
MENTAL HEALTH NEEDS AND SERVICES IN THE CRIMINAL JUSTICE SYSTEM*

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ABSTRACT

Policymakers and practitioners increasingly are concerned about the need to address better the mental health needs of offenders throughout all stages of the criminal justice system. The concern is understandable: Society arguably has a moral obligation to provide treatment to mentally ill offenders, and the presence of a mental illness can make it considerably more difficult for justice-involved offenders to become productive and law-abiding citizens. Juxtaposed against this concern is a lack of reliable and accurate empirical information about (1) the prevalence of mental illness among offenders throughout the criminal justice system, (2) the size of the needs-services gap from one stage of the system to the next, and (3) how best to fill the needs-services gaps at each stage. In this paper, I discuss these issues and suggest avenues for empirical research that can assist policymakers and practitioners to develop defensible strategies for strategically allocating resources to treat mentally ill offenders.

I. INTRODUCTION

In the past, any mention of mental illness and crime in the same sentence would conjure up an image of a psychopathic criminal who needed to be locked away forever. But times have changed: Few people today adhere to this outdated image of the mentally ill as offenders. Moreover, during the past decade, policymakers and practitioners have increasingly expressed considerable

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interest in treating the mentally ill, including those who are under the supervision of the criminal justice system.¹ The interest stems in part from a concern that the justice system is being used as a dumping ground for the mentally ill.² It stems as well from a belief that mental illness should be treated, regardless of whether a crime has been committed.³ And, not least, it stems from pragmatic considerations, including the possibility that treating mental illness can reduce the number of offenders and improve social outcomes, such as increased education and employment among offenders.

The focus on mental illness assumes greater importance when we consider the dramatic growth in and current size of the United States criminal justice system. The number of individuals under some form of justice system supervision almost tripled during the past two decades, rising from 1,842,100 to 6,732,400 between 1980 and 2002, according to data from the U.S. Bureau of Justice Statistics ("BJS").⁴ These data indicate that as of 2002 there were 3,995,165 individuals on probation, 665,475 in jail, 1,367,856 in prison, and 753,141 on parole.⁵ The juvenile justice system has experienced considerable growth as well: The number of youth placed on probation or in juvenile correctional settings increased by 57% between 1985 and 2000, from 532,976 to 815,262,⁶ and releases from juvenile correctional facilities likely have increased commensurately.⁷ These changes have resulted in a dramatic increase in prisoner reentry: Approximately 600,000 offenders are released annually from state or

¹ See COUNCIL OF STATE GOV'TS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT (June 2002), available at <http://www.ncjrs.org/pdffiles1/nij/grants/197103.pdf> (October 29, 2002).

² *Id.*

³ HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 3-5 (Sept. 2003), available at <http://www.hrw.org/reports/2003/usa1003> (last visited July 31, 2004).

⁴ BUREAU OF JUST. STATS., U.S. DEP'T OF JUST., ADULT CORR. POPULATIONS (2003), available at <http://www.ojp.usdoj.gov/bjs/glance/corr2.htm> (last revised Aug. 20, 2003).

⁵ *Id.*

⁶ NAT'L CTR. FOR JUV. JUST., OFFICE OF JUV. JUST. & DELINQ. PREVENTION, EASY ACCESS TO JUVENILE COURT STATISTICS: 1985-2000 (2002), at <http://ojjdp.ncjrs.org/ojstatbb/ezajcs> (revised Aug. 11, 2003).

⁷ Howard N. Snyder, *An Empirical Portrait of the Youth Reentry Population*, 2 YOUTH VIOLENCE & JUV. JUST. 1, 41-44 (Jan. 2004). As Snyder has emphasized, estimating juvenile correctional and release (i.e., parole or aftercare) counts is extremely difficult because of the diversity across states in how the juvenile justice system is structured and the lack of a national juvenile justice database that records information about individuals released from juvenile facilities. *Id.* at 41-42.

federal adult prisons⁸ and juvenile correctional facilities back into communities nationwide. Close to two-thirds of these offenders will commit new crimes within three years of release,⁹ raising obvious policy concerns about how best to improve the transition from prison to society.

Research suggests that a much lower proportion of the U.S. population—approximately 5.4%—suffer from a serious mental illness compared with justice-involved offenders.¹⁰ But we lack precise estimates about the prevalence of mental illness among criminal justice populations, to say nothing of changes over time in prevalence rates. Most commentators point to statistics provided by BJS, indicating that approximately 16% of state prison inmates are mentally ill.¹¹ Some accounts, such as a recent Human Rights Watch report, put the rate of mental illness of prison inmates at 20% or higher.¹² According to one review, “studies and clinical experience indicate that 8 to 19% of prisoners have significant psychiatric or functional disabilities; another 15 to 20% will require some form of psychiatric intervention during their incarceration.”¹³ Comparisons of estimated prevalence rates of specific types of mental disorders typically reinforce these findings, showing that on average a greater proportion of justice-involved offenders are mentally ill.¹⁴ Yet the fact remains that we know little about the true prevalence of mental illness

⁸ Jeremy Travis et al., JUST. POLICY CTR., URBAN INST., FROM PRISON TO HOME: THE DIMENSIONS AND CONSEQUENCES OF PRISONER REENTRY 1 (June 2001), available at http://www.urban.org/UploadedPDF/from_prison_to_home.pdf (last visited July 31, 2004).

⁹ Barry Krisberg & James C. Howell, *The Impact of the Juvenile Justice System and Prospects for Graduated Sanctions in a Comprehensive Strategy*, in SERIOUS AND VIOLENT JUVENILE OFFENDERS: RISK FACTORS AND SUCCESSFUL INTERVENTIONS 346–66 (Rolf Loeber & David P. Farrington eds., 1998); TIMOTHY HUGHES & DORIS J. WILSON, REENTRY TRENDS IN THE UNITED STATES, BUREAU OF JUSTICE STATISTICS, at <http://www.ojp.usdoj.gov/bjs/reentry/reentry.htm> (last visited Apr. 8, 2004).

¹⁰ Ronald C. Kessler, et. al., *A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness*, in MENTAL HEALTH, UNITED STATES 1999 99–109 (Ronald W. Manderscheid & Marilyn J. Henderson eds., 1998).

¹¹ PAULA M. DITTON, BUREAU OF JUST. STATS., U.S. DEP'T OF JUST., MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 1 (JULY 1999), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf> (revised July 31, 2004).

¹² Fox Butterfield, *Study Finds Hundreds of Thousands of Inmates Mentally Ill*, N.Y. TIMES, Oct. 22, 2003, at A14.

¹³ Jeffrey L. Metzner et al., *Treatment in Jails and Prisons*, in TREATMENT OF OFFENDERS WITH MENTAL DISORDERS 211 (Robert M. Wettstein ed., 1998).

¹⁴ NAT'L COMM'N ON CORR. HEALTH CARE, U.S. DEP'T OF JUST., 1 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES 24 (Mar. 2002), available at http://www.ncchc.org/pubs/pubs_str.vol1.html (last visited July 31, 2004).

among offenders throughout all stages of the criminal justice system, or about the extent to which the needs of mentally ill offenders are going unmet.

If we accept at face value the idea that mentally ill offenders should be a focus of public policy, any reasonable and effective policy response requires that we address three critical questions. First, how great is the demand for treatment? For example, how many justice-involved offenders have a mental illness? Second, what is the needs-services gap? That is, what kinds and levels of services currently exist and how short do they fall of demand for them? And, third, what kinds of programs and policies are needed to most effectively fill existing or anticipated mental health needs-services gaps?

This paper addresses each of these questions, beginning first by examining why mentally ill offenders constitute a public policy concern. I then focus on the extent to which empirical data allow the three questions to be answered and emphasize the kinds of research necessary to provide better answers. The paper focuses primarily on what is and is not known empirically about issues relevant to treating mentally ill offenders, and its main conclusion is largely a pessimistic one: Currently, we lack a solid empirical foundation for saying much about treatment need in the criminal justice system nationally or in specific states and jurisdictions, the extent to which there is a needs-services gap, and what programs and strategies would be most effective for addressing specific kinds of gaps. That conclusion, however, is tempered by the observation that recent interest and research provide considerable momentum upon which policymakers, practitioners, and researchers can build to improve treatment and advance knowledge about mentally ill offenders in the criminal justice system.

II. MENTAL HEALTH AS A POLICY CONCERN

There are at least two reasons for society to care about mentally ill offenders. First, mental illness can be viewed as a condition that, on moral grounds, society ought to address, regardless of whether someone has committed a crime. The second reason is pragmatic: By treating mentally ill offenders, society may benefit through reduced recidivism and improvements in social outcomes, such as education and employment among justice-involved populations. If we accept either reason as legitimate, questions naturally arise about the need for mental health treatment, the availability of

treatment services, and strategies for addressing needs-services gaps.

A. The Moral Argument

The moral argument says that mental illness is a condition that, like any physical illness, harms an individual and thus should be treated. From this perspective, treatment is a moral imperative, just as when we treat an individual who suffers from pneumonia or a broken arm. So, if individuals in the criminal justice system are mentally ill, or if they develop a mental illness due to some aspect of criminal justice operations, such as incarceration,¹⁵ then treatment services should be provided.

This view is not subject to empirical refutation or support—either one believes mental illness should be treated or one does not. Support for the idea that mental illness should be treated seems relatively widespread, based on the attention that policymakers have given to mental health issues,¹⁶ and the fact that the public consistently expresses support for rehabilitation and treatment of offenders, even during tough-on-crime eras.¹⁷ Indeed, it appears that public concern about mental illness generally is paralleled by a concern about mental illness among criminal populations.¹⁸

That said, support for treating mentally ill offenders may vary, depending on public views about personal responsibility and its relevance to the etiology or treatment of mental illness. If, for example, some people view responsibility for mental illness as lying with individual volition, they are less likely to support the moral argument for treating mentally ill offenders. Similarly, they may hold individuals accountable for their mental illness if they perceive that the individuals have no obvious desire to recover. Talcott Parsons made a similar observation about physical illness, but the argument appears likely to apply to mental illness even more, perhaps be-

¹⁵ Craig Haney, *The Psychological Impact of Incarceration: Implications for Postprison Adjustment*, in *PRISONERS ONCE REMOVED: THE IMPACT OF INCARCERATION AND REENTRY ON CHILDREN, FAMILIES, AND COMMUNITIES* 33 (Jeremy Travis & Michelle Waul eds., 2003).

¹⁶ See generally CTR. FOR MENTAL HEALTH SERVS., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., NAT'L MENTAL HEALTH INFO. CTR., *MENTAL HEALTH, UNITED STATES, 2000* (Ronald W. Manderscheid & Marilyn J. Henderson, eds., 2001), at <http://www.mentalhealth.org/publications/allpubs/SMA01-3537/default.asp> (last visited July 31, 2004).

¹⁷ Julian V. Roberts & Loretta J. Stalans, *Crime, Criminal Justice, and Public Opinion*, in *THE HANDBOOK OF CRIME & PUNISHMENT* 52 (Michael H. Tonry ed., 1998).

¹⁸ See COUNCIL OF STATE GOV'TS, *supra* note 1, at xii.

cause the problem seems to be located in the mind and thus should be more susceptible to individual control.¹⁹ These possibilities notwithstanding, increased policymaker interest among states and at the national level clearly suggests that considerable support exists for treating mentally ill offenders.

The moral argument gains support not only from the extent to which the public believes in it, but also the extent to which empirical evidence documents a basis for concern. For example, if research shows that the criminal justice system houses or supervises mentally ill persons, then a necessary condition for proceeding with mental health policies, given a moral imperative for doing so, is established. This justification may be reinforced by research assessing the extent to which the mentally ill are disproportionately arrested and punished and whether mental illness is relevant to assessing criminal responsibility.²⁰ And it can be further reinforced by studies that document whether mentally ill offenders have access to appropriate treatment.²¹

B. The Pragmatic Argument

The pragmatic view holds that by treating mentally ill offenders, society benefits because the offenders are less likely to commit crime and more likely to become productive citizens. On this front, empirical research is decidedly mixed. Lurigio and Swartz²² recently reviewed research on the putative link between mental illness and crime and found what they believe to be compelling evidence—most notably the MacArthur Violence Risk Assessment Study²³—that suggests a potentially strong relationship. This study indicates that persons with serious mental illness (“PSMI”) are considerably more likely to commit violent acts, especially if they suffer from a co-occurring substance abuse or dependence disorder.²⁴

But such studies have yet to be sufficiently replicated, and most other research fails to rely on experimental designs or large-

¹⁹ See TALCOTT PARSONS, *THE SOCIAL SYSTEM* 436–37 (1950).

²⁰ See, e.g., Arthur L. Lurigio & James A. Swartz, *Changing the Contours of the Criminal Justice System to Meet the Needs of Persons with Serious Mental Illness*, in OFFICE OF JUSTICE PROGRAMS, U.S. DEP'T OF JUST., 3 CRIM. JUST. 2000, 45–108 (Julie Horney ed., July 2000).

²¹ See Butterfield, *supra* note 12.

²² Lurigio & Swartz, *supra* note 20.

²³ Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES OF GEN. PSYCHIATRY 393 (1998).

²⁴ See Lurigio & Swartz, *supra* note 20, at 53; see also Steadman, *supra* note 23, at 393.

scale surveys that identify distinct groups of serious and less serious mental disorders. "Serious" mental disorders typically are viewed as including serious mental illness (Axis 1) and serious personality disorders (Axis 2).²⁵ These disorders generally include "schizophrenia and other psychotic disorders, bipolar disorder (i.e., manic-depressive disorder), and major depressive disorder,"²⁶ as well as personality disorders such as anti-social personality disorder and borderline personality disorder.²⁷ Unfortunately, such categorizations, while useful, obscure the fact that mental illness can encompass a broad range of behaviors and conditions, ones that do not necessarily fall neatly into "serious" and "less serious" categories and yet may be equally relevant in affecting an individual's behavior and success in transitioning back into society. We also lack empirical research that rigorously establishes which mental disorders are linked to specific types of criminal behavior.

A larger concern lies in the fact that there are few well-developed and empirically tested theories that can explain why there should be a relationship between mental illness and crime.²⁸ What, for example, is the causal mechanism through which depression might lead to specific types of crime, or to crime generally? Why should the severity of mental illness matter? Consider a disease model—in some cases, the amount of a virus present may determine whether a person becomes ill, but in other cases it may simply be the presence of a virus alone that is sufficient to cause illness. In what cases is the severity of a mental illness determinative, and in what cases is its presence sufficient, for causing criminal behavior? In a similar vein, if a general theory concerning mental illness and crime can be identified, to what extent do the mechanisms specified by the theory apply to all types of mental illness? Do they apply equally well, for instance, to schizophrenia, post-traumatic stress disorder, and substance dependence disorder?

Although some explanations have been proffered, the research findings to date, including those from studies going back to the

²⁵ AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, at 25 (4th ed. 2000) (defining serious mental illness and serious personality disorders) [hereinafter DSM-IV].

²⁶ Lurigio & Swartz, *supra* note 20, at 48.

²⁷ DSM-IV, *supra* note 25, at 26–27; but see HUMAN RIGHTS WATCH, *supra* note 3, at 32.

²⁸ See generally SHEILAGH HODGINS, MENTAL DISORDER & CRIME (1993); see also Daniel P. Mears, *Critical Challenges in Addressing the Mental Health Needs of Juvenile Offenders*, 1 JUST. POL'Y J. 40 (Aug. 2001), available at <http://www.cj.org/pdf/justice.doc.pdf> (last visited July 31, 2004).

1920s,²⁹ have focused primarily on documenting that a relationship exists, not how or why.³⁰ The point bears emphasizing: Few researchers have developed theories of crime that show how mental illness causes crime. Instead, hypotheses typically are proffered without much, if any, theoretical grounding. Available explanations therefore tend to lack the kind and level of theoretical backing that generally gives scientists greater confidence in their understanding of criminal or other social behavior.³¹

Without such explanations, policymakers and practitioners will have a difficult time knowing how to intervene. For example, if certain mental illnesses are associated with poor impulse control that in turn causes criminal behavior,³² then it may be possible to develop strategies to develop greater control even if the mental illness itself is not fully resolved. But if mental illness causes crime through some other mechanism, strategies that target impulse control may be unlikely to reduce crime, at least through a reduction in mental illness.

Theories are relevant, too, because they help identify the range of factors that contribute to criminal behavior and, in turn, the relative contribution of each to crime. Empirical research suggests that "the risk of serious mental illness for violence is probably less than or equal to the added risk that is associated with age, educational level, and gender."³³ Thus, as a crime reduction strategy, focusing on mental illness may be less effective than targeting educational achievement. Theories help ensure that we consider all such factors and therefore can put the relevance of any one factor in context.

A more compelling case likely can be made for the role of mental illness in affecting a variety of outcomes other than crime.³⁴ To the extent that society values those outcomes, such as stable employment and housing or, in the area of corrections, management of inmates (e.g., prevention of suicide, reduction of violent or disor-

²⁹ See Lurigio & Swartz, *supra* note 20, at 49 (collecting authorities).

³⁰ See John Monahan & Henry J. Steadman, *Crime and Mental Disorder: An Epidemiological Approach*, in 4 *CRIME & JUST.: AN ANN. REV. OF RES.* 145 (Michael H. Tonry & Norval Morris eds., 1983).

³¹ See generally Daniel P. Mears & Mark C. Stafford, *Central Analytical Issues in the Generation of Cumulative Sociological Knowledge*, 35 *SOC. FOCUS* 5 (2002).

³² See MICHAEL R. GOTTFREDSON & TRAVIS HIRSCHI, *A GENERAL THEORY OF CRIME*, at 90 (1990).

³³ Lurigio & Swartz, *supra* note 20, at 54.

³⁴ See generally *CTR. FOR MENTAL HEALTH SERVS.*, *supra* note 16 (surveying various outcomes for PSMI).

derly behavior, assistance in adhering to daily routines), then a pragmatic argument can be made that it is in society's self-interest to treat mental illness. If an additional outcome includes reduced crime among mentally ill offenders, then an even stronger pragmatic argument can be made.

In sum, support for treating mentally ill offenders ultimately rests on views about morality and societal self-interest. So long as one or the other view enjoys support, it makes sense to examine the scope of the policy problem. But even if we assume that mental illness is widespread among offenders and that public support exists for treating them, it should be emphasized that the policy implications are not necessarily obvious. Mental illness competes with other conditions that concern society, such as physical illness, poverty, and unemployment. Because these conditions typically are even more widespread among criminal justice populations,³⁵ the moral dilemma in a context of scarce correctional resources lies in determining which conditions should be given the greatest priority.³⁶

III. NEEDS-SERVICE GAPS AND STRATEGIES TO ADDRESS THEM

Given that mental illness among criminal justice populations increasingly is a focus of policymakers, there are critical questions that must be addressed to develop reasonable and effective approaches to addressing the needs of mentally ill offenders. We should know how much of a demand for mental health services there is, whether existing levels of service meet that demand, and what strategies would be most feasible and most effective in addressing any needs-services gaps. And ideally, we should have answers to each of these questions for each stage of the criminal justice system, as outlined in Table 1. In this section, I discuss these issues, emphasizing, as the question marks in the table indicate, that we have few solid facts on which to draw, and even fewer when we delve down from the national to state or local level.

³⁵ TRAVIS ET AL., *supra* note 8, at 27.

³⁶ See Laura Winterfield et al., *Strong Science for Strong Practice: Linking Research to Correctional Drug Treatment*, 3 OFFENDER SUBSTANCE ABUSE REP. 17, 26-29 (2003).

TABLE 1. MENTAL HEALTH NEEDS-SERVICES GAPS IN THE CRIMINAL JUSTICE SYSTEM AND STRATEGIES TO ADDRESS THEM: DIMENSIONS ALONG WHICH EMPIRICAL RESEARCH IS NEEDED

	A. Needs-Services Gaps	B. Strategies to Address Gaps
Arrest	?	?
Probation	?	?
Jail	?	?
Prison	?	?
Parole/Release	?	?

Critical questions under A (needs-services gaps) that need to be addressed:

- How many offenders have mental health needs, what is the level of per-offender need, and what type of mental illness, including co-occurring disorders, does each offender have?
- What are the level and quality of services currently provided, how many offenders receive no treatment, and how many treated offenders receive appropriate and sufficient treatment?

Critical questions under B (strategies) that need to be addressed:

- What gaps should be targeted?
- What options exist for addressing each gap?
- Which options are the most effective?
- Which are the most feasible?
- Which gaps should be prioritized to yield the largest or desired impact?

A. The Level of Need for Mental Health Services

To determine the need for mental health services in the criminal justice system, we would need to determine how many offenders at each stage of the justice system—arrest, probation, jail and prison, and parole and release—have a mental illness. We also would want to know the per-offender level of need, the type of mental illness each offender has, whether they suffer from any co-occurring problems (e.g., other mental illnesses), their history of treatment (so we know what has worked and what has not), and, more generally, the particular individual and family risk markers and social capital relevant to creating coherent and effective treatment plans.³⁷

Surprisingly, though, despite persistent calls for addressing mental illness among offenders in the criminal justice system, we have few reliable or accurate empirical estimates of the scope of the

³⁷ See generally REDUCING RISKS FOR MENTAL DISORDERS: FRONTIERS FOR PREVENTIVE INTERVENTION RESEARCH (Patricia J. Mrazek & Robert J. Haggerty eds., 1994).

problem.³⁸ There are no national studies of mental illness in the criminal justice system that rely on comprehensive diagnostic interviews. And there is no national database that records information about mentally ill offenders in the justice system; indeed, typically offenders are not systematically screened and assessed for mental illness, nor is information obtained from any assessments recorded.³⁹ Although studies have been conducted focusing on mentally ill offenders, few use consistent definitions of mental illness, and most have limited generalizability.⁴⁰ Further, studies to date typically have examined jail and prison inmates, so the research picture for offenders on probation or parole is even bleaker.⁴¹

The more commonly cited studies point to higher mental illness rates among justice-involved populations. According to survey data compiled by BJS, state and federal prisons and jails housed 283,800 mentally ill offenders in 1998, or approximately 16% of the state prison population, 7% of federal inmates, and 16% of offenders in local jails.⁴² The BJS analyses of this data relied on inmates' self-reports about their own "mental condition" and their stays in mental health hospitals.⁴³ Thus, while useful for obtaining a general picture of the prevalence of mental illness, the data fall far short of what would be ideal. The ability of inmates to accurately self-report having a mental condition is largely unknown, and many offenders may have an undiagnosed mental disorder that has never been identified or treated.⁴⁴

³⁸ See Lurigio & Swartz, *supra* note 20; Bonita M. Veysey & Gisela Bichler-Robertson, *Prevalence Estimates of Psychiatric Disorders in Correctional Settings*, in 2 NAT'L COMM'N ON CORR. HEALTH CARE 57 (Apr. 2002), available at http://www.ncchc.org/pubs/pubs_stbr.vol2.html (last visited July 31, 2004).

³⁹ ROGER H. PETERS & MARLA GREEN BARTOL, *SCREENING & ASSESSMENT OF CO-OCCURRING DISORDERS IN THE JUSTICE SYSTEM* (1997).

⁴⁰ See HODGINS, *supra* note 28, at ix-x; Mears, *supra* note 28, at 40-41.

⁴¹ See Lurigio & Swartz, *supra* note 20, at 74 ("[Persons with serious mental illness] on probation have been an especially neglected group.").

⁴² DITTON, *supra* note 11, at 1.

⁴³ Respondents to the BJS surveys were asked several questions to measure mental illness. See DITTON, *supra* note 11, at 2. One focused upon whether the respondent had ever taken medication, been admitted to a hospital, or received treatment or services in the past for "an emotional or mental problem." *Id.* The other two questions were: (1) Do you have a mental or emotional condition?; and (2) Have you ever been told by a mental health professional such as a psychiatrist, psychologist, social worker, or psychiatric nurse, that you had a mental or emotional disorder? *Id.*

⁴⁴ Lurigio & Swartz, *supra* note 20, at 68.

Other studies have been conducted that focus on specific cities or counties.⁴⁵ The better designed studies, which typically rely on comprehensive diagnostic interviews, suggest comparable rates of mental illness, ranging from 6 to 16% of correctional populations.⁴⁶ The prevalence of PSMIs is estimated to range between 7% and 9%, but some studies place the upper range at closer to 20%.⁴⁷ Among these and less well designed studies, however, there can be considerable variation not only in the overall prevalence estimates, but also the estimated rates of specific disorders.

A more recent study by Veysey and Bichler-Robertson, drawing on nationally representative data from the U.S. National Comorbidity Survey (NCS), provides more compelling estimates because of the quality of the data on which they rely.⁴⁸ The NCS data are based on comprehensive diagnostic interviews with non-institutionalized members of the U.S. general population, and thus give us one of the richest sources of information about the prevalence of mental illness currently available.⁴⁹ Veysey and Bichler-Robertson applied the NCS prevalence estimates to criminal justice populations, adjusting for demographic differences between the community and justice populations.⁵⁰ The characteristics of justice-involved offenders vary systematically (e.g., they tend to come from lower socioeconomic strata and have higher rates of substance use), and these conditions are correlated with mental disorders.⁵¹ So, Veysey and Bichler-Robertson created three different community-based estimates that could be used to model better the true prevalence rate of specific mental disorders among each of four criminal justice populations (jail, state prison, federal prison, and community corrections, including probation and parole).⁵²

The first sample they termed "Community" (n=7,828), which consisted of individuals drawn from the NCS.⁵³ The second sample,

⁴⁵ *Id.*

⁴⁶ DITTON, *supra* note 11, at 1-2; Veysey & Bichler-Robertson, *supra* note 38.

⁴⁷ Lurigio & Swartz, *supra* note 20, at 67.

⁴⁸ See Veysey & Bichler-Robertson, *supra* note 38.

⁴⁹ See *id.* at 58.

⁵⁰ *Id.* at 59.

⁵¹ *Id.*

⁵² See *id.* at 59; see also NAT'L COMM'N ON CORR. HEALTH Care, *supra* note 14, at 23 (describing the specific mental disorders employed by Veysey and Bichler-Robertson, including schizophrenia, major depression, bipolar disorder, dysthymia, post-traumatic stress disorder, anxiety disorder, and antisocial behavior).

⁵³ *Id.* at 58-59.

Distressed 1 (n=977), consisted of a subsample of individuals from the Community sample with incomes below the poverty level.⁵⁴ The third sample, Distressed 2 (n=247), consisted of a subsample of the Distressed 1 subsample with comorbid substance use disorder.⁵⁵ Veysey and Bichler-Robertson then created six-month and lifetime prevalence estimates.⁵⁶ The former were used for estimating mental illness rates among jail populations (see the discussion below), and the latter were used for estimating similar rates among state and federal prison and community correctional populations.⁵⁷

Table 2 presents the six-month and lifetime prevalence rates for the Community sample, and for the Distressed 1 (individuals living below the poverty line) and Distressed 2 (individuals living below the poverty line and suffering from a substance abuse disorder) subsamples. Whether using the six-month or lifetime estimates, anxiety disorders and major depression occur most commonly among the general population, followed by antisocial personality disorder, post-traumatic stress disorder, dysthymia, bipolar disorder, and schizophrenia. In each instance, the rates are consistently higher for people in poverty (Distressed 1) and people in poverty who suffer from substance use disorder (Distressed 2).⁵⁸ For example, while 18.1% of the U.S. population is estimated to suffer from major depression, the rate is higher among persons living in poverty (20.1%) and even higher among those in poverty who meet the criteria for a substance use disorder (33.6%).⁵⁹

By creating these different samples, the authors were able to generate lower and upper end estimates of the prevalence of mental illness among criminal justice populations, creating ranges within which the true prevalence of mental illness likely lies. Specifically, the authors applied the rates from Table 2 to each of the four criminal justice populations (jail, state prison, federal prison, and community corrections), weighted by the age, race, and gender composition of each population.⁶⁰ Because federal prisoners and community corrections offenders tend to be better off socioeconomically as compared with jail and state prison populations, Veysey

⁵⁴ *Id.* at 59.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *See id.* (discussing the estimation methodology).

⁵⁸ *Id.* at 62.

⁵⁹ *Id.*

⁶⁰ *Id.* at 62-63.

TABLE 2. PREVALENCE ESTIMATES OF SELECT MENTAL DISORDERS IN THE U.S. POPULATION

	6 Month Rates		
	Community Sample (U.S.)	Distressed 1 (Poverty Subsample)	Distressed 2 (Poverty/Drug Use Subsample)
<i>Disorder</i>	%	%	%
Schizophrenia	0.4	0.9	0.8
Major depression	8.4	11.6	20.6
Bipolar	1	1.5	3.6
Dysthymia	2	3.5	7.3
Post-traumatic	3.4	6.7	10.5
Anxiety	14.6	18.5	28.3
Antisocial	—	—	—

	Lifetime Rates		
	Community Sample (U.S.)	Distressed 1 (Poverty Subsample)	Distressed 2 (Poverty/Drug Use Subsample)
<i>Disorder</i>	%	%	%
Schizophrenia	0.8	1.6	1.6
Major depression	18.1	20.1	33.6
Bipolar	1.7	2	5.3
Dysthymia	7.1	8.5	15.8
Post-traumatic	7.2	11	18.2
Anxiety	24.6	28.9	41.3
Antisocial	14.8	20.7	45.3

Source: Bonita M. Veysey & Gisela Bichler-Robertson, *Prevalence Estimates of Psychiatric Disorders in Correctional Settings*, in 2 NAT'L COMM'N ON CORR. HEALTH CARE 63, table 7 (Apr. 2002), available at http://www.ncchc.org/pubs/pubs_stbr.vol2.html (last visited July 31, 2004); see also NAT'L COMM'N ON CORR. HEALTH CARE, U.S. DEP'T OF JUST., 1 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES 24 (Mar. 2002), available at http://www.ncchc.org/pubs/pubs_stbr.vol1.html (last visited July 31, 2004), (describing each of the listed mental disorders).

and Bichler-Robertson applied the Community and Distressed 1 rates to the federal prison and the community corrections populations.⁶¹ Jail and prison populations typically have higher rates of

⁶¹ Veysey and Bichler-Robertson do not explicitly state why they applied these rates to the community corrections population. See Veysey & Bichler-Robertson, *Prevalence Estimates*, *supra* note 38, at 62-3. But in a personal communication, the first author explained that they indeed viewed this population as more similar to general community samples than are the jail and prison populations. E-mail from Bonita M. Veysey, Associate Dean of Academic Programs and Assistant Professor, School of Criminal Justice, Rutgers University, to Daniel P. Mears, Senior Research Associate, The Urban Institute (Nov. 5, 2003, 08:35 EST) (on file with author). The defensible assumption is that individuals on probation and parole typically are better off with respect to prior criminal history, employment,

poverty and substance abuse. So the authors applied the Distressed 1 and Distressed 2 rates to these groups.⁶² Six-month prevalence estimates were used for the jail population because of the shorter average length-of-supervision among jail inmates compared to other criminal justice populations.⁶³ By contrast, lifetime prevalence rates were used for the other criminal justice populations.⁶⁴

Table 3 summarizes the results of their analysis. Inspection of the U.S. community estimates with the criminal justice population estimates in the table highlights three critical points. *First, it does not appear that the prevalence of various mental disorders among criminal justice populations dramatically differs from the prevalence among those members of the general population who most resemble the criminal justice populations with respect to sociodemographic characteristics and substance use.* Compare, for example, the low-end community estimates with the low-end criminal justice estimates, and likewise the high-end community estimates with the high-end criminal justice estimates. In most instances, the difference between the two rates is less than 5%. There are, of course, exceptions. For instance, the high-end estimate of the prevalence of major depression among state prison populations (18.6%) is substantially lower than the high-end community estimate (33.6%).⁶⁵

Second, the prevalence of mental disorders among criminal justice populations generally does not appear to be greater than in the general population if we use the low-end criminal justice estimates. To illustrate, compare the low-end jail prevalence rates in Table 3 with the Community (general population) rates in the first column of Table 2. In most cases, the rates differ only marginally and in some cases the criminal justice rates are lower (e.g., the low-end estimated prevalence of anxiety disorders among jail inmates is 14.1%, compared with 14.6% in the general population).⁶⁶ A similar pattern emerges when we examine the other criminal justice rates in Table 3 with the general population rates in the fourth column of Table 2.

ties to communities, medical and mental health conditions, and substance use than "deeper end" offenders in jails and prisons. *Id.*

⁶² Veysey & Bichler-Robertson, *Prevalence Estimates*, *supra* note 38, at 59.

⁶³ *Id.* ("Most major mental illnesses have periods of quiet and other periods of activity. The rates at any point in time—for example, during a short jail stay—are lower than lifetime prevalence rates. To reflect this consideration, the calculations . . . used 6-month prevalence rates for jail inmates.")

⁶⁴ *Id.*

⁶⁵ *See id.* at 63–64.

⁶⁶ *See id.* at 63.

TABLE 3. PREVALENCE ESTIMATES OF SELECT MENTAL DISORDERS AMONG CRIMINAL JUSTICE SYSTEM POPULATIONS

Disorder	Comparison Rates (U.S.) %	Jails %	Comparison Rates (U.S.) %	State Prisons %	Comparison Rates (U.S.) %	Federal Prisons %	Comparison Rates (U.S.) %	Community Corrections %
Schizophrenia	0.9 - 0.8	1.0 - 1.1	1.6 - 1.6	2.3 - 3.9	0.8 - 1.6	0.8 - 2.5	0.8 - 1.6	0.8 - 2.1
Major depression	11.6 - 20.6	7.9 - 15.2	20.1 - 33.6	13.1 - 18.6	18.1 - 20.1	13.5 - 15.7	18.1 - 20.1	15.2 - 19.3
Bipolar	1.5 - 3.6	1.5 - 2.6	2.0 - 5.3	2.1 - 4.3	1.7 - 2.0	1.5 - 2.7	1.7 - 2.0	1.4 - 2.4
Dysthymia	3.5 - 7.3	2.7 - 4.2	8.5 - 15.8	8.4 - 13.4	7.1 - 8.5	6.8 - 11.6	7.1 - 8.5	6.7 - 11.7
Post-traumatic	6.7 - 10.5	4.0 - 8.3	11.0 - 18.2	6.2 - 11.7	7.2 - 11.0	4.9 - 6.8	7.2 - 11.0	5.9 - 9.3
Anxiety	18.5 - 28.3	14.1 - 20.0	28.9 - 41.3	22.0 - 30.1	24.6 - 28.9	18.2 - 23.0	24.6 - 28.9	22.4 - 27.1
Antisocial	—	26.3 - 46.2	20.7 - 45.3	26.0 - 44.5	14.8 - 20.7	21.3 - 28.2	14.8 - 20.7	16.6 - 25.5
		n=500/483		n=1,010/228		n=91,506		n=3,269/481

Source: Bonita M. Veysey & Gisela Bichler-Robertson, *Prevalence Estimates of Psychiatric Disorders in Correctional Settings*, in 2 NAT'L COMM'N ON CORR. HEALTH CARE 63-65, tables 8-11 (Apr. 2002), available at <http://www.ncchc.org/pubs/stbr.vol12.html> (last visited July 31, 2004); see also NAT'L COMM'N ON CORR. HEALTH CARE, U.S. DEP'T OF JUST., 1 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES 24 (Mar. 2002), available at <http://www.ncchc.org/pubs/stbr.vol11.html> (last visited July 31, 2004) (describing each of the listed mental disorders).

Third, the prevalence of mental disorders among criminal justice populations generally equals or is substantially greater than the prevalence among the general population if we rely on the high-end criminal justice estimates. For the jail population, compare, for example, the high-end estimates in Table 3 with the general population point estimates in the first column of Table 2. In every instance, excepting anxiety disorders, the rates of the disorders among the jail population are at least double those in the general population (e.g., the high-end prevalence estimate of major depression among jail inmates is 15.2%, compared with 8.4% in the general population).⁶⁷ The differences are not quite as pronounced among the other three criminal justice populations, especially the federal prison and the community corrections populations, but nonetheless are striking. For example, the high-end community corrections rates are all higher than the general population estimates in the fourth column of Table 2 (which are also the low-end comparison rates in the seventh column of Table 3). As the discussions above should make clear, these differences arise precisely because criminal justice populations are comprised of individuals who more closely resemble not the general population in the U.S., but rather the subset who are more likely to have mental disorders. Consequently, we should expect rates of mental disorder to be higher in the criminal justice system.

There are two important populations omitted from the above analyses: individuals arrested but not placed in jail and individuals released from prison without supervision. Both groups are large and constitute important targets for mental health treatment since the prevalence of mental illness is likely roughly comparable to what exists in the other criminal justice populations discussed by Veysey and Bichler-Robertson.⁶⁸ During the 1980s and 1990s, between 13 and 18% of all released offenders were released unconditionally because their entire sentence expired during their term of incarceration.⁶⁹ In 2002, there were an estimated 13,741,438 arrests.⁷⁰ The count of arrests overestimates the total number of individuals arrested in a given year because some individuals commit multiple crimes over the course of a year. Nonetheless, a substantial number

⁶⁷ See *id.* at 61, 63.

⁶⁸ See *id.* at 59 (discussing the characteristics of the populations studied).

⁶⁹ See JEREMY TRAVIS & SARAH LAWRENCE, URBAN INST., *BEYOND THE PRISON GATES: THE STATE OF PAROLE IN AMERICA* 8 (Nov. 2002), available at http://www.urban.org/UploadedPDF/310583_Beyond_prison_gates.pdf (last visited July 31, 2004).

⁷⁰ FEDERAL BUREAU OF INVESTIGATION, *CRIME IN THE UNITED STATES 2002*, at 234 tbl. 29 (2003), available at http://www.fbi.gov/ucr/cius_02/htm/web/arrested/04-table29.html.

of individuals are arrested annually, and many are never incarcerated or placed under correctional supervision yet may suffer from some type of mental disorder.

To this point, I have presented aggregate estimates of mental illness among criminal justice populations. However, research shows that rates of specific mental disorders can vary by age, gender, and race or ethnicity.⁷¹ According to the BJS survey, females, whites, and older offenders are, for example, more likely to report having a mental illness.⁷² The analysis conducted by Veysey and Bichler-Robertson provides more refined breakdowns by type of disorder. Women, for example, have "higher rates of major depression, dysthymia, post-traumatic stress disorder, and anxiety disorders," whereas men are more likely to suffer from antisocial personality disorder.⁷³ Whites have higher lifetime rates of major depression and dysthymia, while Hispanics have higher rates of antisocial personality disorder; both whites and Hispanics have higher rates of anxiety disorders than blacks; and blacks and Hispanics have higher six-month rates of schizophrenia compared with whites.⁷⁴ The six-month prevalence rates of major depression and anxiety disorders tend to be higher among young people age nineteen, while rates of post-traumatic stress disorder are higher among 20–29 year-olds; lifetime prevalence estimates indicate that rates of major depression and dysthymia increase with age but anxiety and antisocial personality disorders decrease with age.⁷⁵

Such variations assume greater relevance when we observe that the population of individuals throughout the criminal justice system systematically varies by these same characteristics. Males and minorities, for example, are substantially overrepresented at virtually every stage of the justice system, and young people ages 20–29 constitute close to 40% of all jail and prison inmates.⁷⁶ It is because of this type of patterned variation that studies consistently point to higher rates of mental disorders among the criminal justice population compared to members of the general population.

⁷¹ See Veysey & Bichler-Robertson, *supra* note 38, at 61–62 (including tables demonstrating that the incidence rate for the listed mental disorders vary by age, gender, race and ethnicity).

⁷² See DITTON, *supra* note 11, at 3.

⁷³ Veysey & Bichler-Robertson, *supra* note 38, at 61–62.

⁷⁴ *Id.* at 62.

⁷⁵ *Id.* at 61.

⁷⁶ *Id.* at 60.

For state and local policymakers and practitioners, these general facts should serve primarily to highlight that there is a substantial need for mental health treatment services in the criminal justice system. But they do little to help guide decisions about what is needed in specific states and local jurisdictions. Far better is to have a database system that includes assessment information about the mental health of every offender so as to quantify the level of need for treatment services. Unfortunately, few criminal justice systems rely on systematic and comprehensive offender assessments or even use simple screening instruments to raise flags as to the possibility of potential mental health problems.⁷⁷

Despite these limitations, it nonetheless remains the case that empirical research is absolutely essential for establishing the level of demand for services in the criminal justice system. As the above discussion highlights, the creation of prevalence estimates constitutes an important first step. But there are additional steps to take. For example, development of an appropriate, effective treatment initiative depends on information about the specific types of mental disorders prevalent in a given population, each offender's criminal history, responsiveness to past treatment, existence of co-occurring disorders, and unique risk and protective factors that might affect the success of treatment.⁷⁸ If such information is collected on a systematic basis, then policymakers and criminal justice officials are well-situated to argue for specific levels of funding and for specific types of programming. Although some states and jurisdictions do just that, far too many do not. As a result, making convincing arguments about supporting various mental health treatment initiatives remains a challenge.

At the same time, the risk arises of mistakenly or unwittingly prioritizing treatment of one kind over another when a more comprehensive assessment might well have dictated a different strategy. To illustrate, criminal justice systems nationally have focused considerable attention on treating drug problems.⁷⁹ But few have done so based on systematic evidence that drug problems are more important as a social policy focus than major depression, or that treat-

⁷⁷ See DANIEL P. MEARS ET AL., URBAN INST., DRUG TREATMENT IN THE CRIMINAL JUSTICE SYSTEM (Jan. 2003), available at http://www.urban.org/UploadedPDF/410618_NIDA1_KnowledgeRpt.pdf (last visited July 31, 2004).

⁷⁸ PETERS & BARTOL, *supra* note 39.

⁷⁹ Winterfield et al., *supra* note 36.

ment of drug problems yields greater benefits than treating mental illness.

Similar problems arise with efforts that focus on specific populations. For example, opponents of super-maximum (supermax) security prisons—which house inmates for 23 hours per day by themselves with little or no programming⁸⁰—argue that greater numbers of the mentally ill are being placed in supermaxes and that this type of confinement worsens inmates' mental health.⁸¹ As a result, states are facing pressure to remove the mentally ill from their supermax prisons.⁸² The arguments and the changes certainly have appeal. Yet there is almost no empirical research that systematically documents the prevalence of mental illness among supermax inmates or the negative effects of supermaxes on mental health.⁸³ By the same token, many states have built supermax prisons without any empirical foundation for determining whether the use of such facilities would compromise inmate mental health. Research before and after implementation of supermax prisons—or any other criminal justice initiative—would place policy, program, and funding decisions on firmer ground.

B. The Level of Services to Address Mental Health Needs

We have rough national estimates of the demand for mental health services, as the discussion above shows, and even rougher estimates at state and local levels. Juxtaposed against these estimates is an almost virtual lack of systematic research documenting the level of treatment services currently provided throughout the criminal justice system. By services, I mean specific programs, policies, and practices directly or indirectly related to treating mental illness. Mental health counseling is a service, for example, directly contributing to treatment. So too is a policy requiring the coordination of mental health treatment plans between corrections practitioners and community corrections officers. Screening and assessment, by contrast, might be viewed as indirectly constituting a

⁸⁰ CHASE RIVELAND, NAT'L INST. OF CORRS., U.S. DEP'T OF JUST., SUPERMAX PRISONS: OVERVIEW AND GENERAL CONSIDERATIONS 2 (Jan. 1999), available at <http://www.nicic.org/pubs/1999/014937.pdf> (last visited July 31, 2004).

⁸¹ See Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. REV. L. & SOC. CHANGE 477, 566 (1997).

⁸² Leena Kurki & Norval Morris, *The Purposes, Practices, and Problems of Supermax Prisons*, in 28 CRIME & JUST.: A REVIEW OF RESEARCH 385, 386 (Michael H. Tonry ed., 2001).

⁸³ *Id.*

service because they help to identify the mental health needs of inmates and appropriate treatment modalities but are not themselves treatment.

Because mental health services can encompass a wide range of activities, it would be difficult to take a census of services nationally or locally. Nonetheless, such information must be collected if we are to assess the extent of the needs-services gap. At a minimum, we need to know the level of treatment services currently provided (e.g., how many offenders with mental disorders receive any kind of treatment), the types of treatment services provided per inmate (e.g., screening and assessment, counseling, medication, crisis intervention, case management planning that includes a mental health discharge plan, specialized housing and inpatient care), and some rough assessment of the quality of these services (e.g., what percentage of counselors are certified or are trained psychologists or psychiatrists?). And we need such information for each stage of the criminal justice system, not just, as is frequently the case, for prisons.⁸⁴

So, what do we know about mental health services for mentally ill offenders in the criminal justice system? By and large, not much; at least not much that is based on systematic empirical assessments. We do, however, have suggestive evidence from a few, limited studies. For example, analysis of the *Census of State and Federal Adult Correctional Facilities* data shows that four of every five state prison inmates receive "mental health therapy or counseling services from a trained professional on a regular basis."⁸⁵ The picture suggested by the data suggests grounds for optimism, at least regarding treatment in state prison systems:

Nearly 70% of facilities housing state prison inmates reported that, as a matter of policy, they screen inmates at intake; 65% conduct psychiatric assessments; 51% provide twenty-four hour mental health care; 71% provide therapy/counseling by trained mental health professionals; 73% distribute psychotropic medications to their inmates; and 66% help released inmates obtain community mental health services.⁸⁶

⁸⁴ See Lurigio & Swartz, *supra* note 20, at 74. Studies show that "mental disorders in community corrections populations are likely to be ignored unless the offenders' psychiatric symptoms are an explicit part of their offenses or are florid at the time of sentencing." *Id.*

⁸⁵ ALLEN J. BECK & LAURA M. MARUSCHAK, MENTAL HEALTH TREATMENT IN STATE PRISONS, 2000 3 (July 2001), BUREAU OF JUST. STATS., U.S. DEP'T OF JUST., available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtsp00.pdf> (last visited July 31, 2004).

⁸⁶ *Id.* at 1.

The same data indicate that one in ten inmates received psychotropic medications, one in eight received mental health therapy or counseling, and "fewer than 2 percent of State inmates were housed in a 24-hour mental health unit."⁸⁷ Beck and Maruschak compared these data with the findings from an earlier BJS survey and estimated that 79% of mentally ill inmates "were receiving mental health therapy or counseling services from a trained professional on a regular basis."⁸⁸ However, the authors found substantial variation in the amount of treatment services provided among states, with some reporting that up to one-fourth of inmates received counseling or therapy and one state, Hawaii, reporting that fewer than 5% received these services.⁸⁹

Unfortunately, there have been no studies to assess the validity of these findings. The *Census of State and Federal Adult Correctional Facilities* consists of survey data provided by federal, state, and private facilities.⁹⁰ Officials at each facility indicate whether they conduct screening at intake or psychiatric assessments, provide mental health care or counseling or psychotropic drugs, help inmates obtain community health services, and estimate how many inmates were provided each type of mental health service.⁹¹ The accuracy of the facility-level responses is simply unknown—it is conceivable, for example, that some facilities report providing a certain service, when they do not. Even if we assume the responses are valid, they tell us little about the quality of services. For example, 70% of the facilities reported that they screen inmates at intake, but what is the quality of the screening process and is the information collected used appropriately to inform decisions about mental health treatment? The accuracy of the inmate-level estimates (e.g., the number of inmates who receive counseling) is subject to similar concerns: Officials may over-inflate how many inmates receive counseling or medications, and even if they do not, we have no information on the frequency, timing, appropriateness, or quality of the services. And

⁸⁷ *Id.* The medications include "antidepressants, stimulants, sedatives, tranquilizers, or other anti-psychotic drugs." *Id.*

⁸⁸ *Id.* at 3 (discussing PAULA M. DITTON, BUREAU OF JUST. STAT., U.S. DEP'T OF JUSTICE, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS (July 1999) available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf> (last visited July 31, 1994).

⁸⁹ *Id.* at 4.

⁹⁰ BUREAU OF JUST. STATS., U. S. DEP'T OF JUST., *Census of State & Federal Correctional Facilities* (1995), available at <http://www.icpsr.umich.edu:8080/NACJD-SERIES/00067.xml> (last visited July 31, 2004).

⁹¹ *Id.*

it bears emphasizing that the study focused only on prison inmates; no comparable census has been taken of other criminal justice populations.

These criticisms should not detract from the importance of the study—it gives us a useful sense of the scope of services available in prisons nationally. Taken this way, the portrait raises concerns about needs-services gaps. For example, more than 20% of the study's mentally ill inmates were estimated to receive no regular therapy or counseling, and 34% of the facilities did not help inmates access mental health services upon release.⁹² Because the prison-reported estimates likely may be conservative, they raise concerns that large numbers of mentally ill offenders are receiving little to no treatment in the criminal justice system or the community.

Some studies suggest that these estimates are extremely conservative, that in fact far fewer mentally ill inmates receive any kind of service.⁹³ A recent Human Rights Watch report found, for example, that in many states, mentally ill inmates rarely receive appropriate services.⁹⁴ Although the report suffers from methodological limitations that undermine its generalizability, it provides compelling self-reported evidence from states about their insufficient levels of staffing to address inmate mental health needs.⁹⁵ Iowa, for example, was reported to have three psychiatrists for the approximately 2,000 inmates in the Department of Corrections who are mentally ill.⁹⁶

Additional issues that Human Rights Watch found to be endemic among states included: difficulty hiring and retaining trained and certified staff; implementing appropriate and effective screening and assessment practices; ensuring that the records and treatment plans of identified mentally ill offenders follow them from one part of the system to another; ensuring the quality delivery of treatment services while preserving the confidentiality of offender records and information and maintaining the continuity of services as offenders transition from one stage of the justice system to an-

⁹² See DITTON, *supra* note 11, at 9; HUMAN RIGHTS WATCH, *supra* note 3, at 192.

⁹³ Butterfield, *supra* note 12, at A14; Paul von Zielbauer, *Report Says Many Inmates In Isolation Are Mentally Ill*, N.Y. TIMES, Oct. 22, 2003, at B1.

⁹⁴ HUMAN RIGHTS WATCH, *supra* note 3, at 94.

⁹⁵ *Id.* at 95. The Human Rights Watch report also provides documentation about abuse of mentally ill offenders in the criminal justice system. *Id.* Presumably, any abuses of mentally ill offenders should also be factored into a systematic assessment of needs-services gaps and, more generally, the care and treatment of mentally ill offenders. *Id.* at 79–86.

⁹⁶ *Id.* at 95.

other; limited access to and use of newly developed medications to treat mental illness and its symptoms; over-reliance on medications as the only form of treatment, particularly psychotropic medications and sedatives; and a lack of specialized housing and services for seriously mentally ill offenders.⁹⁷ These issues have also been highlighted by other recent reports,⁹⁸ which suggests that the Human Rights Watch report likely does not dramatically overstate the case.

If we look beyond these sources of information and focus on any of a range of specific issues, the absence of data on practices within the criminal justice system is striking.⁹⁹ Consider two examples. Many states have become increasingly interested in using screening and assessment instruments to identify drug and mental health problems among both their juvenile and adult offender populations.¹⁰⁰ Yet few studies 1) have examined which instruments actually are used at each stage of the justice system or 2) monitor whether they are administered appropriately by trained staff and whether practitioners use the resulting information appropriately. Those that have been conducted suggest widespread discrepancies in how particular instruments are viewed and used by practitioners.¹⁰¹ Similarly, many opponents of supermax prisons point to the

⁹⁷ *Id.* at 94–134.

⁹⁸ See, e.g., Lurigio & Swartz, *supra* note 20, at 63–78; see also CTR. FOR MENTAL HEALTH SERVS., *supra* note 16, at 9; COUNCIL OF STATE GOV'TS, *supra* note 1; The Sentencing Project, *Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription* (Jan. 2002), available at <http://www.sentencingproject.org/pdfs/9089.pdf> (last visited July 31, 2004); Bonita M. Veysey & Gisela Bichler-Robertson, *Providing Psychiatric Services in Correctional Settings*, in 2 NAT'L COMM'N ON CORR. HEALTH CARE 157 (2002), available at http://www.ncchc.org/pubs/pubs_stbr.vol2.html (last visited Apr. 8, 2004).

⁹⁹ See Ingrid Goldstrom et al., *The Availability of Mental Health Services to Young People in Juvenile Justice Facilities*, in MENTAL HEALTH, UNITED STATES 2000 248, 257 (Ronald W. Manderscheid & Marilyn J. Henderson eds., 2001), available at <http://www.mentalhealth.org/publications/allpubs/SMA01-3537/chapter18.asp> (last visited July 31, 2004). Goldstrom et al. recently examined data from a national survey—the 1998 *Inventory of Mental Health Services in Juvenile Justice Facilities*—and painted a similar picture of mental health services in the juvenile justice system. *Id.* As but one example, only 69% of all 2,798 facilities in the study reported providing some form of therapy. *Id.* Variation in the specific types of services available (screening, evaluation, emergency, medication, twenty-four hour, separate residential, and therapy) was found to differ across specific types of facilities (detention, shelters, reception/diagnostic centers, group homes and half-way houses, ranches/camps/farms, residential treatment facilities, and training schools). *Id.* As with the criminal justice system, few in-depth studies examine the level and quality of mental health services provided in various states and jurisdictions' juvenile justice systems. *Id.* The authors did not examine arrest, probation, or aftercare/release.

¹⁰⁰ Winterfield et al., *supra* note 36, at 26.

¹⁰¹ See Daniel P. Mears & William R. Kelly, *Assessments and Intake Processes in Juvenile Justice Processing: Emerging Policy Considerations*, 45 CRIME & DELINQ. 509, 524 (1999).

dearth of treatment programming provided to mentally ill inmates in these high security facilities.¹⁰² Yet recent reviews indicate that we lack even the most basic information about the levels and kinds of treatment supermax or other facilities provide the mentally ill.¹⁰³ In these and other related areas, including those identified in the Human Rights Watch report,¹⁰⁴ empirical research is much needed, both to document the extent to which there is a needs-services gap, and to help prioritize which areas of practice could be targeted to realize the greatest gain.¹⁰⁵

C. Strategies to Address the Mental Health Needs-Services Gap

Any attempt to systematically address needs-services gaps requires knowledge about those gaps. Only then can we begin assessing which gaps should be prioritized and, ultimately, the strategies best suited and most feasible for filling those gaps. As the discussion above highlights, we currently have no systematic assessment nationally or at state or local levels of the specific needs-services gaps that exist or which gaps, among those identified, ought to be given the greatest priority. Should medication underprescription be given primary attention? Or improved case management and planning throughout all stages of the criminal justice system? Improved screening and assessment? We simply do not know. But we should, because few if any jurisdictions can do everything that is recommended or desirable; most need to carefully decide where to expend their limited resources. Without the ability to make explicit cost-benefit decisions about funding one type of initiative or another, we may fail to fully capitalize on opportunities to generate the largest gains in treating mentally ill offenders. A jurisdiction may, for example, expend considerable social, political, and economic capital on developing a mental health court, even though investing in mental health counselors and treatment services might prove to be far more beneficial. A listing of needs-services gaps

¹⁰² HUMAN RIGHTS WATCH, *supra* note 3, at 203, 214.

¹⁰³ See Kurki & Morris, *supra* note 82, at 410.

¹⁰⁴ HUMAN RIGHTS WATCH, *supra* note 3, at 94–134.

¹⁰⁵ From a pragmatic perspective, the reality would seem to be that only a limited set of criminal justice resources will be devoted to addressing the needs of mentally ill offenders. See Winterfield et al., *supra* note 36 at. So it seems essential to document empirically exactly what needs-services gaps are the greatest, and which ones, if addressed, would yield the greatest benefits, whether by improving outcomes or satisfying the desire, to the extent such is present in society, to treat mental illness out of a sense of moral obligation.

thus is an essential first step before selecting specific strategies to address those gaps.

In the absence of research quantifying any of a range of potential gaps, it may be helpful to catalogue some of the more prominent strategies and areas of focus that recent reviews have highlighted as critical for improving mental health services—which are assumed to be deficient—throughout the criminal justice system.¹⁰⁶ At virtually any stage—arrest, probation, jail, prison, parole/release—there are opportunities to identify and treat mentally ill offenders. However, the approaches taken at each stage should vary depending on the specific contexts and issues associated with each stage (e.g., jails hold inmates for considerably shorter periods of time than prisons and so should focus primarily on crisis intervention and referrals to services). In each instance, effective programs exist that can help improve mental health treatment:

- Screening, assessment, and evaluation. Ideally, offenders are screened using validated instruments as soon as they enter the criminal justice system (e.g., at booking). Complete assessments are then conducted with individuals for whom the screens suggest a mental disorder might be present, and psychiatric evaluations are conducted with those individuals for whom mental health services are deemed necessary or appropriate. Co-occurring disorders should be identified during the assessment and evaluation phases, and mentally ill offenders should be diverted to treatment programs, services and the civil justice system where possible and appropriate.
- Crisis intervention. Crisis intervention facilities, staff, programs, and plans should be readily available for mentally ill offenders at risk of suicide or harm to others. Plans should take account of an individual's particular disorder and needs; they should not necessarily involve isolation of the offender.
- Treatment. A range of mental health treatment modalities have been found to be effective with specific types of mental health and co-occurring disorders. These, along with medication, should be selected as is appropriate for specific individuals and the capacities of the criminal justice system to provide them. Mentally ill offenders should receive appropriate medications at

¹⁰⁶ See e.g., Suzanne M. Morris, *Mental Health Services in United States Jails: A Survey of Innovative Practices*, 24 CRIM. JUST. & BEHAV. 3 (1997); PETERS & BARTOL, *supra* note 39; Lurigio & Swartz, *supra* note 20; Goldstrom et al., *supra* note 102; COUNCIL OF STATE GOV'TS, *supra* note 1; The Sentencing Project, *supra* note 101; Veysey & Bichler-Robertson, *Providing Psychiatric Services*, *supra* note 101; HUMAN RIGHTS WATCH, *supra* note 3, at 94-134.

the prescribed dosages, and all medication plans should be consistently implemented regardless of offender transitions from one stage of the criminal justice system to another. A continuum of comprehensive care should be implemented that ensures the offender's full range of needs are addressed, including co-occurring disorders, throughout all stages of the criminal justice system and release back into the community.

- Specialized housing. For offenders identified with mental disorders, specialized housing should be available, depending on the severity of each offender's disorder and needs, and on his risk of suicide.
- Case management, including reentry planning. All mentally ill offenders should have clear and consistent case management plans for treating their mental illnesses. These plans should include the steps that will be taken to ensure the involvement of mental health and other service providers, as well as a successful transition from criminal justice supervision to self-supervision. Where possible, treatment should involve referral to organizations and agencies better able to provide appropriate and effective services.
- Collaboration among justice system and other agencies. The criminal justice system is ill-suited to address all the needs of mentally ill offenders. More and better treatment of this population is likely to occur in jurisdictions where the criminal justice system forges working collaborative relationships with state and local community agencies, including welfare, health, and mental health, human, and social services organizations, and where responsibility for managing and treating mentally ill offenders lies with all agencies. Among other things, these collaborations can reduce the duplication of services.
- Increase and improve community-based mental health services. By increasing and improving community-based mental health services, criminal justice systems can more effectively address the criminogenic characteristics of offenders and allow mental health professionals to more effectively address the mental health needs of offenders. The existence of such services can reduce the criminalization of the mentally ill.
- Training. Law enforcement and criminal justice system practitioners should be trained to understand and effectively intervene with mentally ill offenders and to divert offenders to mental health service agencies where appropriate. This training should include courses on cultural competency and sensitivity.

Of course, no list can be comprehensive, and this one is not. It does, however, provide a succinct overview of the spectrum of efforts needed to develop a rounded and effective response to mental illness among criminal justice populations. The recent report by the Council of State Governments¹⁰⁷ provides a truly comprehensive listing of mental health strategies, including forty-six specific policy recommendations (and additional implementation recommendations) that span all stages of the criminal justice system. It must be emphasized, however, that there is a need for empirically-based assessments of needs-services gaps. Only with such information can policymakers and practitioners effectively decide which of the Council's recommendations are most relevant to their specific policy context, which are feasible and affordable to implement, and, most importantly, which are most likely to succeed.

IV. CONCLUSION

Policymakers and practitioners increasingly are concerned about addressing the needs of mentally ill offenders. Yet we still lack sufficient national or local-level data to adequately inform decisionmaking about the precise nature and magnitude of the mental health needs-services gaps in the criminal justice system. As a result, policy decisions perforce must fall back on anecdotes, hunches, and analyses of potentially questionable relevance. Nonetheless, in recent years, better data have emerged. The bulk of these data suggest that mental illness is as prevalent if not far more so in the criminal justice system than in society at large, and that services to treat mentally ill offenders are far from sufficient. Although researchers have identified a host of strategies to improve the treatment of this population, local policymakers have been left largely to their own discretion to determine which of these are needed in what "dose" to be effective in their communities.

Typically, research recommendations come at the end of lists of strategies for improving mental health treatment in the criminal justice system. I would argue that it should have equal, if not greater, footing with program and policy recommendations. Without solid research, it is a certainty that scarce resources will be unnecessarily (and presumably unintentionally) diverted from efforts that would yield far greater returns. Better data and research estab-

¹⁰⁷ See generally COUNCIL OF STATE GOV'TS, *supra* note 1; see also HUMAN RIGHTS WATCH, *supra* note 3, at 94-134.

lishes a platform for evaluating initiatives, including documenting what works and how less-than-successful efforts can be improved. In addition, policymakers can monitor the precise strengths and weaknesses of current strategies and determine where to strategically focus their efforts in coming years. And better research can help policymakers and practitioners minimize the dramatic swings in support for mental health treatment by consistently documenting the existence of mental health needs and of effective (and improving) efforts to address these needs.

At the top of any research list should be documenting, by jurisdiction, the number of offenders with various types of mental disorders at every stage of the juvenile and criminal justice system. This information should be easily consolidated with other sources of information both to inform treatment decisions and to enable researchers to document potential disparities in how the mentally ill are processed by the criminal justice system. At the same time, jurisdictions should map the entire array of strategies they currently use to help mentally ill offenders. Where possible, they should show the number of offenders served and the funds and resources used. If done well, the result should be the equivalent of a thermal picture of a house, showing exactly where there are obvious gaps in services and whether the gaps occur at critical junctures (e.g., research can show whether the absence of community-based mental health services and a lack of awareness among law enforcement agents are the primary reasons that many mentally ill proceed from booking to jail rather than to some form of treatment).

What should policymakers do in the meantime? Again, I would argue that improved applied research at the local level is absolutely essential, with a particular emphasis on identifying the full range of needs-services gaps. Mental illness clearly is widespread in the criminal justice system, and likely far more so than in society at large. But without a clear sense of the precise scope of the problem in specific jurisdictions and states, policymakers would do well to exercise common sense, focusing on developing initiatives that, as best as possible, identify and treat those with the most serious mental disorders, while at the same time promoting efforts to identify and fill existing gaps in treatment and services throughout the criminal justice system. If, for example, a particular jurisdiction currently uses no screening or assessment instruments, or relies on ones that have not been validated, this gap likely should be addressed. Otherwise, it will be impossible to develop reasonable esti-

mates of the numbers of mentally ill offenders, much less to develop appropriate treatment plans.

To the extent that policymakers feel compelled to pursue treatment initiatives, they should consider embracing a multi-faceted view of offender treatment that focuses on all of an offender's mental health needs. They also should develop a comprehensive continuum of services and do so through the creation of a collaborative multi-agency initiative, one that includes communities and a sense of shared responsibility for ensuring that the mentally ill receive appropriate, effective, and timely treatment. Finally, any such effort should recognize the diversity of mental health issues and, as the Council of State of Governments report shows, the diversity of strategies to address them, from individual-level to systems-level efforts.¹⁰⁸

Ultimately, the best potential for improving the identification and treatment of mentally ill offenders likely lies in a general reorientation of the criminal justice system from one that focuses primarily on punishment to one that views the treatment of all offender needs as a basic feature of justice. This view need not necessarily imply a "soft" or "feel good" approach or a swinging of the pendulum toward a rehabilitative, non-punishment philosophy. But it does imply that a truly effective and just criminal justice system must view offenders as individuals with diverse needs, not simply as punishment-deserving entities. It just might be that a solid foundation of research on these individuals would help contribute to such a reorientation.

¹⁰⁸ COUNCIL OF STATE GOV'TS, *supra* note 1, at 19-22.