, a 50-bed step-down unit, and ambulatory clinics for inmates.

2. Magistrates and delegates employ a restrictive commitment criterion for involuntary hospitalization. Neither a threat of dangerousness nor grave disability is sufficient evidence for commitment. An individual must have been observed to have acted in furtherance of the threat within the last 30 days in order to be considered dangerous enough for commitment.

3. The adult probation and parole division has specialized psychiatric units.

4. In addition, the jails are overcrowded and under court order to limit their inmate population, which is indicative of a national problem. Therefore, incarceration has to be used judiciously.

In this context, a clinical study of case management services was conducted using a team approach. The patients were seriously mentally ill, were homeless, and were being released from jail. This article addresses issues regarding the interaction of the mental health and criminal justice systems that arose during the course of the study. Illustrative material is drawn from three case studies.

Case Summaries

Case 1 Ms. A is a 30-year-old black woman, mother of seven children, who was released on probation after incarceration on drug-related charges. Her diagno-

sis is chronic schizophrenia, undifferentiated type.

Ms. A was hostile toward psychiatric treatment from the time of release. She had been stabilized in jail on a regimen of trifluoperazine hydrochloride (Stelazine), 10 mg three times a day, plus benztropine mesylate (Cogentin) to prevent side effects. She accepted her medication in jail, but upon release she informed the psychiatrist on the aftercare team that she no longer wanted the medicine because it made her feel stiff and slow, and she felt she did not need the medicine. Ms. A was reporting frequent but nondisturbing auditory hallucinations, depressed mood, and lethargy at the time. After some negotiation, she agreed to continue Stelazine at a dose reduced to 5/5/10 mg plus 1 mg of Cogentin twice a day.

One month later, Ms. A returned for follow-up. She was very angry, stating that even at the reduced dose she still felt "slowed down" by the Stelazine, and she had ceased taking it two weeks earlier. Furthermore, Ms. A had a new boyfriend who supplied her with cocaine: she had resumed cocaine and alcohol use. The hallucinations were now more prominent and constant. She nevertheless refused to accept a prescription for an oral neuroleptic. She was offered a low dose of haloperidol (Haldol Decanoate), which she summarily rejected. Ms. A was cautioned about the need for contraception and was advised to discontinue all street-drug and alcohol use.

Follow-up was scheduled for one week later, and Ms. A did not show up. The psychiatrist telephoned her at her residence. She said that she did not intend to return for any more appointments. Ms A. was reminded that psychiatric treatment was a condition of her probation. She stated that she did not care.

Ms. A's refusal of treatment was discussed in the next case management team meeting. The team agreed that Ms. A was in need of antipsychotic medication and that every effort should be made to reengage her in treatment. The intensive case manager contacted Ms. A's probation officer, notifying her of Ms. A's failure to accept treatment. An appointment with the psychiatrist was scheduled for one week later, and Ms. A appeared for her appointment.

Ms. A was hostile, stating that she came only because her probation officer told her that she should and that she would be put back in jail if she continued to refuse psychiatric follow-up. Ms. A was dishevelled and looked depressed. She refused to answer mental status examination questions but appeared internally preoccupied, as if hallucinating. She had tested positive for cocaine and heroin earlier in the week when the probation officer obtained a urine drug screen. Ms. A was again offered antipsychotic medication and was assured that the lowest possible dose would be used and that medicine would be given to her for any side effects. Ms. A refused the neuroleptic but requested a sedative for sleep. She was offered trazodone for sleep and for treatment of depression. She rejected the trazodone and angrily stated that she did not want anything after all.

The probation officer and the judge were informed by letter that Ms. A was refusing treatment. The psychiatrist

requested a court order allowing for involuntary administration of Haldol Decanoate. Two weeks later, the judge issued an order for involuntary antipsychotic treatment, but Ms. A refused to visit the psychiatrist. Shortly thereafter, she was reincarcerated and charged with narcotics violations.

Case 2 Mr. B is a 27-year-old unmarried white man; he is the father of one child out of wedlock, with whom he has no contact. Mr. B was released on probation after an eight-month jail term for violation of a restraining order obtained by his parents because of Mr. B's violent behavior during a psychotic episode. Mr. B's diagnosis is schizoaffective disorder. While in jail, Mr. B had been stabilized on fluphenazine hydrochloride (Prolixin Decanoate), and had only negative symptoms of his illness at the time of release.

Mr. B came from an educated, upper-middle-class Philadelphia family and had functioned well before his psychotic break, which occurred at the end of his training to be a naval pilot. He was hospitalized for treatment of manic psychosis before completing his training and was given a medical discharge from the Navy. Both Mr. B and his mother had tremendous difficulty accepting a diagnosis of mental illness. His mother never did accept the diagnosis and insisted that the psychiatrists had made Mr. B "act crazy" by giving him mind-altering drugs.

Mr. B always attended his appointments with the team psychiatrist. He also expressed his doubts about having a psychiatric illness at each visit, and each time asked if he could have a lower dose of Prolixin. Because Mr. B's symptoms were well controlled, the Prolixin dose was gradually lowered to a monthly dose of 12.5 mg. At that dose, Mr. B experienced a slight breakthrough of both grandiose delusion and auditory hallucinations. The Prolixin dose was increased to 16 mg/month, and the psychotic symptoms abated.

All during this time (about eight months), Mr. B questioned his diagnosis and the need for any psychoactive medications. He expressed his feeling that he could succeed in a teaching career or similar discipline and that he could again resume competitive rowing if he could just get off the Prolixin. He reasoned that the Prolixin made his thinking slow and his body weak. Mr. B was told that his mental illness was mainly responsible for his decreased functioning and that the Prolixin helped him to be free of hallucinations and delusions. Mr. B was not convinced. Family meetings were held to address this.

One day Mr. B came to his appointment with the psychiatrist and announced that he would no longer accept Prolixin injections. He was told that he was making an error and was scheduled to return for another appointment one week later. He was to consider the ramifications of his decision in the meantime, including possible decompensation and need for rehospitalization.

Mr. B returned for his next scheduled appointment. He looked miserable but stated that he still refused the Prolixin. Mr. B was reminded that compliance with treatment was a condition of probation. Another appointment was scheduled for three days later.

The intensive case manager contacted

the probation officer, who came to the next psychiatric appointment with Mr. B. He still refused Prolixin. The probation officer, the case manager, and the psychiatrist met briefly. They then confronted Mr. B and told him that if he did not accept his injection at that time, he would be arrested on the spot and returned to jail. After some deliberation, Mr. B chose to receive the injection. He accepted the Prolixin grudgingly thereafter, stating that he intended to discontinue the medication upon termination of probation a few months later. He did discontinue Prolixin upon termination of probation. Mr. B's ultimate outcome is not known.

Case 3 Mr. C is a 25-year-old, unmarried white man. He was released on probation after a drug conviction. Mr. C has a history of amphetamine, cocaine, and alcohol abuse. His diagnosis at entry into the study was chronic paranoid schizophrenia, although when drug-free and alcohol-free for a period of weeks, the symptoms of paranoid schizophrenia remit, and Mr. C can do well without antipsychotic medication.

Mr. C had been stabilized on neuroleptic while he was in jail. Upon release, he was maintained for a short time on Prolixin tablets. Because of Mr. C's complaints about lethargy and dystonia while he was on Prolixin, he was (at his request) gradually taken off antipsychotic medication during a period of two months. Mr. C was maintained with no medication for the next six months.

Mr. C made good use of his psychiatric appointments. He requested additional time to talk with the team psychiatrist, and he was scheduled for 45-minute therapy appointments every 7 to 10 days. Mr. C began to address issues of personal concern, specifically family conflict and the rejection by a former girlfriend with whom he had attempted to reestablish contact. In addition to supportive psychotherapy, Mr. C began to attend Alcoholics Anonymous meetings. For a period of four to five months, Mr. C was drug-free and sober.

With the approach of the holiday season, conflict escalated between Mr. C and his father, with whom he lived. Mr. C began to miss scheduled appointments with the team psychiatrist. When the psychiatrist telephoned his home to inquire about the failed appointments, Mr. C's father reported that Mr. C had begun staying away from home for days at a time.

Mr. C intermittently called the psychiatrist to reschedule missed appointments. When he was seen after a hiatus of five weeks, Mr. C admitted that he had returned to drinking and occasional cocaine use and that he felt very guilty about it. He also reported increasing suspiciousness and a vague sense of being followed by someone.

Mr. C was told to cease the drug and alcohol use. If the paranoia continued, a neuroleptic would then be prescribed. Mr. C made several attempts to quit but was unable to do so. His attendance at appointments was irregular. When the paranoid symptoms began to include visual and auditory hallucinations, the team concluded that Mr. C must be hospitalized. He agreed over the telephone to come in to see the psychiatrist the next morning.

When Mr. C arrived at the office, he was extraordinarily ambivalent. After one

hour and 45 minutes of first agreeing and then refusing to be hospitalized, Mr. C walked across the street to the psychiatric emergency room. The psychiatrist had attempted to secure a bed on the adult inpatient unit, but because of staffing limitations, a bed was not available until the following day. Mr. C would therefore have had to spend the night in the emergency room.

After meeting much resistance from the medical and psychiatric emergency room staff (as well as the ambivalence of Mr. C), the psychiatrist was eventually able to get Mr. C into the psychiatric emergency room. Mr. C reluctantly signed a voluntary admission form. Although he would have met the criterion for an involuntary hold in a state with a "grave disability" criterion, he did not meet the Pennsylvania standard for "clear and present danger" to self or others. Consequently, when Mr. C began to experience another wave of suspiciousness and paranoia about one hour later, he signed himself out of the emergency department and walked away.

Mr. C was not seen for five days, at which time the team psychiatrist was called by the psychiatrist who was on call at a neighboring hospital. Mr. C had walked into the emergency room at that hospital requesting some medicine to help control his paranoia. He told the on-call doctor that he was avoiding his regular psychiatrist because she wished to hospitalize him. Mr. C was in a highly deteriorated and confused state, and the psychiatrist at that hospital applied for and received authorization for a five-day involuntary commitment. Arrangements were made to transfer Mr. C back to the hospital where his regular psychiatrist could treat him. Mr. C was placed into an ambulance for transfer, but he escaped from the vehicle en route. For reasons that are unclear, the police were not notified, and the psychiatrist was not informed of the escape.

At this point, Mr. C's probation officer was notified of his decompensation and disappearance. The probation officer put out a warrant for Mr. C to be apprehended by police, but he was able, with his father's collusion, to evade arrest for a number of weeks. Mr. C no longer called the team psychiatrist nor was he discovered seeking treatment elsewhere.

About two months later, Mr. C was arrested for vagrancy and drug charges. He was then seen in jail by the team psychiatrist. Mr. C was extremely paranoid, ambivalent, and disorganized. He admitted to having abused amphetamines and cocaine for the previous few months. He had both delusions of persecution and hallucinations of a "dark man" pursuing him. Mr. C was offered antipsychotic medication, which he refused on the basis that the psychiatrist might be hoping to poison him.

Discussion

As has been noted in the probation literature, more intensive monitoring and supervision of probationers frequently results in the increased likelihood of their reincarceration.[16] When intensive case management services are combined with a restrictive commitment standard and an availability of psychiatric treatment within the jail system, there is an incentive on the part of mental health providers

to return patients to jail who are noncompliant with treatment, who are decompensating, and who are unwilling to be admitted voluntarily for psychiatric hospitalization. Because court stipulations of release often include compliance with treatment, probation officers can file for a technical violation with the court. In addition, many of the patients who are noncompliant with treatment are also violating probation by using alcohol and drugs.

These cases provide examples of the use of jail as an alternative treatment modality for those mental health patients who have been released from jail and who have remained under the supervision of the court. It is important to note that the mechanisms of the criminal justice system are often complex. A number of competing interests may influence the outcome of a specific case, which thus cannot be generalized to the criminal justice system as a whole. For example, the fact that none of the patients in these cases returned to jail explicitly for technical violations of probation or parole should not discount the impact of probation and parole authority in the process of returning patients to jail. The final decision regarding return to jail is made by a judge, and in the two instances (cases 1 and 3) in which patients did return to jail, new drug charges may have been preferable to a simple technical violation as a strategy for assuring a jail stay. Probation and parole officers may advocate such dispositions, inasmuch as a new violation of a drug law is a violation of probation or parole (as is the simple possession of drugs).

Another important point exemplified by these cases is that coercive strategies involving probation and parole were not employed until compliance with treatment became an issue between the psychiatrist and the patient. If the patients who had substance use relapses had initially been more compliant with their psychiatric treatment, strategies more consistent with the disease and recovery models of addiction treatment may have been employed. Therefore, return to jail may have hinged on three factors: noncompliance with treatment, involvement with an intensive community psychiatric intervention, and supervision by the court through probation and parole.

These cases also raise questions concerning the strengthening of in-jail mental health services as a means of obtaining needed psychiatric treatment for patients who refuse medication and/or refuse to stop abusing alcohol and drugs, which frequently exacerbate their psychiatric symptoms. There seems to be a need for more innovative services that would enhance compliance for patients with multiple problems who are resistant to complying with existing mental health services. Abram and Teplin[22, 23] have noted the failure of the mental health service delivery system to treat persons with co-occurring disorders (e.g., substance abuse, depression, or antisocial personality disorders) or younger severely mentally disabled individuals. They indicate that the criminalization of the mentally ill may primarily affect persons with co-occurring disorders, such as those represented in these case examples.

In those jurisdictions that focus exclusively on a strict dangerousness standard,

consideration might be given to broadening the criteria to include grave disability for involuntary commitment more generally. This suggestion does not mean to dismiss the importance of civil rights protection for mentally ill persons. It merely suggests that mentally ill people who are in jail because of a need for psychiatric treatment would be more appropriately and humanely treated in a hospital. This broadened standard may assist in alleviating the trend toward incarcerating these individuals for treatment purposes. There is also a need to develop appropriate community-based interventions for psychiatric probationers and parolees with multiple problems in order to avoid technical violations as a means to obtain treatment because of a lack of alternatives.

Conclusions

Case managers and other professionals who provide treatment and services for psychiatric probationers and parolees often experience frustration in gaining involuntary hospitalization for these individuals who experience psychiatric decompensation and who also refuse voluntary treatment, be it inpatient or outpatient. The frustration arises from failed efforts to get patients to comply with necessary treatment, which results in exacerbation of symptoms to the point of serious concern but not serious enough to meet the dangerousness standard of involuntary commitment. Because such an individual does not meet dangerousness criteria for involuntary hospitalization, alternative means may be sought for acquiring treatment. A jail psychiatric treatment program as discussed here can provide such means for those patients who are under probation and parole.

The mechanisms of detention for technical violations of probation or parole are criminal justice mechanisms that serve the manifest function of public safety. They may also serve a latent function of providing hospitalization for persons with serious mental illness. The use of these mechanisms when psychiatric treatment is available in the jail system enables probationers and parolees with mental illness to be coerced into a jail treatment environment on the basis of criteria that are often less stringent than the dangerousness criterion of involuntary civil commitment for psychiatric hospitalization. These criteria involve violation of legal conditions that are imposed on a probationer or parolee, which may be only a lack of compliance with treatment (i.e., refusing prescribed medication or not keeping psychiatric appointments). One need only establish that judicial orders were not followed in order to seek the incarceration of an individual rather than an assessment of whether an act was clinically dangerous on the basis of involuntary commitment statutes. Individuals with mental illness find it difficult to shed legal entanglements such as probation or parole, which increases their chances of future incarceration for behavioral management purposes.

Policies and programs need to be developed to ensure that the mental health system does not abrogate its responsibility for this difficult subpopulation of the severely mentally disabled who are under probation and parole, who often resist treatment, and who abuse chemical sub-

stances. There is a need for the establishment of diversion programs to keep the psychiatric population whose criminal behavior is the consequence of their illness from entering the criminal justice system. The avoidance of legal entanglements from the onset will keep this population from becoming so enmeshed in the criminal justice system that it becomes difficult for them to disentangle themselves from the system. It may also eliminate the possibility of using this system as an alternative to mental health treatment and behavioral management. Diversion programs operated by the mental health system ensure that the responsibility of treatment for this population remains within the domain of the mental health system. These diversionary programs may include residential crisis services, which are community-based alternatives to both hospitalization and jail[24] and may be more attractive to patients than hospitalization. Patients may be more agreeable to entering such services voluntarily because these programs may more directly address their immediate treatment and service needs.

Programs for diversion of this population need to be carefully designed, implemented, and monitored so that intensive surveillance does not become the *modus operandi*, with a deemphasis on treatment. Alternatives to incarceration for technical violations need to be considered and tried. More stringent criteria for treatment stipulation violations need to be employed to make incarceration difficult when it is motivated by treatment purposes. Although there is a need for a well-developed mental health program within the jail system (given the lack of diversionary programs), these jail mental health psychiatric services need to be less easily accessible so that they are not a more viable alternative than involuntary hospitalization for patients on probation or parole.

It is unlikely that criteria for involuntary commitment would be broadened. However, these criteria need to be reviewed and rigorously studied in order to ensure that a more dehumanizing and inappropriate alternative is not being substituted for hospitalization for some populations. A possible alternative is the use of advanced directives in which there is a collaboration among the patient, the family, and the service providers to develop a contract, while the patient is in remission, that the patient will voluntarily agree to involuntary treatment when decompensation occurs.[25, 26] This approach places more control regarding treatment decisions with the patient.

Future research must address the issue of incarceration for the treatment and behavioral management of this population. A systematic assessment of the extent to which technical violations are used for these purposes needs to be undertaken. With this type of data, directions for possible interventions can be developed to avoid such situations. The mental health system has a responsibility to psychiatric probationers and parolees and cannot abandon that responsibility to the criminal justice system by default.

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