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People With Serious Mental Illness in the Criminal Justice System: Causes, Consequences, and Correctives

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Abstract

This article examines the rising number of people with serious mental illness (PSMI) in the criminal justice system and suggests remedies for improving care and services for this troubled population. Of note, mental illness is not the primary cause of criminal behavior nor is deinstitutionalization principally responsible for the disproportionate criminal justice system representation of PSMI. Rather, harsh crime control policies and draconian drug laws, in particular, account for the apparently large numbers of PSMI who are arrested and incarcerated. Recommendations are offered for service providers to focus on the amelioration of criminogenic factors, not simply on treating mental illness among PSMI in the criminal justice system. Furthermore, larger investments should be made in treating co-occurring disorders and funding aftercare services, which are essential to maintaining treatment gains and sustaining recovery.

Keywords

PSMI (people with serious mental illness), co-occurring disorders, aftercare services

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Overview

For more than four decades, people with serious mental illness (PSMI) have been falling outside the country's social safety net—a net that has been steadily shrinking—and simply "landing in the criminal justice system at an alarming rate" (Council of State Governments, 2002, p. 4). The mentally ill often will cycle repeatedly through the criminal justice and mental health systems (Draine, Salzer, Culhane, & Hadley, 2002; Lurigio & Swartz, 2000; Massaro, 2004; Petrila, Ridgely, & Borum, 2003). Gross racial and economic disparities in mental health care and increasingly punitive crime control polices have resulted in the presence of more and more PSMI in the criminal justice system (Mauer, 2006; U.S. Surgeon General, 1999). In short, the nation's "unmet mental health needs are shaped by a broader national care crisis, and criminal justice involvement by persons with mental illness is embedded in a broader American criminalizing trajectory" (Fichtner & Cavanaugh, 2006, p. 1511).

Research suggests that the percentages of most types of mental illness are significantly higher in correctional populations than in the general population (Council of State Governments, 2002). In one investigation, for example, certain diagnoses were particularly elevated in correctional settings, including schizophrenia and psychotic disorders (rates were up to four times higher in jails and prisons than in the general population), bipolar disorder (rates were up to three times higher in jails and prisons than in the general population), and posttraumatic stress disorder (rates were up to two times higher in jails and prisons than in the general population; Veysey & Bichler-Robertson, 2002).

The mental health and criminal justice systems have porous boundaries with respect to the people they serve and the professionals available to treat the mentally ill, particularly at the local level. What happens in one system can frequently affect what happens in the other. For example, the absence of emergency psychiatric services in the community can lead to more PSMI being arrested and detained. The limited availability of community-based care also affects the ability of jails to comply with court orders that require the release of mentally ill detainees with a comprehensive discharge plan (Massaro, 2004).

Better treatment for mental illness can stem the tide of criminalizing PSMI, keeping more mentally ill persons off ever-expanding court dockets and out of overcrowded jails (Massaro, 2004; Petrila, Ridgely, & Borum, 2003). Undeniably, more accessible and effective mental health treatment for criminally involved PSMI is viewed widely as the key to addressing the problem of the mentally ill in the criminal justice system at every stage in the process (Council of State Governments, 2002). Furthermore, mandatory treatment is

the centerpiece of most criminal justice-based programming for PSMI. However, mental health services are not a sufficient condition for reducing criminalization and recidivism (Draine, Wilson, & Pogorzelski, 2007). Notwithstanding, the provision of psychiatric treatment is a sound criminal justice investment; the stabilization of symptoms can enhance the receptivity of PSMI to other interventions that can reduce crime and recidivism.

Definitional and Diagnostic Issues

In this article, PSMI are defined as individuals who meet the diagnostic criteria for schizophrenia, bipolar disorder, and major depression. As described on Axis I of the American Psychiatric Association's *Diagnostic and Statistical Manual* (4th ed., text revision [*DSM-IV-TR*]), these brain diseases are among the most distressing, debilitating, and persistent of all psychiatric disorders (American Psychiatric Association, 2000). They are most certainly caused by anomalies in brain structure and processes and have a strong genetic component (Hales, Yudofsky, & Gabbard, 2008). Although pharmacological treatment advances for serious mental illness have been made in the past three decades, PSMI are a markedly undertreated population because of ignorance, stigmatization, lack of insurance coverage and equity, and a paucity of treatment options and settings (President's New Freedom Commission on Mental Health, 2003).

The National Comorbidity Survey has shown that mental disorders of all types are likely to co-occur; that is, people often meet the diagnostic criteria for two or more psychiatric disorders at the same time. This is akin to other serious medical conditions that also have high rates of comorbidity, such as heart disease and diabetes (Kessler & Merikangas, 2004; Piotrowski, 2007). Symptoms of depression and anxiety are core or ancillary clinical features of many psychiatric problems; distress and dysfunction generally characterize most of the Axis I disorders (American Psychiatric Association, 2000). Consequently, comorbid psychiatric diagnoses are common in the general population (Kessler & Merikangas, 2004).

Of primary relevance to this article is the co-occurrence of psychiatric and substance use disorders. As I note later, among PSMI, high rates of substance use, abuse, and dependence have become an avenue into the criminal justice system. Simply put, drug possession has led to the arrest of a considerable (but unknown) number of PSMI since the most recent war on drugs was launched in the late 1980s. Indeed, much research suggests that a large proportion of PSMI have comorbid substance abuse and dependence disorders—a combination that renders them more susceptible to arrest, recidivism, and incarceration (Lurigio, 2009; Mueser & Drake, 2007).

Whereas psychiatric disorders form the basis for an affirmative insanity defense, addiction does not. Even if a defendant fails to prove insanity, mental illness is more likely than addiction to be an exculpatory or mitigating factor in criminal sentencing (Erickson & Erickson, 2008). Despite their devastating sequelae, substance use disorders alone—also classified on Axis I—are not commonly regarded as a serious mental illness, at least not in the same manner as the three disorders mentioned above (schizophrenia, bipolar disorder, and major depression). In the research and clinical literature, the treatment arena, and the legal system, substance use disorders are set apart from serious mental illness. For instance, possessing an illegal substance, by itself, is a crime; having a mental illness, by itself, is not. According to the law, the former is a willful act of commission; the latter is an affliction with disease. People who are abusing or dependent on illegal drugs use them habitually and problematically, by definition, and are at risk of arrest for possession. The presence of abuse and dependence disorders also intensifies the rate at which other crimes (e.g., violent and income-generating offenses) are committed, which further increases the likelihood of arrest for people with substance use disorders (Lurigio & Swartz, 1999).

Ground-breaking research and public education campaigns, led by the National Institute on Drug Abuse, have been instrumental in promoting the view of addiction as a brain disease. Despite these efforts and resultant improvements in people's appreciation of substance use disorders as a medical problem, a significant minority of the general public still perceives "drug addicts" as dangerous and undeserving of their sympathies (Institute of Medicine, 1997; Substance Abuse and Mental Health Services Administration, 2008). Furthermore, unlike PSMI, people with substance use disorders are commonly viewed in the courts of public opinion and of law as bearing responsibility for their conditions—a view that is captured in such sentiments as "nobody forced them to snort the coke, shoot up the heroin, shallow the pills, etc." (Schaler, 2000). No such perceptions pertain to PSMI, who are commonly misunderstood, maligned, and feared but are commonly seen as assuming no responsibility for their disease (Corrigan, Watson, & Ottati, 2003). Nonetheless, PSMI frequently enter the criminal justice system as "drug offenders" because of high rates of comorbidity between psychiatric and substance use disorders. Their mental illness can go undiagnosed (and untreated) even if they receive services in the criminal justice system for their drug abuse and dependence disorders (Lurigio & Swartz, 2000).

Similarly, people with Axis II diagnoses, which are rigid, enduring, and maladaptive patterns of relating to others, are also excluded from the category of serious mental illness for clinical and legal reasons. People with Axis II

disorders are not only troubled but are also troublesome, especially those diagnosed with antisocial, borderline, and paranoid personality disorders. They are likely to harm others and are generally regarded as "bad," not "mad" (Erickson & Erickson, 2008). Axis II diagnoses can rarely be used as a criminal defense (see American Law Institute's [1962] criteria for insanity). In fact, a diagnosis of antisocial personality disorders usually leads to the attribution that a person is "criminal by nature" and should be punished more harshly in the legal arena (Erickson & Erickson, 2008).

Axis II disorders have no clear biological etiology, strong heritability, or definitive pharmacologic remedies. Medications can be prescribed to treat the secondary, but not the primary, symptoms of Axis II disorders, which are experienced as ego syntonic and therefore rarely compel those affected to seek psychiatric services (borderline personality disorder is the exception; Million, 1996). PSMI can also be comorbid for Axis II disorders. People with co-occurring psychiatric, substance, and antisocial personality disorders are at particularly high risk for criminal and violent behavior (Swartz & Lurigio, 2007).

As I suggested in the preceding discussion, an understanding of the involvement of PSMI in the criminal justice system is complicated by definitional and diagnostic issues. The term *mentally ill* refers to a diverse group of people who differ from one another on the nature and severity of their disorders. These variations characterize PSMI within both the general and correctional populations. Thus, the "mentally ill in the criminal justice system" are not a monolithic group. PSMI can enter the system through a variety of pathways. They can be arrested for low-level (public-order) offenses that stem from the symptoms of mental illness. When a mental health option is preferable but unavailable, such arrests constitute an instance of criminalization. They can be arrested for drug possession that stems from the presence of a co-occurring addiction. In addition, they can be arrested for serious crimes that stem from criminal thinking and antisocial personality disorders in combination with severe mental illness.

Current Article

The current article examines the rise of PSMI in the criminal justice system and suggests remedies for improving care and services for this troubled population. I argue that deinstitutionalization contributed to, but was not principally responsible for, the disproportionate representation of PSMI in the criminal justice system. I also suggest that mental illness is not the primary cause of criminal behavior. The issue is that mental health services are sparse, and long-term psychiatric care with follow-up services is generally unavailable

in the criminal justice system, which frequently fails to address the criminogenic needs of PSMI. In addition, I note that harsh crime control policies and, in particular, draconian drug laws account greatly for the apparently large number of PSMI at every step in the criminal justice process. I note further that the criminal justice system has made several programmatic efforts to accommodate the presence of the mentally ill in correctional institutions and in community-based correctional programs.

I recommend that service providers focus their attention on ameliorating criminogenic factors and not simply on treating mental illness among PSMI in the criminal justice system. Furthermore, I recommend that a greater investment be made to treat co-occurring disorders. To more precisely capture data on the prevalence of mental illness in correctional populations and to develop more effective treatment services, I also recommend that researchers use consensual definitions of mental illness and standard tools to measure psychiatric disorders. Finally, I recommend greater funding for aftercare services, which are essential to maintaining treatment gains and sustaining recovery.

Deinstitutionalization's Role in the Criminalization of PSMI

The belief that deinstitutionalization (i.e., the closing of the state hospitals) caused an influx of PSMI into the criminal justice system is based in part on the correlational fallacy and rests on untenable assumptions. The emptying of state hospitals began a decade before the precipitous growth of crime and the politicization of the crime problem in the 1960s and 25 years before the implementation of the policy of mass incarceration. Nevertheless, major policy changes in mental health care and crime control have run parallel for several decades, suggesting concomitance but not causality. If the population of the hospital simply shifted to the prison, then the populations of "patients" and "criminals" would have to overlap substantially in their composition.

In fact, research suggests that the population of state hospitals changed in the 1970s, resulting in an increase in the rate of arrests for released patients because of the "changing clientele of state hospital[s]," that is, the growing number of patients with previous offense histories (Cocozza, Steadman, & Melick, 1978). This intersection between the two populations is attributable to shared demographic characteristics and not to the increased risk of criminality among former patients attributable to mental illness. A review of 200 studies on the relationship between crime and mental disorders concluded that [the association] "can be accounted for largely by demographic and historical characteristics that the two groups share. When appropriate statistical controls are

applied for factors, such as age, gender, race, social class, and previous institutionalization, whatever relations between crime and mental disorder are reported, tend to disappear" (Monahan & Steadman, 1983, p. 152). A much more recent investigation found that the rise in the percentage of incarcerated PSMI from 1950 to 2000 has been modest and is predictable in light of the overall increase in the number of people incarcerated during that time period. Specifically, while the proportion of PSMI in psychiatric institutions fell by 23%, the percentage of incarcerated PSMI increased only 4% in the last half of the last century (Frank & Glied, 2006).

Poverty and Mental Illness

PSMI typically reside in highly criminogenic and impoverished environments that exert pressures on them to become engaged in criminal behaviors. The factors that characterize these environments also affect poor persons with no serious mental illness (e.g., joblessness, gang influences, failed educational systems, and housing instability; Draine et al., 2002; Lamberti, 2007; Silver, Mulvey, & Swanson, 2002). The risk factors that predict crime among PSMI are the same risk factors that predict crime among people with no serious mental illness (Bonta, Law, & Hanson, 1998; Skeem, Eno Louden, Manchak, Vidal, & Haddad, 2008).

Since the earliest epidemiological studies of mental illness, researchers have found a correlation between poverty and serious mental illness; people of lower socioeconomic status are more likely than those of higher socioeconomic status to be diagnosed with a serious mental disorder (U.S. Surgeon General, 1999). The unrelenting stress of being poor can precipitate mental illness (Eaton & Muntaner, 1999). In a process of downward drift, mental illness can also pull a person into poverty because the symptoms of mental illness can interfere with going to school and finding and maintaining employment. In addition, poor people frequently have no insurance coverage for primary mental health care or have trouble accessing the care provided through entitlement programs. Therefore, their symptoms go untreated, which can produce irreversible clinical deterioration and recurrence of more severe episodes of psychiatric disease. Moreover, repeated rearrests for low-level crimes can also launch a downward spiral for PSMI, who with each criminal justice contact are more likely to penetrate more deeply into the criminal justice system. In other words, an accumulating criminal record for nonserious offenses can eventually lead to incarceration and reentry problems.

Poor communities with high levels of social disorganization and weak informal social control mechanisms also have a higher tolerance for deviant

behaviors and are more welcoming to PSMI who can find cheaper places to live in communities where crime is rampant and police presence is elevated. A large-scale, 7-year study of the relationship between socioeconomic status and mental illness suggested that poverty, acting through economic stressors, such as unemployment and lack of affordable housing, is more likely to be a precursor than a sequelae of serious mental illness (Hudson, 2005). Thus, the correlates of crime are also the correlates of serious mental illness. Lacking in social capital, estranged from family and friends, and living in poor neighborhoods, PSMI can gravitate toward illicit drug use and associates who eschew prosocial values and afford them with opportunities for criminal involvement and the adoption of a criminal lifestyle (Fisher, Silver, & Wolff, 2006).

The Prison Explosion and the War on Drugs

The prison population in the United States quadrupled from 1980 to 2000 and has exceeded the 1 million mark every year since 1995. The rate of incarceration per 100,000 Americans climbed from 139 in 1980 to 478 in 2000—a 243% increase (Bureau of Justice Statistics, 2002a). By mid-year 2009, the number of incarcerated adults had grown to 2.3 million (Bureau of Justice Statistics, 2010). The United States now has the highest documented incarceration rate in the world (714 per 100,000 persons) and the highest documented prison and jail populations in the world followed by Russia and South Africa (Walmsley, 2006/2009).

Since the 1980s, an overwhelming emphasis on law enforcement strategies to combat illegal drug use and sales has resulted in dramatic increases in the nation's arrest and incarceration rates. Rates of arrest and incarceration for drug offenses has continued at a record pace into the 21st century, although general population surveys reported declines in illegal drug use in the United States during the 1990s (Tonry, 1995, 1999). Drug offenses have been among the largest categories of arrests since the 1980s. From 1980 to 2000, for example, arrests for drug offenses more than doubled. In 2000 alone, more than 1.5 million persons were arrested for drug offenses—more than four fifths for drug possession (Bureau of Justice Statistics, 2002b). PSMI who live in poor neighborhoods have easy access to illicit substances, which are more likely to be sold on the street in those communities, and they are likely to be arrested for possession because of the increased police presence in underclass areas.

Offenders convicted of drug possession and sales (who also have high rates of drug use) have been incarcerated with greater frequency and for longer prison terms than previously and represent one of the fastest rising subgroups

in the nation's prison and probation populations (Beck, 2000). A fairly large proportion of these individuals have co-occurring psychiatric disorders, thus increasing the number of mentally ill offenders in the nation's criminal justice system (Lurigio, 2004; Swartz & Lurigio, 1999). Like dolphins among tuna, many mentally ill, drug-using persons are caught in the net of rigorous drug enforcement policies (Lurigio & Swartz, 2000).

In summary, the current war on drugs and the high rate of comorbidity between drug use and psychiatric disorders accounts partially for the large numbers of PSMI in our nation's jails and prisons. Fragmented drug and mental health treatment systems fail to provide fully integrated care for persons with such co-occurring disorders, compounding their problems in both areas of concern and elevating the risk for arrest and incarceration (Lurigio & Swartz, 2000). PSMI share many of the same socioeconomic and other characteristics as criminally involved people (young, unemployed, poor, uneducated, substance using) and live in the same criminogenic neighborhoods where the presence of police and the likelihood of arrest are high (especially for drug crimes), presenting an expansive gateway for PSMI to enter the criminal justice system.

Treating Mental Illness Alone is Unlikely to Lower Recidivism

A practical motivation for providing services to PSMI in jails and prisons and also to those on community supervision is to reduce recidivism. However, no pathogenesis between mental illness and crime has ever been established. The untreated symptoms of the three most serious mental illnesses (schizophrenia, bipolar, and major depression) have no or a weak causal relationship to crime. No theoretical model explains or predicts a clear-cut association between serious mental illness and criminal behavior (Mears, 2004). Thus, major mental illness, in and of itself, would seem to present little or no added risk of criminal activity.

No studies have shown that the alleviation of psychiatric symptoms alone affects recidivism among criminally involved PSMI (Skeem, Manchak, Vidal, & Hart, 2009; Steadman, Dupius, & Morris, 2009). In fact, treating only mental illness among those who are criminally involved, without providing any other interventions directed at criminogenic factors, could arguably increase the risk of crime. For example, treated depression increases vitality and energy among criminals and noncriminals alike, which is not to suggest that PSMI in the criminal justice system be deprived of treatment. Instead, it is important to recognize that psychiatric treatment might have no effect on reducing crime. In contrast, research suggests overwhelmingly that the co-occurrence of

substance use disorders and other Axis I diagnoses accelerates criminal activities among people, especially those with criminal intent and inclinations. Evidence for the relationship between violence and alcohol misuse, abuse, or dependence is also abundant and unequivocal (Lurigio & Swartz, 2000).

Treating mental illness could, however, have an indirect effect on recidivism. Specifically, relieving symptoms could help PSMI become sober, employed, find and retain stable housing, develop better self-control, return to school, mend relationships with family, and follow the designated rules of supervision, thereby avoiding probation and parole violations. Furthermore, relieving the symptoms of major mental illness can make PSMI more amenable to interventions that will have a positive effect on crime, such as cognitive behavioral therapies that can change criminal thinking (Bonta et al., 1998). Even if mental health services have no effect on criminality, jails and prisons still have a moral, ethical, and legal obligation to treat PSMI effectively and compassionately. Notwithstanding their pathway into the system, PSMI are entitled to services.

Serious mental illness alone rarely leads people to commit crimes and, therefore, the treatment of mental illness alone is unlikely to prevent or reduce crime or recidivism. PSMI can benefit from the same evidence-based cognitive behavioral therapies that affect criminal thinking among people with no mental illness (Landenberger & Lipsey, 2005). Most important, integrated treatment for co-occurring psychiatric and substance use disorders is critical in helping PSMI manage their symptoms and changing their criminal trajectories (Center for Substance Abuse Treatment, 2005; Roskes, Feldman, Arrington, & Leisher, 1999).

Attempts to Handle PSMI in the Criminal Justice System

The notable presence of the mentally ill in the criminal justice system has created significant resource demands and clarion calls for specialized, cross-disciplinary approaches to serve their diverse needs. Mental health practitioners have recently been enlisted to play central roles in police departments, jails, prisons, and probation and parole agencies. By the same token, criminal justice professionals now are learning new ways to case manage offenders with psychiatric and behavioral disorders (Council of State Governments, 2002).

Jails and prisons have become the largest de facto treatment settings for the mentally ill, and correctional mental health care providers often contend with inadequate services and overwhelmingly large caseloads. Specialized programs for PSMI, such as mental health courts (MHCs), hold great promise

for diverting PSMI from the criminal justice system and ensuring that they receive proper interventions (Bernstein & Seltzer, 2004; Watson, Hanrahan, Luchins, & Lurigio, 2001). Nonetheless, current resources for psychiatric treatment and other services rarely meet the demand for such care (Council of State Governments, 2002).

With respect to programs and services, the criminal justice system has created interventions at each point of interception with PSMI. The literature abounds with instances of such initiatives (Council of State Governments, 2002). Major national efforts such as the federally funded GAINS Center, the Criminal Justice/Mental Health Consensus Project, and the Council of State Government's Justice Center have promoted an ambitious research and service agenda and facilitated the sharing of evidence-based practices among different jurisdictions at the federal, state, and local levels. In addition, important federal legislation (e.g., Law Enforcement Mental Health Project Act of 2000 and the Mentally Ill Treatment and Crime Reduction Act of 2004) has provided an impetus for more and better collaboration between the criminal and mental health systems and brought increasing valuable attention to PSMI in the criminal justice system. The Criminal Justice/Mental Health Consensus Project's website presents an up-to-date description of programs for criminally involved PSMI from arrest to reentry as well as resources for court and corrections practitioners interested in learning more about what works for this special population (www.consensusproject.org).

The criminal justice system has made many efforts to meet the challenge of handling PSMI at every stage in the process. The criminal justice and the mental health system are built on different foundations. They adhere to different philosophies, possess different capabilities, and satisfy different institutional imperatives. Yet the former has done a lot of the work that was exclusively placed in the hands of the latter; that is, providing mental health care for poor PSMI, who have a passel of other problems, such as substance use disorders, homelessness, and unemployment.

Conclusions and Recommendations

The Use of Standardized Assessment Tools

A necessary step in estimating the need for treating any disease in a population is to determine its nature and extent, and that requires the use of standard screening and assessment tools with sound psychometric properties. Several such tools (e.g., Mental Health Inventory [MHI-5]; Structured Clinical Interview for *DSM-IV* [SCID]) have been tested and should be administered

consistently to screen for distress, basic symptoms, and functional impairment among criminal justice populations (Rumpf, Mayer, Hapke, & John, 2001; Ventura, Liberman, Green, Shaner, & Mintz, 1998). Screening should also be undertaken as the first step in an evaluation of the pervasiveness of major diagnoses (schizophrenia, bipolar disorder, and major depression), which must be done in accordance with well-defined diagnostic criteria. In addition, the generation of baseline measures can be used to chart the incidence and prevalence of psychiatric disorders over time. Specialized screening tools (e.g., Brief Jail Mental Health Screen) have been created or adapted for correctional populations and should be employed at intake by trained professionals in jail, prison, and probation settings (Steadman, Scott, Osher, Agnese, & Robbins, 2005). In short, the results of screening can serve as the basis for a further evaluation of serious mental illness as well as for the development of placement and case management plans.

The End of Criminalization

The first order of business in the field of criminal justice is to end the criminalization of PSMI. Police, court, and jail-based diversionary programs must be fully resourced and staffed with practitioners who are serious about diversion and who understand the operations of the mental health system. Stepped-up efforts to divert PSMI who commit public-order or nuisance-type violations will require a strong will to establish diversionary mechanisms that are tied to the emergency commitment process and codified in memoranda of understanding between police departments and local hospitals. Such memoranda should describe a clear protocol for how the police can escort a seriously distressed person for an expeditious evaluation and admittance to the hospital for stabilization and treatment. Community-based, drop-in centers for PSMI, who require no emergency care, would also be a useful option in lieu of hospitalization and arrest in instances of disruptive public behavior. Crisis intervention teams are an effective front-end diversionary program that uses arrest and detention only as a last resort for PSMI (Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006).

Criminalization also includes punishing PSMI because of their inability to conform to either the rules or regulations of jails and prison that govern behavior in carceral settings or to the mandates that constitute the conditions of probation and parole supervision. For example, the use of administrative segregation or special housing units for inmates with mental illness should be reconsidered because of the extremely harmful consequences of such punishment (Human Rights Watch, 2003). Segregation can cause PSMI to severely

decompensate and can precipitate mental health problems in inmates without symptoms who are predisposed to psychiatric conditions during periods of severe stress and isolation (Kupers, 1999). In addition, studies suggest that PSMI in administrative segregation stay in confinement longer than those with no mental illness (Correctional Association of New York, 2004). Although administrative segregation units are a necessary component of prison discipline and population control, they should be used sparingly or not at all for PSMI who are unable to respond to a correctional officer's commands because of auditory hallucinations, cognitive impairment, or delusions (Haney, 2003, 2008). Mentally ill inmates who are unable to conform to prison rules should instead be reevaluated for a medication adjustment and placed in a hospital environment.

Similarly, PSMI on probation and parole supervision should undergo administrative review for technical (noncriminal) violations of the conditions of release in lieu of formal revocation hearings that can lead to (re)incarceration and other harsh penalties. Technical violations should be regarded as vehicles to enhance treatment and other services, such as relapse prevention and a reevaluation of medication regimens. A redoubling of supportive services following technical violations is commonplace in drug courts and specialized probation programs for PSMI (Skeem, Emke-Francis, & Louden, 2006).

The Importance of Case Management and Treatment

Serious mental illness should be treated like any other disease in correctional institutions, which are obligated to provide such care on legal (e.g., *Ruiz v. Estelle*) and moral grounds (Mears, 2004). Sophisticated technologies that visualize the living brain have revealed aberrations in brain structure and processing among PSMI; these differences establish the biological, and possibly the genetic, underpinnings of serious mental illness and suggest breakthroughs in medical interventions (Kramer, 2009). For the reasons I articulated in this article, a disproportionate percentage of PSMI will continue to be processed through the criminal justice system as long as punitive crime and drug control policies remain in place. Hence, prisons and jails should be prepared to accept long-term responsibility for the care of PSMI in the same manner that they care for people with other chronic diseases and medical conditions.

The provision of mental health services is obligatory and should be an expectation of care for PSMI in jails, prisons, and community corrections programs. In institutional settings, psychiatric medications should be prescribed along with other types of care in a safe and secure environment to alleviate

symptoms, not for the purpose of controlling the population with sedating drugs (Human Rights Watch, 2003). Budgets for psychiatric services and staffing in correctional settings should be increased to meet clinical needs, which will be consistently greater than those found in the general population because of the shared demographic and illicit drug-use profiles of PSMI and criminally involved people. Many studies suggest that mental health care is woefully underfunded in correctional institutions, and thus a significant percentage of inmate psychiatric needs are left unmet (Human Rights Watch, 2003; James & Glaze, 2006).

The most effective strategy for responding to PSMI on community supervision is assertive case management, in specialized caseloads, with specially trained officers who can deliver supportive services in-house and broker external resources that can help meet the wide-ranging needs of this population, including housing, employment, education, and family reunification (Wolff, Epperson, & Fay, 2010). Mandatory psychiatric care must be at the hub of case management plans. Without symptom stabilization, PSMI will be less likely to take full advantage of other services and more likely to violate the conditions of supervision, thereby leading to probation and parole revocation and incarceration (Eno Louden, Skeem, Camp, & Christensen, 2008).

For parolees and released detainees, transitional services should be offered during incarceration to prepare future releasees to cope with their diseases after they leave the structure of the prison and jail environment (Lurigio, 2001). The purpose of aftercare is to manage symptoms because a cure is not a reasonable option. Aftercare has been too long just an "afterthought" and must instead become a priority; otherwise, the successful provision of services in institutional settings is squandered after the release of PSMI, especially among those with co-occurring disorders who experience a high rate of relapse. The provision of effective aftercare services (reentry planning and case management) is essential to the continued recovery of PSMI and recognizes that serious mental illness is a chronic disease that must be addressed at various levels of services (Wolff & Shi, 2010). In the final analysis, the success of any aftercare program hinges on the availability of locally accessible mental health services.

MHC appears to be a useful intervention for criminally involved PSMI in the community. Usually reserved for lower level offenders, preadjudication MHCs are a diversionary mechanism to keep the mentally ill out of jail. On the successful completion of treatment and other service programs, participants in such MHCs can have their cases dismissed. In general, MHCs are based on the principle of therapeutic jurisprudence and the drug court model. The MHC team's nonadversarial approach draws on the expertise of mental health and drug treatment professionals as well as probation officers and social service

providers who work closely with the judge to implement a coordinated case management plan (Goldcamp & Irons-Guynn, 2000).

The Reduction of Criminality and Recidivism

As I have maintained throughout this article, no evidence supports the notion that the treatment of mental illness, ipso facto, will lead to a reduction in crime and recidivism. Serious mental illness is not included among the major factors that predict criminal risk, known as the "big four": history of antisocial behaviors, antisocial personality patterns, antisocial cognitions, and antisocial associates (Andrews & Bonta, 2006). However, psychiatric treatment can make PSMI more receptive to interventions that can help lower the risk of criminality. Case management strategies for PSMI in any criminal justice program must include evidenced-based practices in assessments and interventions that are geared toward the remediation of criminogenic needs and thinking and the inculcation of skills and competencies necessary to lead more productive, law-abiding lives (Morgan, Fisher, & Wolff, 2010). For example, scales to evaluate criminal thinking should be incorporated into evidence-based risk assessment strategies, which are known as fourth-generation evaluations of risk. Such tools focus on criminogenic needs and dynamic (i.e., mutable) factors derived from statistical models of prediction (Bonta & Wormith, 2008). Therefore, case management plans for PSMI must also include specific interventions to reduce criminal thinking and behavior (Calsyn, Yonker, Lemming, Morse, & Klinkenberg, 2005).

The greatest investments in the care of PSMI in the criminal justice system should be directed at treating co-occurring psychiatric and substance use disorders. A wealth of consistent evidence shows that illicit drug use is a crime intensifier. Comorbidity is associated with crime, violence, relapse, and recidivism. Integrated treatment works and should involve a component to address trauma (Sacks & Ries, 2005).

In conclusion, PSMI will continue to be overrepresented in the criminal justice system because of the interrelationships among serious mental illness, poverty, and substance use disorders. Punitive drug and crime control policies have created correctional populations of unprecedented size, and PSMI have borne the brunt of those policies in terms of criminal justice processing. PSMI engaged in public-order violations should be diverted from the criminal justice system. Those with more serious charges should be properly assessed and served, which is the legal, moral, and ethical obligation of criminal justice administrators.

Case management approaches are the most effective strategies for addressing the complicated problems that encumber people with mental illness and criminal involvement. Most important is the provision of fully integrated programming for those with co-occurring disorders—who are inclined to be more criminally active and pose a greater risk to public safety. Finally, the treatment of mental illness must be at the hub of successful interventions for PSMI but, by itself, is unlikely to reduce crime or recidivism. The effectuation of such changes among PSMI and non-PSMI alike requires the implementation of evidence-based practices that focus specifically on modifying criminal thinking and behavior.

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