

**ASSESSING THE NATURE AND PREVALENCE OF  
THE MENTALLY ILL IN SUFFOLK COUNTY'S  
CRIMINAL JUSTICE SYSTEM**

**March 2000**

**Suffolk County Criminal Justice Coordinating Council**

**Robert J. Gaffney  
Suffolk County Executive**



To the Citizens of Suffolk County:

In June 1997, members of the Suffolk County Criminal Justice Coordinating Council (C.J.C.C.) expressed concern that the number of mentally ill individuals processed by the criminal justice system in Suffolk County had increased significantly in recent years and were taxing an already overburdened system. Although the exact nature and prevalence of the problem was not known, there was general agreement that this had become a significant problem in all aspects of the criminal justice system and required attention. I immediately approved the creation of a Subcommittee of the CJCC and charged its members with the dual tasks of accurately assessing the problem and of recommending an action plan that would result in program and systemic improvements.

While crime is on a significant downward trend, I believe further reductions can be fostered with sound planning, proper investment of our financial resources in programs that have a proven track record, and coordinated, targeted, criminal justice efforts. As a former FBI Agent, I know the value of criminal justice partnerships coming together to carry out a well thought-out plan. In calling for an action plan to reduce crime committed by mentally ill individuals, I wanted criminal justice, mental health and social service experts to identify what we need to do as a County government, and as citizens, to enter the new millennium with a renewed commitment to safeguard our residents from crime.

The Council members reflect the diversity of ideas and disciplines needed to formulate a comprehensive approach and include representatives from Probation, the Health Department, the Suffolk County Mental Health Association, the District Attorney's Office, the Legal Aid Society, the Sheriff's Office, Suffolk County Courts, NYS Office of Mental Health and NYS Parole.

The Council has met my objective. This report represents the most comprehensive look at mentally ill individuals who commit crime in Suffolk County in over two decades. I thank the Council members for the diligent, thoughtful effort in producing this valuable analysis and report.

The research-based recommendations will be used as the core of an action plan that ultimately will result in a further reduction of crime in Suffolk County. However, our efforts are continuing in investigating this very complex, social problem.

Sincerely,

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ROBERT J. GAFFNEY  
Suffolk County Executive



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OF THE MENTALLY ILL IN SUFFOLK COUNTY'S  
CRIMINAL JUSTICE SYSTEM**

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## I. INTRODUCTION

*The truth is always the  
strongest argument.*

Sophocles

Suffolk County is undertaking initiatives to address the problem of crime and violence in the County committed by mentally ill individuals. One of these initiatives involved the creation of the MICA/MI Subcommittee of the Criminal Justice Coordinating Council (CJCC) in 1998. The purpose of this subcommittee is to document the nature and prevalence of mentally ill in the justice system and to develop effective responses that will reduce crime committed by this population. This current study is a joint effort between the County Executive's Office, Probation, the Department of Health Services, the District Attorney's Office, the Sheriff's Office, the Legal Aid Society, the New York State Division of Parole, the Suffolk County Courts, the Suffolk County Attorney's Office, the NYS Office of Mental Health, and the Suffolk County Mental Health Association. While Suffolk County has experienced significant decreases over the past several years in overall crime rates, the incidents of crime committed by mentally ill individuals in the County continues to be a significant component of the overall crime rate.

All elements of the criminal justice system are trying to cope with a growing number of mentally ill offenders who frequently have multiple problems and are often multiple recidivists. However, valid and reliable information regarding the specific nature and prevalence of this population in Suffolk County is elusive. There is a general consensus that this population presents serious problems to the Criminal Justice system, and utilizes an inordinate amount of resources.

However, empirical documentation is needed before serious planning and systemic improvements can have a major impact.

The goals of this research study are as follows:

1. To promote public safety through the reduction of crime committed by the mentally ill population in Suffolk County;
2. To develop initiatives aimed at identifying, preventing, and responding to criminal activity committed by mentally ill residents.
3. To improve **efficiencies** of treating the mentally ill within the criminal justice system.
4. **To enhance cooperative and collaborative law enforcement efforts** to suppress criminal activity by mental ill individuals through the development of a strategic planning process and information-sharing system among criminal justice agencies.
5. To foster better treatment of the mentally ill within the criminal justice system by developing a multi-disciplinary interagency strategy.

The subjects of this study are those **seriously mentally ill** individuals who came into contact with the criminal justice system as defendants in Suffolk County **during 1998 and 1999.**

Instead of developing a rigid definition of **'severe mental illness'**, the proposed strategy is to identify all of the mentally ill in the criminal justice system, and to categorize these individuals by **severity level** during the course of the research. Using this research strategy, a rich understanding of the nature and prevalence of the mentally ill in criminal justice could be achieved with typologies of severity developed using several different definitions.

Therefore, the mentally ill in criminal justice have been studied using the following operational identifiers:

1. Current or prior hospitalization for mental illness;

2. Diagnosis of mental illness or mental disorder especially those that interferes with daily functioning;
3. Evidence of currently prescribed psychotropic, antidepressant, and mood stabilizing medications; and
4. Documented evidence of disturbed behavior (severe depression, phobia, obsessive, compulsive, etc.), although a diagnosis, medication, or history of hospitalization is not reported by line staff.

The target population does not include individuals **without mental illness** that experience dependency or addiction to alcohol, or other drugs. **However, the MICA and CAMI populations are included, and special attention is given to those individuals with psychotic disorders, bipolar and depression disorders.**

Information was collected from the police, pretrial services, the Sheriff's Office, as well as Probation and Parole community supervision. The strictest confidentiality safeguards have been employed throughout the course of this research, and a unique case identifier was recorded in the data file instead of client names.

The results presented in this report represent the first of a series of research results that will be reported in 1999 and 2000 regarding the mentally ill populations in Suffolk County's juvenile and criminal justice systems.



## **II. SUMMARY OF MAJOR FINDINGS**

### **\*National:**

1. As of June 1998, an estimated **283,800** mentally ill persons were incarcerated in the United States prison and jail systems, compared to the total number of inmates in custody in mid 1998 which was 1,102,653. (Bureau of Justice Statistics, 1999).

2. According to the Bureau of Justice Statistics' 1999 report, **16%** of state prison inmates, **7%** of federal inmates, **16%** of local jail inmates, and 10% of probationers said they had had a mental condition or stayed overnight in a psychiatric hospital at some point in their life.

### **\*Suffolk County:**

3. The number of police responses to 'emotionally disturbed person' (EDP) incidents in Suffolk County increased from **1,384** in 1988 to **2,063** in 1997 or by **679** incidents or **49.1%**. (Refer to Table 1 on page 17.)

4. The estimated total of police EDP incidents for 1998 is **2,486** incidents, based on **1,243** incidents during the first 6 months of 1998. The 1998 estimated total represents an **80%** increase as compared to 1988.

5. Suffolk Police responses to situations where the individual actually committed suicide increased from **94** in 1988 to **135** in 1997 or by **44%**.

6. Suffolk Police responses to attempted suicides increased from **268** in 1988 to **290** in 1997 or by **22** attempts or **8.2%** during that period.

7. Based upon a sample of 1,541 offenders from four of Suffolk County's

main criminal justice sources, Probation, Pretrial Service, the Suffolk County Jail, and New York State Parole, **estimates indicate that 9.5% of individuals in Suffolk County's criminal justice system are seriously mentally ill.**

**8. Current estimates indicate that 4,707 individuals with a serious mental illness will have been incarcerated, detained, or supervised by Probation, Parole, Jail or Pretrial Services in Suffolk County in 1999.** (Refer to Table 2.)

This estimate has been made based on the research sample, after controlling for multiple admissions and multi-agency duplication.

**9. On an annual basis, 10.4% of the Probation population, 7.7% of The pretrial population, 7.1% of parolees and 16% of the jail population are seriously mentally ill based on the current sample.** (Refer to Table 2 on page 23.)

**10. After adjusting for multiple admissions or contact with the different components of the criminal justice system, the combined number of mentally ill people expected to receive police crisis or criminal justice services from the police, probation, parole, pretrial and jail in 1999 is 6,365 individuals.** (Refer to Table 3 on page 24.)

**\*Jail Mental Observation Unit \***

**11. Between 1991 and April 27, 1999 there were 10,168 admissions to the jail mental observation unit in Suffolk County.**

**12. In 1998, there were 1,320 admissions to Suffolk County's jail mental observation unit, representing 1,052 individuals during the course of the year.**

\*On 2/24/2000, there were **42** individuals **on suicide watch** detained at the Suffolk County Correctional Facility.

13. A total of **77** offenders were admitted to the mental observation unit one or more times in 1998.

14. A total of **372** offenders admitted to the mental observation unit in 1998 had at least one other prior admission in another year (1991-1998).

15. A total of 128 offenders with an admission to the mental observation unit in 1998 had 4 or more admissions between the years 1991-1998, 92 of these offenders had 5 or more admissions.

#### **\*Characteristics of the Mentally Ill in Criminal Justice**

In our sample of 1,541 offenders we found the following:

16. Mentally ill offenders committed mostly (**75%**) non-violent crimes.

17. Almost one-third (**31%**) of mentally ill offenders were charged with alcohol or drug related offenses (DWI or drug-related).

18. Almost two-thirds (**64%**) of the mentally ill offenders were identified as substance abusing. Offenders in jail (**83.8%**) and on parole (**82.9%**) had a higher rate of substance abuse than offenders on probation.

19. Approximately **61%** of the sample or **938** individuals had at least one DSM IV diagnosis in their case record. Out of that subtotal percentages of the diagnoses were as follows: Schizophrenia - **12.2%**, Bipolar - **14.3%**, Depression - **58.3%**, Anxiety Disorder - **7.5%**, ADD - **5%**, PTSD - **2.2%**, OCD - **.5%**. (Refer to Table 3 on page 24.)

20. Over **66%** of mentally ill offenders were receiving care for a mental disorder while in the criminal justice system. Those in jail were slightly more likely to be receiving care while in jail.

21. Approximately one-half of mental ill offenders have been in a hospital for a

mental disorder at some time in their life.

22. Almost one-half of mentally ill offenders are taking medication for a mental disorder. Those in the jail (**69.4%**) were more likely to be taking medication than those on either probation, parole or pretrial services.

23. Over one-half of the sample (**53.7%**) were identified as either individuals with psychotic disorders, depression, or bipolar.

### **\*Special Populations**

#### 25. **MICA Offenders**

A. While 64% of all mentally ill offenders used substances, a higher percentage of those with depression (76.6%) bipolar disorder (73.9%) and schizophrenia (73%) were more likely to be identified as substance abusers. Males and females did not differ use of substances.

B. Offenders with schizophrenia (63.5%), bipolar disorder (63.4%), and depression (58%) were most likely to abuse alcohol. Marijuana use was higher for those with ADD (42.6%) and depression (31.1%) than the rest of the sample groups (24%).

C. Over one-quarter (28.9%) of the offenders used cocaine. Those with schizophrenia (41.7%) were the more likely to use cocaine. Heroin use was low and did not appear to differ among the diagnostic groups.

D. Alcohol was identified as the most used substance among the sample (48.7%). Those in the jail were the most likely to be identified (65.6%) as abusing alcohol. Cocaine use was high among the parolees

(62.4%). Not many offenders were identified as abusing marijuana (24.3%) or heroin (7%).

26. **Psychotic Disorders**

A. Nine percent (9.1%) of the sample or **140** individuals were diagnosed as Schizophrenic (115) or Psychotic Disorder NOS (25).

B. Of the individuals within the psychotic subgroup, **29.5%** are charged with violent offenses, **71.8%** have a history of substance abuse, **83.8%** have been prescribed psychotropic medications and **90%** have a history of treatment for mental illness.

C. In Suffolk County's criminal justice system, in 1999, the estimated annual total of individuals diagnosed with psychotic disorders is 428.

27. **Bipolar Disorder**

A. The Bipolar Disorder population comprises **8.7%** of the sample equaling **134** individuals, which represents an estimated number of **400** people on an annual basis in the Suffolk County Criminal Justice System.

B. Of the individuals within the bipolar disorder subgroup, **13.8%** are charged with violent offenses, **73.9%** have a history of substance abuse, **73.9%** have been prescribed medications, and **80.6%** have a history of treatment for a mental illness.

28. **Depression**

A. The Depression subgroup comprises **35.5%** of the sample

equaling **547** individuals which represents an estimated number of **1,671** people on an annual basis in the Suffolk County Criminal Justice System.

B. Of the individuals within the Depression subgroup, **22.7%** are charged with violent offenses, **76.6%** have a history of substance abuse, **73.7%** have been prescribed psychotropic medication and 55.8% have a history of treatment for mental illness.

29. **Violent Offenders**

A. The violent subgroup comprises **24.9%** of the mentally ill population in criminal justice.

B. Over one-third (**36%**) of the violent subgroup were undiagnosed and were included in the sample based on other indicators (past treatment, medication, behavior, or suicide attempt). Offenders with mood disorders committed the highest number of violent offenses (**139**). However, as noted earlier in Table 35, offenders with diagnoses of schizophrenia and ADD had a slightly higher rate of committing violent crime than those in other diagnostic groups.

30. The findings, in this present study of mentally ill offenders in the criminal justice system in Suffolk County, are consistent with previous studies conducted nationally to identify the mentally ill within the criminal justice system. National estimates indicate that **7%** to **16%** of individuals in the criminal justice system have a mental illness. The characteristics of the sample also appear to be consistent with the mental health literature. Most mentally ill offenders come in contact with the criminal justice system after

committing non-violent offenses and that the crimes committed are related to substance abuse and lack of consistent treatment.



### **III. METHODS & PROCEDURES:**

A survey was developed and distributed to all probation and parole officers in Suffolk County. It consisted of questions regarding the defendant's date of birth, current psychological or psychiatric care (except if solely for substance abuse treatment), current psychiatric medication, whether the defendant spoke or acted in a bizarre manner, any suicide attempts, other indicators of mental illness, DSM IV codes, drugs of abuse, categories of mental illness, types of medications and all known psychiatric medications. The same form was used at the jail, however data was obtained from case files by the researchers. The form for pretrial (ROR) varied slightly. The variation of the form was necessary because there is less information available about the defendant at this stage of involvement in the criminal justice system and the limited time available for the probation investigator to gather information. The pretrial form (ROR) consisted of information regarding date of birth, current psychiatric or psychological care, hospitalizations, current psychiatric medications, and whether the defendant was acting or talking in an abnormal or bizarre manner. (See Appendix for survey.)

To survey all active probation supervision caseloads:

Probation officers were instructed to fill out the survey for all probationers on their current caseload during the month of April 1999.

To survey all active parole supervision caseloads:

Parole officers were instructed to fill out the survey for all parolees on their current caseload during the month of June 1999.

To survey pretrial (ROR) cases:

Pretrial (ROR) probation investigators were instructed to fill out the survey for all the people they interviewed for a two-month period. (From March 8 to May 8, 1999)

For the jail population:

Prison officials provided the researchers with a daily census report for April 27, 1999. This is a list of all inmates residing at the mental observation unit on a particular day. Using this list the researchers went to the jail and gathered information on these inmates from case files.

Police provided information on the number of emotionally disturbed person's reports for a 5-year period and the number of suicide attempts and completed suicides in Suffolk County.

**Sample:**

The total number of subjects in the sample is 1,541. 1,023 subjects from probation supervision, 149 subjects from the jail, 213 subjects from pretrial (ROR), 115 subjects from parole, and 6 subjects missing an identifier such as probation, parole, jail or pretrial. One subject was identified by both jail and probation, 7 subjects were identified by jail and pretrial (ROR), 12 subjects were identified by probation and pretrial (ROR), 2 subjects were identified by probation and parole, and 1 subject was identified by jail, probation and pretrial (ROR).

96. 1% of our sample had at least one of the first three questions on the survey checked off as positive. Subjects were under the care of a psychiatrist, social worker or psychologist for treatment of a mental disorder (not including treatment solely for substance abuse), or they had been hospitalized for a mental illness, or were currently on medication for a psychiatric or psychological condition. 3.9% of the subjects had only the fourth and fifth questions, pertaining to bizarre behavior or suicide attempts, checked off as positive.

The age range of individuals in the sample ranged from 16 years to 89 years old. The mean age was 34.71. 75.7% (1,166) of the subjects are male, 24.1% (373) are female. 13.5% (208) of the sample is African American/Black, 4.9% (76) is Hispanic, 57.9% (891) is Caucasian/White and the race/ethnicity of 23.7% (364) of the sample is unknown.

#### **IV. PREVALENCE OF THE MENTALLY ILL IN THE CRIMINAL JUSTICE SYSTEM**

This section presents the latest national research documenting the prevalence of the mentally ill in this nation's criminal justice system. Also, the number or prevalence of the mentally ill in Suffolk County's criminal justice system is presented for analysis. Documentation of involvement with the police, pretrial services, probation and parole supervision; as well as with Suffolk's correctional facilities are presented in this section.

##### **1. National Statistics**

As of June 1998, an estimated 283,800 mentally ill persons were incarcerated in the United States prison and jail systems, while total number of inmates in prison custody was 1,102,653. This is approximately 26% of the total population incarcerated. The Bureau of Justice estimates that 16% or 179,200 of state prison inmates, 7% or 7,900 federal inmates, 16% or 96,700 of local jail inmates, and approximately 16% or 547,800 probationers replied yes to either a mental condition or an overnight stay in a psychiatric hospital. The Bureau of Justice bases these findings on data collected via personal interviews and surveys conducted in 1995, 1996 and 1997. (*The Bureau of Justice obtained data via interviews and surveys of inmates in State and Federal Correctional Facilities in 1997, inmates in local jails in 1996, and adults on probation in 1995*). (Bureau of Justice Statistics, 1999).

The criteria used to identify a person as mentally ill were based only on self-reporting of a current mental or emotional condition and/or a self-report of an overnight stay or longer in a psychiatric unit or involvement in a treatment program. A DSM (Diagnostic Statistical Manual) diagnosis was not necessary to be considered as having a mental disorder. (Bureau of Justice Statistics, 1999).

\*Demographics for inmates identified as mentally ill:

CATEGORY	STATE	FEDERAL	NATIONAL
<b>GENDER</b>			
<i>Male</i>	15.8%	7 %	15.6%
<i>Female</i>	23.6%	12.5%	22.7%
<b>RACE</b>			
<i>White</i>	22.6%	11.8%	21.7%
<i>Black</i>	13.5%	5.6%	13.7%
<i>Hispanic</i>	11%	4.1%	11.1%
<b>AGE</b>			
<i>24 or younger</i>	14.4%	6.6%	13.3%
<i>25-34</i>	14.8%	5.9%	15.7%
<i>35-44</i>	18.4%	7.5%	19.3%
<i>45-54</i>	7 %	10.3%	22.7%
<i>55 or older</i>	15.6%	8.9%	20.4%

\*Demographics for probationers identified as mentally ill (*Nationally*)

CATEGORY	PROBATION
<b>GENDER</b>	
<i>Male</i>	14.7%
<i>Female</i>	21.7
<b>RACE</b>	
<i>White</i>	19.6%
<i>Black</i>	10.4%
<i>Hispanic</i>	9%
<b>AGE</b>	
<i>24 or younger</i>	13.8%
<i>25-34</i>	13.8%
<i>35-44</i>	19.8%
<i>45-54</i>	21.1%
<i>55 or older</i>	16%

These figures correspond with other research data that indicates that white inmates are more likely than Black or Hispanic inmates to report mental illness and female inmates report a higher incidence of mental illness than males. The highest rates of mental illness were among white females in state prison, estimated at 29%, black female inmates 20% & Hispanic females 22%. Offenders between the ages of 45-54 are in the age category identified most as mentally ill.

Bureau of Justice Statistics, 1999

- Based on Bureau of Justice Statistics, 1999

**\*The mentally ill violent offender**

<b>Mentally ill violent offenders</b>	<b>Percentage</b>
Federal Prison	16.6%
State Prison	18.2%
Probation	22.8%
Total in the Criminal Justice System	16%

The mentally ill offender, typically served 15 months longer than other state prison inmates and on average were usually sentenced to 5 months longer than other inmates for committing a violent crime.

**\*% OF MENTALLY ILL OFFENDERS CHARGED WITH VIOLENT OFFENSES**

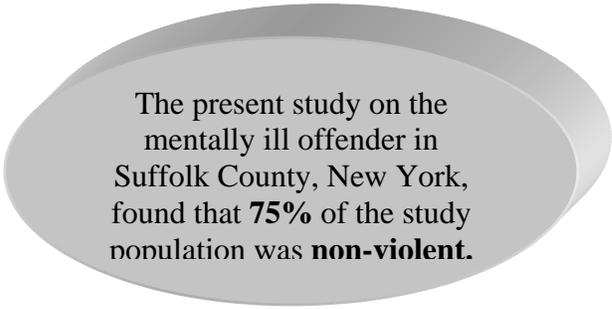
<b>Charges of Violent Offenses</b>	<b>Federal Prison</b>	<b>State Prison</b>	<b>Local Jails</b>	<b>Probation</b>
Murder	1.9%	13.2%	3.5%	.5%
Sexual Assault	1.9%	12.4%	5.2%	6.8%
Robbery	20.8%	13%	4.7%	2%
Assault	3.8%	10.9%	14.4%	14%

**\* % OF MENTALLY ILL OFFENDERS CHARGED WITH OTHER NON-VIOLENT OFFENSES**

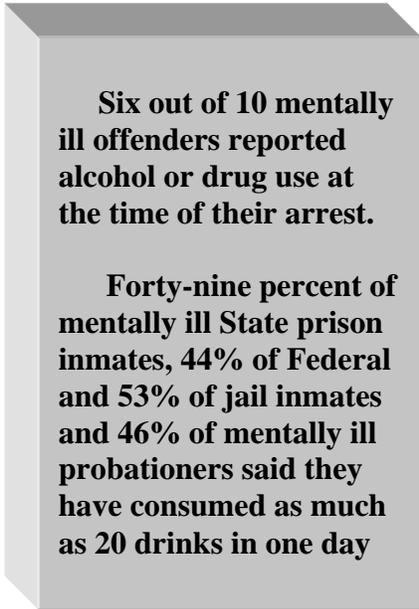
<b>Other Offenses</b>	<b>Federal Prison</b>	<b>State Prison</b>	<b>Local Jails</b>	<b>Probation</b>
Burglary	1%	12.1%	9.1%	6.4%
Larceny/Theft	1.3%	6.4%	8.4%	5.3%
Fraud	3.1%	5%	5.2%	11.7%
Drug Charges Possession	3.9%	5.7%	3.7%	7.3%
Drug Trafficking	35.7%	6.6%	7%	6.7%
Public order offenses	17%	9.9%	23.2%	24.7%

*\*Based on Bureau of Justice Statistics, 1999*

In the present study on the mentally ill Offender in Suffolk County 1,125 out of 1,497 persons were considered non violent, and 372 were considered violent. Of the violent offenders, 15 committed murder, 85 committed robbery, 76 committed sex offenses, 154 committed crimes against another person, (assault, menacing, harassment), 16 were involved in weapon sales or possession, 16 committed arson, 2 motor vehicle deaths or assaults, and 8 were charged with criminally negligent homicide or manslaughter.



The present study on the mentally ill offender in Suffolk County, New York, found that **75%** of the study population was **non-violent**.



**Six out of 10 mentally ill offenders reported alcohol or drug use at the time of their arrest.**

**Forty-nine percent of mentally ill State prison inmates, 44% of Federal and 53% of jail inmates and 46% of mentally ill probationers said they have consumed as much as 20 drinks in one day**

A third of the mentally ill offenders exhibited a history of alcohol dependence I (*based on CAGE an acronym for four questions used by the diagnostic instrument to assess alcohol dependence or abuse*) Mentally ill inmates were more likely than other inmates to be under the influence of alcohol or drugs while committing their present offense, the percentages were about 60% of the mentally ill and 51% of the other inmates were under the influence respectively at the time of their current offense. Rates of substance abuse at the time of their current offense was even higher amount mentally ill jail inmates at approximately 65% compared to 57% of other jail inmates. Among probationers, 49% of the mentally ill and 46% of others were reported under the influence at the time of committing their offense (Bureau of Justice Statistics, 1999). National statistics estimate that 35% of mentally ill

State prisoners had been arrested or held at a police station due to drinking and 46% had gotten into a fight and arrested while drinking. (Bureau of Justice Statistics, 1999).

Mentally ill offenders reported high rates of homelessness, unemployment, alcohol and drug use, and physical and sexual abuse prior to their present incarceration. 20.1% of mentally ill offenders in State prison reported homelessness in the year before their arrest and 38.8% were unemployed in the month prior to their arrest. 18.6% of mentally ill Federal prison inmates were homeless in the year prior to their arrest and 37.7% were

unemployed in the month prior to their arrest. (Bureau of Justice Statistics, 1999). These circumstances experienced by the mentally ill, are compelling reasons in and of themselves for preventative treatment approaches such as jail diversion programs.

**30.3% of mentally ill local jail inmates were homeless in the year before their arrest and 47.1% were unemployed in the month before their arrest**

## 2. Police Responses Between 1988 and 1998 in Suffolk County

**Police responses to emotionally disturbed persons increased by 49% in 1997 when compared to 1988. And the 1998 estimated total incidents of EDP responses, represents 80% increase as compared to 1988.**

As illustrated in Figure 1, there were **1,384** incidents involving emotionally disturbed persons that the police responded to in 1988. The total increased by 679 incidents or 49% in 1997 to **2,063** police responses. These incidents included crisis situations, the need to transport to psychiatric hospitalizations, as well as minor and major criminal behavior. Also, the 1998 estimated total of **2,486** incidents involving EDP responses, represents a **1,102** person or **80%** increase as compared to 1988. (This estimate is based on the actual figures for the first 6 months of 1998 of 1,243 incidents.)

Suicide incidents involving the police increased from 94 suicides in 1988, to 99 in 1996, and to 135 suicides in 1997. **The increase in suicides with police involvement between 1988 to 1997 represents a 41 suicide or 43.6% increase during this period.** Suicide attempts increased from **268** in 1988 to **290** in 1997, which represents a **22** incident or 8.2% increase.

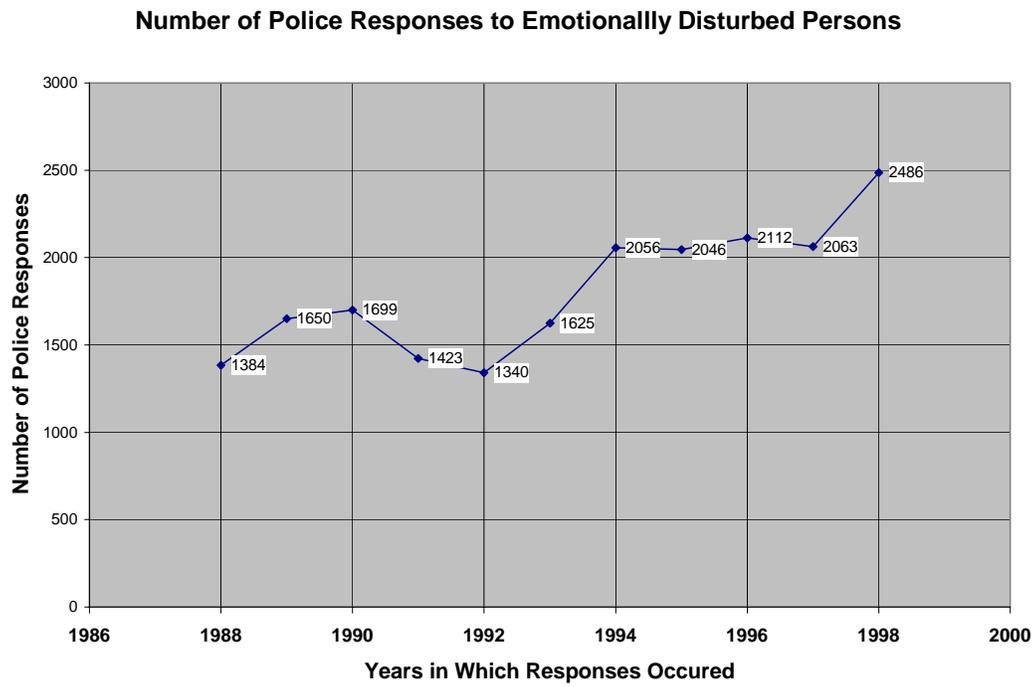
In summary, Police responses to Emotionally Disturbed Person (EDP) incidents increased by **49.1%** or **679** incidents between 1988 and 1997, while suicides increased by **43.6%** and attempted suicides by **8.2%** during the same period. The total number of EDP incidents in 1998 is expected to increase to 2,486 in 1998, based on the first six-month total of 1,243 incidents reported to the police. This 1998 estimated total represents a 1,102 incident or 80% increase in EDP incidence as compared to 1988.

**TABLE 1: 1998 SUFFOLK COUNTY POLICE 'EMOTIONALLY DISTURBED PERSONS' (EDP) INCIDENTS, SUICIDE ATTEMPTS AND SUICIDES**

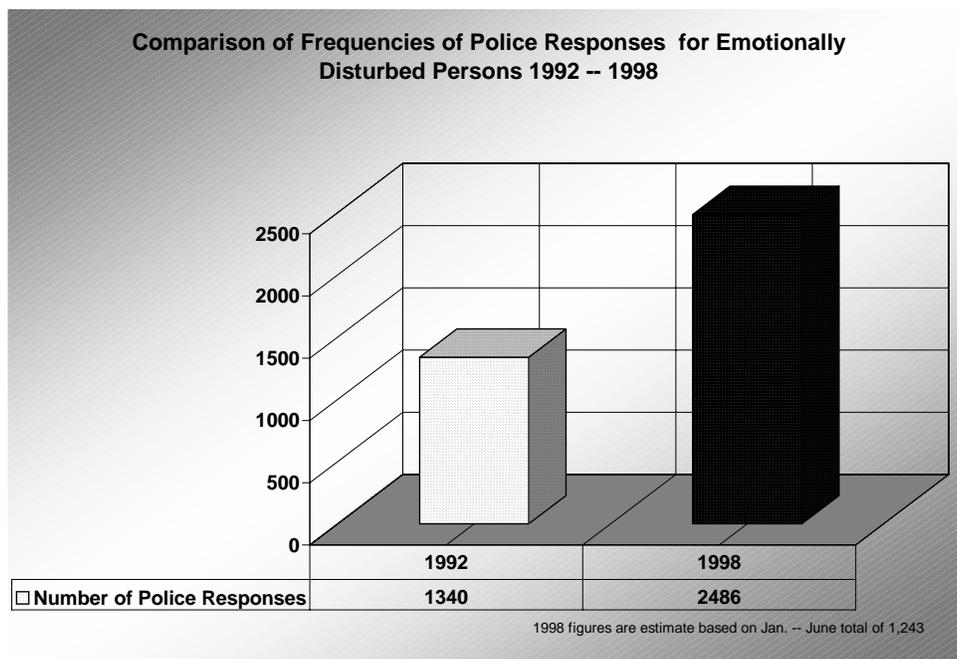
<b><u>Type of Incident</u></b>	<b><u>1988</u></b>	<b><u>1997</u></b>	<b><u>Increase/Decrease</u></b>	
			<b><u>#</u></b>	<b><u>%</u></b>
EDP Incidents*	1,384	2,063	+679	+49.1%
Suicide Attempts	268	290	+22	+8.2%
Suicides	94	135	+41	+43.6%

\*Estimate total for 1998 is **2,486** based on **1,243** incidents during first 6 months of 1998 which represents an 80% increase in 1998 as compared to 1988.

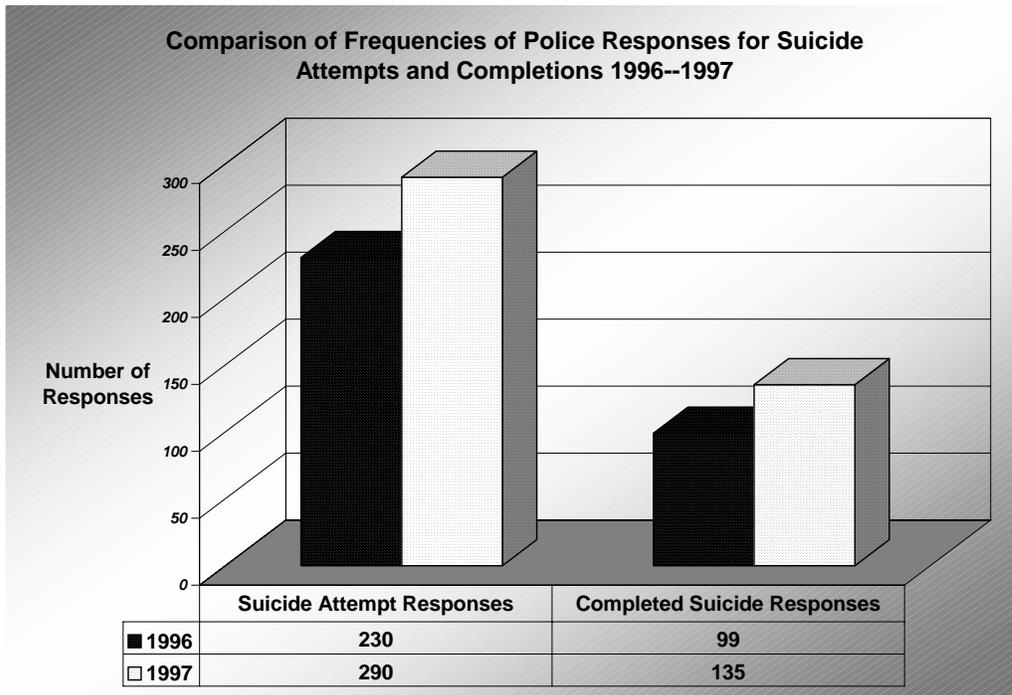
**Figure 1**



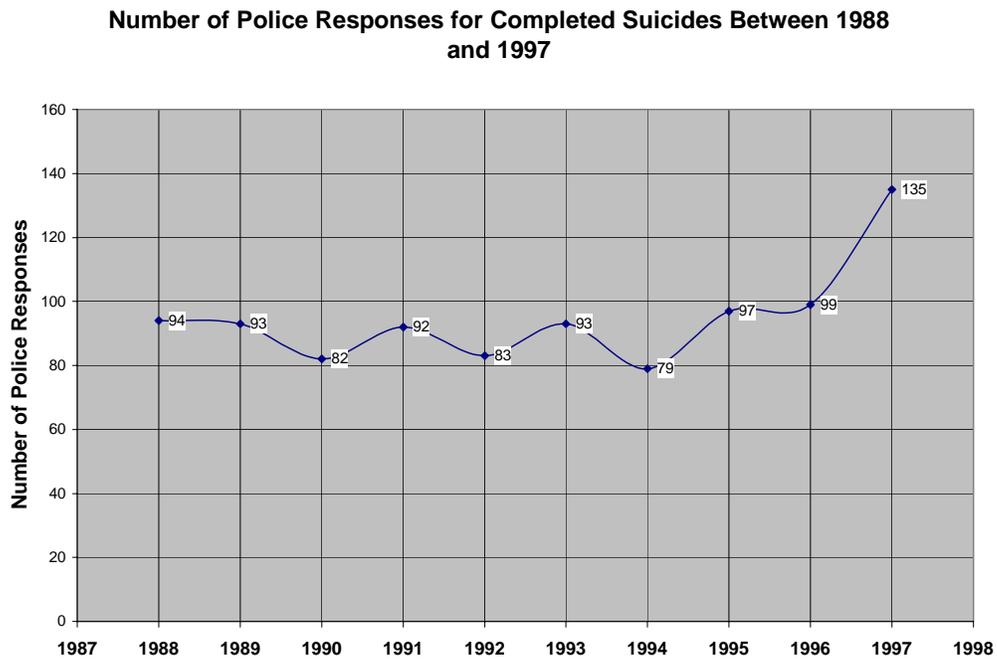
**Figure 2**



**Figure 3**



**Figure 4**



### 3. Prevalence of the Mentally Ill in Suffolk's Criminal Justice System

In addition to police responses involving the mentally ill, the mentally ill are involved in all of the other areas of the criminal justice system in Suffolk County. In this section, estimates of the mentally population are calculated, based on surveys conducted at probation, pretrial services and parole; as well as data collection of the jail census of the mental observation unit. In addition, estimates of the mentally ill in Suffolk County are made based on the latest national research.

#### A. Police Responses

As illustrated in Table 1, there were 2,063 Emotional Disturbed Person (EDP) incidents responded to by the Suffolk County Police Department in 1997, which represents a 49.1% increase as compared to 1988. The 1998 estimate is 2,486 EDP incidents ( based on the first six-month total of 1,243 incidents).

Therefore, the 1998 estimated total represents an 80% increase over 1988's total of 1,384 EDP responses.

In addition, 1997's totals for suicide attempts responded to by the police increased to 290 incidents while the actual number of suicides increased to 135 in 1997.

#### B. Jail Mental Observation Unit

The census of the Jail Mental Observation Unit has expanded rather dramatically during the last two decades. The following statistics are indicative of the increased prevalence of the mentally ill in the criminal justice system:

**T Between 1991 and April 27, 1999 there were 10,168 admissions to the jail mental observation unit.**

T The total numbers of **admissions** to the Mental Observation Unit in 1998 was **1,320** (*an individual may have been admitted more than one time during the year*).

T The total number of **individuals** admitted to the Mental Observation Unit in 1998 was **1,052** (*the individual is only accounted for one time, regardless of how many admissions to the Mental Observation Unit in 1998*).

T **77 offenders were admitted to the mental observation unit one or more times in 1998.**

T **372** offenders admitted to the mental observation unit in 1998 had at least one other prior admission in another year (1991-1998).

T **128 offenders with an admission to the mental observation unit in 1998 had 4 or more admissions between the years 1991-1998, 92 of these offenders had 5 or more admissions.**

T **21** offenders seen for the first time in the mental observation unit in 1998 had at least one other admission in 1999.

### C. Probation, Pretrial, Parole and Jail Components

In addition to a DSM IV diagnosis, there are five other indicators of serious mental illness used in this study. The description and incidence of each indicator are as follows:

	<u>Number</u>	<u>Percent of Sample</u>
1. Receiving Care for a Mental Illness	1,029	66.8%
2. Prior Hospitalizations for a Mental Illness	761	49.4%
3. Prescribed Medication for a Mental Disorder	731	47.4%
4. Acts or Talks in a Bizarre or Abnormal Manner	327	21.2%
5. Ever Attempted Suicide	<u>315</u>	20.4%
Total Responses	3,163	

As illustrated in Table 2, there are 1,541 seriously mentally ill individuals identified in the 1999 criminal justice sample in Suffolk County. The 1,541 sample individuals represent 4,707 people on an annual basis after adjusting for multiple admissions and duplicative identification by different components of the justice system. This 4,707 total only includes probation, parole pretrial and jail cases and does not include police response to incidents of emotionally disturbed people (EDP).

**Table 2: 1999 Estimated Annual Number of Mentally Ill Identified In  
Suffolk County's Criminal Justice System Based  
on the Research Sample (Non-Police Subtotal)**

<b>Criminal Justice Agency</b>	<b>Research Sample Totals</b>	<b>Sample of Agency Totals</b>	<b>Estimated Annual Total of Mentally Ill</b>
1. Probation C.C. Supervision	1,023 <sup>A</sup>	10.4%	1,634
2. Pretrial (ROR)	213 <sup>B</sup>	7.7%	1,417
3A. Jail #1 - mental observation unit	149 <sup>C</sup>	8.0%	1,052 <sup>E,F</sup>
B. Jail #2 - all other jail	-	8.0%	882 <sup>G</sup>
4. Parole	115 <sup>D</sup>	7.1%	192
5. Multiple Agency Involvement* (probation, parole, pretrial, jail)	35	2.3%	-
6. Unidentified	<u>6</u>	.4%	<u>6</u>
Total	1,541		5,183

\*Adjustment of estimated 9.2% for multi-agency duplication **477**

Grand Total Estimate of Mentally Ill in Criminal Justice **4,707**

- A. Sample total based on actual probationers identified in one month caseload survey.
- B. Sample based on actual defendants identified in a 60-day survey at pretrial lockup.
- C. Based on analysis of one-day census of jail mental observation unit (does not include all other inmates).
- D. Based on actual parolees identified in one-month survey.
- E. Based on actual 1998 total of **1,052** inmates.
- F. The 1,052 inmate total represents **1,320** admissions for year.
- G. Based on national estimate of 16% in jail facilities.

By calculating the documented number of mentally ill individuals identified for the **sample** to the **annual** caseload, an estimated 4,707 mentally ill individuals are processed by probation, parole, pretrial services and the jail yearly. This is considered a conservative measurement which has been adjusted for duplicative counts of the same individual within several components of the justice system. A **unique identifier** was used during this study to avoid duplication and multiple admissions throughout the year.

The probation supervision component of **1,634** people annually represent **10.4%** of the probationer population; as compared to **192** individuals or **7.1%** of the parole population, and **1,417** detainees or **7.7%** of the pretrial population. The jail calculations represent actual annual counts from 1998 of **1,320** admissions to the mental observation unit by 1,052 individuals; as well as **882** additional individuals housed throughout the other jail facilities.

As illustrated in Table 3, 60.9% of the sample have a DSM diagnosis in their case record, and out of this subgroup, the diagnosis categories are as follows: Schizophrenia - 12.2%, Bipolar - 14.3%, Depression - 58.3%, Anxiety Disorder - 7.5%, ADD - 5%, PTSD - 2.2%, and OCD - .5%. There were 39.1% or 603 individuals of the sample who were included in the sample because of one of the other indicators such as prior hospitalization, current medication for a mental disorder, current treatment, bizarre behavior or suicide attempts.

**Table 3: Type of Primary Diagnosis in Sample and Estimates for the Annual Mentally Ill Criminal Justice Population**

<b>Type of Diagnosis</b>	<b>Number Of Sample</b>	<b>Percentage of Total Sample</b>	<b>Percentage of Sample With A Diagnosis</b>	<b>Estimated Number of Annual Population</b>
Schizophrenia	114	7.4%	12.2%	348
Bipolar	134	8.7%	14.3%	410
Depression	547	35.5%	58.3%	1,671
Anxiety Disorder	70	4.5%	7.5%	212
ADD	47	3.1%	5.0%	146
PTSD	21	1.4%	2.2%	66
OCD	5	.3%	.5%	14
No dx Indicated	<u>603</u>	<u>39.1%</u>	-	<u>1,840</u>
<b>Total</b>	<b>1,541</b>	<b>100.0%</b>	<b>100.0%</b>	<b>4,707</b>

**D. Combined Total of Mentally Ill in Criminal Justice**

This section presents the police, probation, jail, parole, and pretrial combined total after adjusting for multiple contacts or admissions throughout the year and after adjusting for multiple agency contacts. A unique identifier was used for the sample and a statistical adjustment was used for the police and other annual estimates.

As illustrated in Table 4, current estimates indicate that the combined criminal justice system will have provided services to 6,365 mentally ill individuals in Suffolk County in 1999.

**Table 4: 1999 Combined Total of Mentally Ill in Criminal Justice**

<b>Agency</b>	<b>Sample/Actual</b>	<b>Estimated 1999 Annual Total</b>	<b>Adjusted for Duplication and Multiple Admission</b>
1. Police (EDP Incidents)	1,243 (1 <sup>st</sup> 6 months of 1998)	2,486	1,658*
2. Jail #1 (m.o. unit)	149	1,052	955
3. Jail #2 (all other)	-	882	801
4. Probation	1,023	1,634	1,484
5. Pretrial	213	1,417	1,287
6. Parole	115	192	174
7. Multiple Agency	35	-	-
8. Unidentified	6	6	6
Total	2,784	7,669	6,365

\*The police incident total was adjusted by one-third since some of the EDP incidents would result in arrest for moderate or serious offenses requiring detention or further involvement in the criminal justice system.



V. **AN ANALYSIS OF THE NATURE AND PREVALENCE OF THE MENTALLY ILL POPULATION**

1. **Profile of the Total Sample**

A. **Source of Sample**

<p><b>Sample</b>  <b>N=1541</b>  <b>Probation</b>  <b>(n=1023)</b>  <b>Pretrial ROR</b>  <b>(n=213)</b>  <b>Parole (n=115)</b>  <b>Jail (n=149)</b></p>
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We estimated the prevalence of mentally ill offenders in the Suffolk County criminal justice system by selecting a sample from four of Suffolk County's main criminal justice sources, Probation, Probation ROR, The Suffolk County Jail, and Suffolk County Parole. The table below indicates the numbers of mentally ill offenders in each of the systems. A small number of offenders (35) were known to more than one system. Including multiple agency involvement there were 1,051 probation cases, 233 pretrial cases, 170 jail inmates and 117 parolees.

**TABLE 5: SOURCE OF 1999 SAMPLE BASED ON TYPE OF AGENCY STATUS, MULTIPLE AGENCY INVOLVEMENT, AND NUMBER OF UNIQUE INDIVIDUALS IDENTIFIED FOR SAMPLE**

<i>SAMPLE SOURCE</i>	<i>Total Number of Cases</i>	<i>Number of Unique Individuals in Sample</i>
Probation	1,023	1,023
Jail	149	149
ROR	213	213
Parole	115	115
Jail AND Probation	26	13
Jail AND ROR	14	7
Probation AND ROR	24	12
Probation AND Parole	4	2
Jail, Probation, AND ROR	3	1
Not identified	6	6
<b>TOTAL</b>	<b>1,577</b>	<b>1,541*</b>

**\*Note** - There were 35 individuals or 2.2% that were identified by more than one agency during the data collection phase, resulting in a sample size of 1,541 individuals.

**TABLE 6: PERCENTAGE OF SAMPLE BY AGENCY OR  
MULTIPLE AGENCY INVOLVEMENT**

<i>SAMPLE SOURCE</i>	<i>Total Number Selected</i>	<i>Percent of Sample</i>
Probation	1,023	66.40%
Jail	149	9.67%
ROR	213	13.82%
Parole	115	7.46%
Jail AND Probation	13	.84%
Jail AND ROR	7	.45%
Probation AND ROR	12	.78%
Probation AND Parole	2	.13%
Jail, Probation, AND ROR	1	.06%
Not identified	<u>6</u>	<u>.39%</u>
<b>TOTAL</b>	<b>1,541</b>	<b>100.00%</b>

**TABLE 7: AGENCY SAMPLE SIZE BY PERCENTAGE  
OF TOTAL 1999 POPULATION**

<u>Source</u>	<u>Case Sample Size</u>	<u>Total Agency Population</u>	
		<u>#</u>	<u>%</u>
Probation	1,051	10,120	10.39%
Pretrial	233	3,195	7.3%
Jail	170*	1,713	9.9%
Parole	117	1,652	7.1%
Unidentified	<u>6</u>	<u>-</u>	<u>-</u>
<b>TOTAL</b>	<b>1,577</b>	<b>16,680</b>	<b>9.45%</b>

\*Data Collection conducted only with inmates in the mental observation unit. Other inmates at-large in the correctional facility not included in the sample.

## B. Characteristics of Sample

### Age Distribution

Based upon our sample, mentally ill offenders in Suffolk County's criminal justice system range in age from 16 to 89 years of age. The mean age of the mentally ill offenders was 34.7 years of age.

#### Age Range and Mean and For Entire Sample

	N	Range	Minimum	Maximum	Mean
AGE	1539	73	16	89	34.71

Most offenders were between the ages of 20 and 39 years of age (see table 8. below).

**Table 8.**

#### age group

		Frequency	Percent
Age ranges	16 to 19	157	10.2
	20 to 29	420	27.3
	30 to 39	485	31.5
	40 to 49	331	21.5
	50 to 59	111	7.2
	60 to 69	27	1.8
	70 to 79	6	.4
	80 to 89	2	.1
	Total	1539	99.9

Mentally ill offenders on Parole tended to be slightly older (mean age of 40.37) than offenders either on probation, in jail, or in ROR (see table 9.).

**Table 9.**

**Mean Age by Sample Group**

AGE

sample group	Mean	N
probation Supervision	34.07	1050
ROR	34.61	212
Jail	34.89	160
parole	40.37	117
Total	34.71	1539

**Gender Distribution**

Females account for approximately one-quarter of the mentally ill population in Suffolk County's criminal justice system. As can be seen in table 10 parolees with mental illness were slightly more likely to be male (85.5%).

**Table 10.**

**Gender For Sample Group**

			gender		Total
			male	female	
sample group	probation Supervision	Count	791	258	1049
		% within sample group	75.4%	24.6%	100.0%
	ROR	Count	151	61	212
		% within sample group	71.2%	28.8%	100.0%
	Jail	Count	124	36	160
		% within sample group	77.5%	22.5%	100.0%
	parole	Count	100	17	117
		% within sample group	85.5%	14.5%	100.0%
Total	Count		1166	372	1538
	% within sample group		75.8%	24.2%	100.0%

### Race/Ethnicity

Obtaining information regarding the race/ethnicity for the mentally ill population was difficult in some instances due to the data collection methodology. Table 11. Shows the race/ethnicity for the sample group. Many of the jail records did not indicate the race/ethnicity of the inmates. The ROR screening instruments do not include race/ethnicity. The majority of the parole records did not indicate race/ethnicity.

**Table 11.**

			Race/ethnicity for Sample Groups				
			race/ethnicity				
			black	hispanic	white	Unknown	Total
sample group	probation Supervision	Count	155	64	781	50	1050
		% within sample group	14.8%	6.1%	74.4%	4.8%	100.0%
	ROR	Count	22	5	55	130	212
		% within sample group	10.4%	2.4%	25.9%	61.3%	100.0%
	Jail	Count	24	5	48	83	160
		% within sample group	15.0%	3.1%	30.0%	51.9%	100.0%
	parole	Count	7	2	7	101	117
		% within sample group	6.0%	1.7%	6.0%	86.3%	100.0%
Total	Count		208	76	891	364	1539
	% within sample group		13.5%	4.9%	57.9%	23.7%	100.0%

### C. Indicators of Mental Illness

In order to help identify offenders who may have mental illnesses, we selected five indicators of mental illness to use as part of our screening. These indicators are: currently receiving care for a mental disorder, prior hospitalization for a mental disorder, taking medication for a mental disorder, acts or speaks in a bizarre or abnormal manner, and ever attempted suicide. The results are listed below.

#### Receiving Care for a Mental Disorder

Over 66% of mentally ill offenders were receiving care for a mental disorder while in the criminal justice system. Those in jail were slightly more likely to be receiving care while in jail.

**Table 12. Receiving Care for a Mental Disorder**

Receiving care for mental disorder by Sample Groups

sample group		care for mental disorder			Total
		yes	no	Unkown	
probation Supervision	Count	712	326	14	1052
	% within sample group	67.7%	31.0%	1.3%	100.0%
ROR	Count	117	94	1	212
	% within sample group	55.2%	44.3%	.5%	100.0%
Jail	Count	121	32	7	160
	% within sample group	75.6%	20.0%	4.4%	100.0%
parole	Count	79	34	4	117
	% within sample group	67.5%	29.1%	3.4%	100.0%
Total	Count	1029	486	26	1541
	% within sample group	66.8%	31.5%	1.7%	100.0%

## Prior Hospitalization

Approximately one half of mentally ill offenders have been in a hospital for a mental disorder at some time in their life.

**Table 13. Prior Hospitalization**

			hospital for mental disorder			Total
			yes	no	Unknown	
sample group	probation Supervision	Count	465	537	50	1052
		% within sample group	44.2%	51.0%	4.8%	100.0%
	ROR	Count	130	79	3	212
		% within sample group	61.3%	37.3%	1.4%	100.0%
	Jail	Count	99	55	6	160
		% within sample group	61.9%	34.4%	3.8%	100.0%
	parole	Count	67	44	6	117
		% within sample group	57.3%	37.6%	5.1%	100.0%
Total		Count	761	715	65	1541
		% within sample group	49.4%	46.4%	4.2%	100.0%

## Taking Medication for a Mental Disorder

Almost one half of mentally ill offenders are taking medication for a mental disorder. Those in the jail (69.4%) were more likely to be taking medication than those on either probation, parole, or ROR.

**Table 14. Taking Medication for a Mental Disorder**

			medication for disorder			Total
			yes	no	Unknown	
sample group	probation Supervision	Count	437	566	49	1052
		% within sample group	41.5%	53.8%	4.7%	100.0%
	ROR	Count	123	87	2	212
		% within sample group	58.0%	41.0%	.9%	100.0%
	Jail	Count	111	42	7	160
		% within sample group	69.4%	26.3%	4.4%	100.0%
	parole	Count	60	49	8	117
		% within sample group	51.3%	41.9%	6.8%	100.0%
Total		Count	731	744	66	1541
		% within sample group	47.4%	48.3%	4.3%	100.0%

## Acts or Speaks in a Bizarre or Abnormal Manner

Most offenders were not identified as acting or speaking in a bizarre manner. While this assessment is subjective and based upon each officer's assessment of their client, we

included it as one of five indicators. We did find that almost 20% of the mentally ill probationers were identified as acting or speaking abnormally.

**Table 15.**

		<b>Acts or Talks Bizarre or Abnormal</b>				
		act or talk abnormal			Total	
		yes	no	Unknown		
sample group	probation Supervision	Count	202	823	27	1052
		% within sample group	19.2%	78.2%	2.6%	100.0%
	ROR	Count	51	157	4	212
		% within sample group	24.1%	74.1%	1.9%	100.0%
	Jail	Count	46	79	35	160
		% within sample group	28.8%	49.4%	21.9%	100.0%
	parole	Count	28	83	6	117
		% within sample group	23.9%	70.9%	5.1%	100.0%
Total		Count	327	1142	72	1541
		% within sample group	21.2%	74.1%	4.7%	100.0%

### **Ever Attempted Suicide**

Of the 160 offenders in the jail mental health unit, almost one half were identified as having attempted suicide at least one time. This was a much higher percentage than other offenders on probation, parole, or ROR.

**Table 16.**

		<b>Ever Attempted Suicide</b>				
		ever attempted suicide			Total	
		yes	no	Unknown		
sample group	probation Supervision	Count	198	776	78	1052
		% within sample group	18.8%	73.8%	7.4%	100.0%
	ROR	Count	4	1	207	212
		% within sample group	1.9%	.5%	97.6%	100.0%
	Jail	Count	79	60	21	160
		% within sample group	49.4%	37.5%	13.1%	100.0%
	parole	Count	34	67	16	117
		% within sample group	29.1%	57.3%	13.7%	100.0%
Total		Count	315	904	322	1541
		% within sample group	20.4%	58.7%	20.9%	100.0%

### **D. Primary Diagnoses for Sample**

In this section we identified each of the offenders according to their primary diagnosis using the diagnostic categories from the DSM IV (see Table 17). Most offenders (44.5) were identified with mental disorders that were classified as Mood Disorders. A large group (419 or 27%) were identified only through the indicators of mental illness categories (currently receiving care for a mental disorder, prior hospitalization for a mental disorder, taking medication for a mental disorder, acts or speaks in a bizarre or abnormal manner, and ever attempted suicide).

For our analysis of the sample group we reduced the categories of diagnoses to the following groups:

1. anxiety disorder
2. attention deficit disorder (ADD)
3. bipolar
4. depression
5. obsessive compulsive disorder (OCD)
6. post traumatic stress disorder (PTSD)
7. schizophrenia
8. no primary diagnosis (dx) or other.

Table 18 shows how we identified the above categories in relationship to the DSM IV categories.

**Table 17.**

**primary diagnosis (according to DSM Categories)**

		Frequency	Percent
Valid	Adjustment Dis.	34	2.2
	Anxiety Dis.	97	6.3
	ADD	48	3.1
	Dissociative Dis.	1	.1
	Eating Dis.	3	.2
	Impulse Control Dis.	28	1.8
	Mood Dis.	686	44.5
	Personality Dis.	20	1.3
	Schizophrenia & Psychotic Dis.	142	9.2
	Sexual Behavior	25	1.6
	Conduct Dis.	10	.6
	Tourettes Dis.	1	.1
	Tx = only indicator	219	14.2
	Hosp. = only indicator	122	7.9
	Meds = only indicator	19	1.2
	Behavior = only indicator	38	2.5
	Suicide att/idea = only indicator	21	1.4
	other indicators	13	.8
	no indicators of MI	14	.9
	Total	1541	100.0

**Table 18.**

**primary diagnosis (according to DSM Categories) and primary diagnosis**

Count			
primary diagnosis (according to DSM Categories)	Adjustment Dis.		no dx indicated or other 34
		Total	34
	Anxiety Dis.		anxiety disorder (includes panic dis.) 70
			PTSD 21
			OCD 5
			no dx indicated or other 1
		Total	97
	ADD		ADD 47
			no dx indicated or other 1
		Total	48
	Dissociative Dis.		no dx indicated or other 1
		Total	1
	Eating Dis.		no dx indicated or other 3
		Total	3
	Impulse Control Dis.		no dx indicated or other 28
		Total	28
	Mood Dis.		depression 548
			bipolar 134
			no dx indicated or other 6
		Total	688
	Personality Dis.		no dx indicated or other 20
		Total	20
	Schizophrenia & Psychotic Dis.		schizophrenia 115
			no dx indicated or other 25
		Total	140
	Sexual Behavior		no dx indicated or other 25
		Total	25
	Conduct Dis.		no dx indicated or other 10
		Total	10
	Tourettes Dis.		no dx indicated or other 1
		Total	1
	Tx = only indicator		no dx indicated or other 219
		Total	219
	Hosp. = only indicator		no dx indicated or other 122
	Total	122	
Meds = only indicator		no dx indicated or other 19	
	Total	19	
Behavior = only indicator		no dx indicated or other 38	
	Total	38	
Suicide att/idea = only indicator		no dx indicated or other 21	
	Total	21	
other indicators		no dx indicated or other 13	
	Total	13	
no indicators of MI		no dx indicated or other 14	
	Total	14	
Total		schizophrenia 115	
		depression 548	
		bipolar 134	
		anxiety disorder (includes panic dis.) 70	
		ADD 47	
		PTSD 21	
		OCD 5	
		no dx indicated or other 601	
	Total	1541	

Table 19 indicates the numbers of offenders in each diagnostic category according to their primary diagnosis. The percentages indicate the percentage of offenders with that specific diagnosis within each of the sample groups.

Parolees had a higher rate of schizophrenia than the other offender sample groups. As can be seen in table 19, mentally ill offenders with a primary diagnosis of schizophrenia accounted for 18.8% of the parolee sample. Offenders with diagnoses of schizophrenia accounted for only 7.5% of the entire sample.

**Table 19.**

**sample group and primary diagnosis**

				Count	% within sample group
primary diagnosis	schizophrenia	sample group	probation Supervision	68	6.5%
			ROR	4	1.9%
			Jail	21	13.1%
			parole	22	18.8%
		Total	115	7.5%	
	depression	sample group	probation Supervision	422	40.1%
			ROR	27	12.7%
			Jail	57	35.6%
			parole	42	35.9%
		Total	548	35.6%	
	bipolar	sample group	probation Supervision	108	10.3%
			ROR	11	5.2%
			Jail	6	3.8%
			parole	9	7.7%
		Total	134	8.7%	
	anxiety disorder (includes panic dis.)	sample group	probation Supervision	53	5.0%
			ROR	6	2.8%
			Jail	2	1.3%
			parole	9	7.7%
		Total	70	4.5%	
ADD	sample group	probation Supervision	43	4.1%	
		ROR	1	.5%	
		Jail	2	1.3%	
		parole	1	.9%	
	Total	47	3.0%		
PTSD	sample group	probation Supervision	19	1.8%	
		ROR	2	.9%	
	Total	21	1.4%		
OCD	sample group	probation Supervision	5	.5%	
	Total	5	.3%		
no dx indicated	sample group	probation Supervision	334	31.7%	
		ROR	161	75.9%	
		Jail	72	45.0%	
		parole	34	29.1%	
	Total	601	39.0%		
Total	sample group	probation Supervision	1052	100.0%	
		ROR	212	100.0%	
		Jail	160	100.0%	
		parole	117	100.0%	
	Total	1541	100.0%		

Most offenders had only one diagnosis. Those in jail tended to have slightly more than one diagnosis (mean of 1.4 diagnoses).

**Table 20.**

**Mean Number of Diagnoses by Sample Group**

number of diagnoses		
sample group	Mean	N
probation Supervision	1.10	1052
ROR	1.00	212
Jail	1.41	160
parole	1.13	117
Total	1.12	1541

Female offenders appeared more likely to be diagnosed as either depressed or bipolar. Table 21 shows the diagnoses for males and females in the entire sample.

**Table 21.**

		Primary Diagnosis and Gender			
		gender			Total
		male	female		
primary diagnosis	schizophrenia	Count	100	14	114
		% within primary diagnosis	87.7%	12.3%	100.0%
	depression	Count	382	165	547
		% within primary diagnosis	69.8%	30.2%	100.0%
	bipolar	Count	91	43	134
		% within primary diagnosis	67.9%	32.1%	100.0%
	anxiety disorder (includes panic dis.)	Count	53	17	70
		% within primary diagnosis	75.7%	24.3%	100.0%
	ADD	Count	47		47
		% within primary diagnosis	100.0%		100.0%
	PTSD	Count	17	4	21
		% within primary diagnosis	81.0%	19.0%	100.0%
	OCD	Count	5		5
		% within primary diagnosis	100.0%		100.0%
	no dx indicated	Count	471	129	600
		% within primary diagnosis	78.5%	21.5%	100.0%
Total		Count	1166	372	1538
		% within primary diagnosis	75.8%	24.2%	100.0%

### E. Medications used

In this section we looked at which medications the offenders were taking according to the officers knowledge. Table 22 shows the number of mentally ill offenders taking anti-anxiety medications according to the sample groups. The percentages indicate the percent of offenders, within the sample group taking anti-anxiety medications. Most of the offenders on probation (16%) were more likely to be identified as taking anti-anxiety medications.

**Table 22.****Taking Anti-anxiety Medication and Sample Group**

			taking anti-anxiety medication			Total
			yes	no	Unknown	
sample group	probation Supervision	Count	166	851	18	1035
		% within sample group	16.0%	82.2%	1.7%	100.0%
	ROR	Count	20	178	14	212
		% within sample group	9.4%	84.0%	6.6%	100.0%
	Jail	Count	14	145	1	160
		% within sample group	8.8%	90.6%	.6%	100.0%
	parole	Count	12	97	8	117
		% within sample group	10.3%	82.9%	6.8%	100.0%
Total		Count	212	1271	41	1524
		% within sample group	13.9%	83.4%	2.7%	100.0%

Table 23 shows the number of mentally ill offenders taking anti-psychotic medications according to the sample groups. The percentages indicate the percent of offenders, within the sample group taking anti-psychotic medications. Most of the offenders in the jail (39.4%) were more likely to be identified as taking anti-psychotic medications.

**Table 23.****Taking Anti-psychotic Medication and Sample Group**

			taking anti-psychotic medication			Total
			yes	no	Unknown	
sample group	probation Supervision	Count	117	896	18	1031
		% within sample group	11.3%	86.9%	1.7%	100.0%
	ROR	Count	25	173	14	212
		% within sample group	11.8%	81.6%	6.6%	100.0%
	Jail	Count	63	96	1	160
		% within sample group	39.4%	60.0%	.6%	100.0%
	parole	Count	28	80	9	117
		% within sample group	23.9%	68.4%	7.7%	100.0%
Total		Count	233	1245	42	1520
		% within sample group	15.3%	81.9%	2.8%	100.0%

Table 24 shows the number of mentally ill offenders taking anti-depressant medications according to the sample groups. The percentages indicate the percent of offenders, within the sample group taking anti-depressant medications. Almost one half (45.6%) of the offenders in jail were identified as taking anti-depressant medications.

**Table 24.**

**Taking Anti-depressant Medication and Sample Groups**

			taking anti-depressant medication			Total
			yes	no	Unknown	
sample group	probation Supervision	Count	323	698	23	1044
		% within sample group	30.9%	66.9%	2.2%	100.0%
	ROR	Count	71	127	14	212
		% within sample group	33.5%	59.9%	6.6%	100.0%
	Jail	Count	73	86	1	160
		% within sample group	45.6%	53.8%	.6%	100.0%
	parole	Count	34	73	10	117
		% within sample group	29.1%	62.4%	8.5%	100.0%
Total		Count	501	984	48	1533
		% within sample group	32.7%	64.2%	3.1%	100.0%

Table 25 shows the number of mentally ill offenders taking mood-stabilizing medications according to the sample groups. The percentages indicate the percent of offenders, within the sample group, taking mood-stabilizing medications. More of the offenders in jail (18.1%) were identified as taking mood stabilizing medications.

**Table 25.**

**Mood Stabilizing Medication and Sample Groups**

			Mood Stabilizing Medication		Total
			yes	no	
sample group	probation Supervision	Count	95	957	1052
		% within sample group	9.0%	91.0%	100.0%
	ROR	Count	15	197	212
		% within sample group	7.1%	92.9%	100.0%
	Jail	Count	29	131	160
		% within sample group	18.1%	81.9%	100.0%
	parole	Count	10	107	117
		% within sample group	8.5%	91.5%	100.0%
Total		Count	149	1392	1541
		% within sample group	9.7%	90.3%	100.0%

Table 26 lists the known medications being taken by the entire sample.

**Table 26.**

known medications

Valid		Frequency	Percent
	ADDERAL	1	.1
	AMBIEN	4	.3
	AMITRIPTYLENE	4	.3
	ATAVAN	8	.5
	atenol	1	.1
	BENZPTROPINE	1	.1
	BUSPAR	24	1.6
	CELEXA	1	.1
	CHLORDIAZEPOXIDE	1	.1
	CLONAZEPAN	2	.1
	CLONIPIN	5	.3
	CLORPROMAZINE	1	.1
	CLOXARIL	1	.1
	COGENTIN	8	.5
	CYLERT	1	.1
	DEPACOTE	44	2.9
	DESIROL	2	.1
	dexadrine	1	.1
	DIAZEPAM	1	.1
	DILANTIN	3	.2
	DIOXOPIN	1	.1
	DURACET	1	.1
	EFFEXOR	16	1.0
	ELAVIL	13	.8
	HALDOL	37	2.4
	HYDROXINE	1	.1
	IMEPROMINE	2	.1
	insulin	1	.1
	LEOPROZINE	1	.1
	LIBRIUM	2	.1
	LITHIUM	29	1.9
	Iodine	1	.1
	LORAZEPAM	1	.1
	LUVOX	4	.3
	LYPREXA	1	.1
	MELLARIL	11	.7
	MORAZIPAN	1	.1
	NAPRONIN	1	.1
	NAVANE	4	.3
	NEUROTIN	2	.1
	no	822	53.3
	NORPRAMINE	1	.1
	NORTRIPTALENE	1	.1
	PAMELAR	1	.1
	PAXIL	85	5.5
	PENADOL	1	.1
	PROLIXIN	13	.8
	PROZAC	111	7.2
	REMERON	1	.1
	RESPERIDOL	22	1.4
	RESPERIDONE	2	.1
	RESPITORE	1	.1
	RITALIN	12	.8
	SERAQUIL	1	.1
	SERAZONE	6	.4
	SINEQUAN	6	.4
	TAZADONE	2	.1
	TEGRETOL	6	.4
	THORAZINE	18	1.2
	TOFRANIL	2	.1
	TOPROL XL	1	.1
	TRAZADONE	34	2.2
	VALIUM	12	.8
	VISTARIL	13	.8
	WELLBUTRIN	12	.8
	XANAX	18	1.2
	zoloft	66	4.3
	ZYPREXA	26	1.7
	ZYRTEC	1	.1
	Total	1541	100.0

## F. Substance Abuse

Substance abuse was indicated for almost two-thirds (64%) of mentally ill offenders. Offenders in jail (83.8%) and on parole (82.9%) had a higher rate of substance abuse than offenders on probation. Those in the ROR group could not be identified according to use of substances due to the limited time and information available at ROR. Table 27 shows the use of substance among the sample groups.

**Table 27.**

		Substance Abuse and Sample Groups			
		substance abuse			
		yes substance abuse	no known substance abuse	Total	
sample group	probation Supervision	Count	754	298	1052
		% within sample group	71.7%	28.3%	100.0%
	ROR	Count	2	210	212
		% within sample group	.9%	99.1%	100.0%
	Jail	Count	134	26	160
		% within sample group	83.8%	16.3%	100.0%
	parole	Count	97	20	117
		% within sample group	82.9%	17.1%	100.0%
Total		Count	987	554	1541
		% within sample group	64.0%	36.0%	100.0%

### Specific Substances Used

Tables 28-31 shows the specific substances used by the offenders in each sample group. Almost one half (48.7%) of the entire sample were identified as using alcohol. Two-thirds (65.6%) of those in the jail abused alcohol. Cocaine use was high among the parolees (62.4%). Approximately one quarter (24.3%) of the offenders abused marijuana and only 7% abused heroin.

**Table 19. Alcohol Use and Sample Groups**

			alcohol use			Total
			yes	no	Unknown	
sample group	probation Supervision	Count	581	469	1	1051
		% within sample group	55.3%	44.6%	.1%	100.0%
	ROR	Count	2		210	212
		% within sample group	.9%		99.1%	100.0%
	Jail	Count	105	52	3	160
		% within sample group	65.6%	32.5%	1.9%	100.0%
	parole	Count	62	54	1	117
		% within sample group	53.0%	46.2%	.9%	100.0%
Total		Count	750	575	215	1540
		% within sample group	48.7%	37.3%	14.0%	100.0%

**Table 20. Cocaine Use and Sample Groups**

			cocaine use			Total
			yes	no	Unknown	
sample group	probation Supervision	Count	312	736	3	1051
		% within sample group	29.7%	70.0%	.3%	100.0%
	ROR	Count			212	212
		% within sample group			100.0%	100.0%
	Jail	Count	60	95	5	160
		% within sample group	37.5%	59.4%	3.1%	100.0%
	parole	Count	73	43	1	117
		% within sample group	62.4%	36.8%	.9%	100.0%
Total		Count	445	874	221	1540
		% within sample group	28.9%	56.8%	14.4%	100.0%

**Table 21. Marijuana Use and Sample Groups**

			marijuana use			Total
			yes	no	Unknown	
sample group	probation Supervision	Count	291	756	2	1049
		% within sample group	27.7%	72.1%	.2%	100.0%
	ROR	Count			212	212
		% within sample group			100.0%	100.0%
	Jail	Count	49	106	5	160
		% within sample group	30.6%	66.3%	3.1%	100.0%
	parole	Count	34	82	1	117
		% within sample group	29.1%	70.1%	.9%	100.0%
Total		Count	374	944	220	1538
		% within sample group	24.3%	61.4%	14.3%	100.0%

**Table 22. Heroin Use and Sample Groups**

			heroin use			Total
			yes	no	unknown	
sample group	probation Supervision	Count	82	966	2	1050
		% within sample group	7.8%	92.0%	.2%	100.0%
	ROR	Count			212	212
		% within sample group			100.0%	100.0%
	Jail	Count	13	142	5	160
		% within sample group	8.1%	88.8%	3.1%	100.0%
	parole	Count	12	104	1	117
		% within sample group	10.3%	88.9%	.9%	100.0%
Total		Count	107	1212	220	1539
		% within sample group	7.0%	78.8%	14.3%	100.0%

### Substance Abuse and Diagnoses

While 64% of all mentally ill offenders abused substances, a higher percentage of those with depression (76.6%) bipolar (73.9%) and schizophrenia (73%) abused substances.

**Table 32.**

#### Substance Abuse and Primary Diagnosis

			substance abuse		Total
			yes substance abuse	no known substance abuse	
Primary Diagnosis	schizophrenia	Count	84	31	115
		% within primary diagnosis	73.0%	27.0%	100.0%
	depression	Count	420	128	548
		% within primary diagnosis	76.6%	23.4%	100.0%
	bipolar	Count	99	35	134
		% within primary diagnosis	73.9%	26.1%	100.0%
	anxiety disorder (includes panic dis.)	Count	42	28	70
		% within primary diagnosis	60.0%	40.0%	100.0%
	ADD	Count	34	13	47
		% within primary diagnosis	72.3%	27.7%	100.0%
	PTSD	Count	15	6	21
		% within primary diagnosis	71.4%	28.6%	100.0%
	OCD	Count	4	1	5
		% within primary diagnosis	80.0%	20.0%	100.0%
	no dx indicated	Count	289	312	601
		% within primary diagnosis	48.1%	51.9%	100.0%
Total	Count	987	554	1541	
	% within primary diagnosis	64.0%	36.0%	100.0%	

Most offenders were identified as using one substance (mean number of substances - 1.24). Table 33 shows the mean number of substances used by the mentally ill offenders according to diagnosis. Those with diagnoses of depression, bipolar, and schizophrenia used an average of 1.5 substances.

**Table 33.****Mean Number of Substances Used by Diagnostic Group**

number of substances known to use		
primary diagnosis	Mean	N
schizophrenia	1.51	115
depression	1.55	548
bipolar	1.54	134
anxiety disorder (includes panic dis.)	.99	70
ADD	1.36	47
PTSD	1.43	21
OCD	.80	5
no dx indicated	.85	601
Total	1.24	1541

There were no significant differences between males and females substance abuse rate. Substance abuse for both males and females was approximately 64%.

**Table 34.****Substance Abuse and Gender**

		substance abuse			
		yes substance abuse	no known substance abuse	Total	
gender	male	Count	756	410	1166
		% within gender	64.8%	35.2%	100.0%
	female	Count	229	143	372
		% within gender	61.6%	38.4%	100.0%
Total		Count	985	553	1538
		% within gender	64.0%	36.0%	100.0%

### Specific Substances and Diagnoses

Tables 35-38 show the specific substances used by the offenders according to their diagnoses. A large percentage of offenders with schizophrenia (63.5%), bipolar (63.4%) and depression (58%) abused alcohol. Marijuana use among the sample was 24% but was very high for those with ADD (42.6%) and depression (31.1%). Approximately one quarter (28.9%) of the offenders used cocaine. Those with schizophrenia (41.7%) were the most likely to use cocaine. Heroin use did not appear to differ among the diagnostic groups.

**Table 35.**

**Alcohol Use and Primary Diagnosis**

		alcohol use			Total	
		yes	no	Unknown		
primary diagnosis	schizophrenia	Count	73	38	4	115
		% within primary diagnosis	63.5%	33.0%	3.5%	100.0%
	depression	Count	318	203	27	548
		% within primary diagnosis	58.0%	37.0%	4.9%	100.0%
	bipolar	Count	85	38	11	134
		% within primary diagnosis	63.4%	28.4%	8.2%	100.0%
	anxiety disorder (includes panic dis.)	Count	32	32	6	32
		% within primary diagnosis	45.7%	45.7%	8.6%	100.0%
	ADD	Count	24	22	1	47
		% within primary diagnosis	51.1%	51.1%	46.8%	2.1%
	PTSD	Count	12	7	2	21
		% within primary diagnosis	57.1%	33.3%	9.5%	100.0%
	OCD	Count	3	2		5
		% within primary diagnosis	60.0%	40.0%		100.0%
	no dx indicated	Count	203	233	164	600
		% within primary diagnosis	33.8%	38.8%	27.3%	100.0%
Total		Count	750	575	215	1540
		% within primary diagnosis	48.7%	37.3%	14.0%	100.0%

**Table 36.**

**Marijuana Use and Primary Diagnosis**

		marijuana use			Total	
		yes	no	Unknown		
primary diagnosis	schizophrenia	Count	23	88	4	115
		% within primary diagnosis	20.0%	76.5%	3.5%	100.0%
	depression	Count	170	347	29	546
		% within primary diagnosis	31.1%	63.6%	5.3%	100.0%
	bipolar	Count	37	86	11	134
		% within primary diagnosis	27.6%	64.2%	8.2%	100.0%
	anxiety disorder (includes panic dis.)	Count	10	54	6	70
		% within primary diagnosis	14.3%	77.1%	8.6%	100.0%
	ADD	Count	20	26	1	47
		% within primary diagnosis	42.6%	55.3%	2.1%	100.0%
	PTSD	Count	6	13	2	21
		% within primary diagnosis	28.6%	61.9%	9.5%	100.0%
	OCD	Count		5		5
		% within primary diagnosis		100.0%		100.0%
	no dx indicated	Count	108	325	167	600
		% within primary diagnosis	18.0%	54.2%	27.8%	100.0%
Total		Count	374	944	220	1538
		% within primary diagnosis	24.3%	61.4%	14.3%	100.0%

**Table 37.**

**Cocaine Use and Primary Diagnosis**

		cocaine use			Total	
		yes	no	Unknown		
primary diagnosis	schizophrenia	Count	48	63	4	115
		% within primary diagnosis	41.7%	54.8%	3.5%	100.0%
	depression	Count	209	310	29	548
		% within primary diagnosis	38.1%	56.6%	5.3%	100.0%
	bipolar	Count	49	74	11	134
		% within primary diagnosis	36.6%	55.2%	8.2%	100.0%
	anxiety disorder (includes panic dis.)	Count	19	45	6	70
		% within primary diagnosis	27.1%	64.3%	8.6%	100.0%
	ADD	Count	8	38	1	47
		% within primary diagnosis	17.0%	80.9%	2.1%	100.0%
	PTSD	Count	6	13	2	21
		% within primary diagnosis	28.6%	61.9%	9.5%	100.0%
	OCD	Count		5		5
		% within primary diagnosis		100.0%		100.0%
	no dx indicated	Count	106	326	168	600
		% within primary diagnosis	17.7%	54.3%	28.0%	100.0%
Total		Count	445	874	221	1540
		% within primary diagnosis	28.9%	56.8%	14.4%	100.0%

**Table 38.**

		Heroin Use and Primary Diagnosis				
		heroin use			Total	
		yes	no	unknown		
primary diagnosis	schizophrenia	Count	11	100	4	115
		% within primary diagnosis	9.6%	87.0%	3.5%	100.0%
	depression	Count	53	466	29	548
		% within primary diagnosis	9.7%	85.0%	5.3%	100.0%
	bipolar	Count	10	113	11	134
		% within primary diagnosis	7.5%	84.3%	8.2%	100.0%
	anxiety disorder (includes panic dis.)	Count	2	62	6	70
		% within primary diagnosis	2.9%	88.6%	8.6%	100.0%
	ADD	Count	1	45	1	47
		% within primary diagnosis	2.1%	95.7%	2.1%	100.0%
	PTSD	Count	1	18	2	21
		% within primary diagnosis	4.8%	85.7%	9.5%	100.0%
	OCD	Count		5		5
		% within primary diagnosis		100.0%		100.0%
	no dx indicated	Count	29	403	167	599
		% within primary diagnosis	4.8%	67.3%	27.9%	100.0%
Total		Count	107	1212	220	1539
		% within primary diagnosis	7.0%	78.8%	14.3%	100.0%

### G. Offenses Committed

The offenders in the sample committed a wide range of offenses with DWI being the most common offense. Drug sales and theft were the next highest offense categories. See table 39.

**Table 39.**

**categories of offenses**

		Frequency	Percent
Valid	DWI (includes BWI)	297	19.3
	motor vehicle (not including deaths/injuries)	96	6.2
	sex offenses (not prostitution)	76	4.9
	crimes against another person (asslt., menacing, harassment)	154	10.0
	theft (not robbery or burglary)	180	11.7
	burglary and criminal trespass	112	7.3
	robbery	85	5.5
	drugs (sale, possession, includes paraphenalia)	176	11.4
	forgery (includes poss. of instruments, fraudulent acts)	39	2.5
	false reports (includes impersonation)	10	.6
	weapons (sales, possession)	16	1.0
	disorderly conduct (inc. loitering, prostitution)	29	1.9
	arson	16	1.0
	murder	15	1.0
	conspiracy, contempt	120	7.8
	endangering wel. of child	7	.5
	criminal failures (pay, report, register, resisting arrest)	16	1.0
	reckless endangerment	17	1.1
	motor vehicle deaths/assaults	2	.1
	CRIM. NEG. HOMICIDE/MANSLAUGHTER	8	.5
other	26	1.7	
Total	1497	97.1	
Missing	System	44	2.9
Total		1541	100.0

Females were more likely (17%) to be involved in drug related offenses than males (10%). Overall, there were no other significant differences between males and females according to offense committed. See table 40.

**Table 40.**

**Gender and Categories of Offenses**

		gender				Total	
		male		female			
		Count	% within gender	Count	% within gender	Count	% within gender
categories of offenses	DWI (includes BWI)	221	19.5%	76	21.0%	297	19.9%
	motor vehicle (not including deaths/injuries)	74	6.5%	22	6.1%	96	6.4%
	sex offenses (not prostitution)	73	6.4%	3	.8%	76	5.1%
	crimes against another person (asslt., menacing, harassment)	113	10.0%	39	10.8%	152	10.2%
	theft (not robbery or burglary)	120	10.6%	59	16.3%	179	12.0%
	burglary and criminal trespass	103	9.1%	9	2.5%	112	7.5%
	robbery	79	7.0%	6	1.7%	85	5.7%
	drugs (sale, possession, includes paraphernalia)	113	10.0%	63	17.4%	176	11.8%
	forgery (includes poss. of instruments, fraudulent acts)	21	1.9%	18	5.0%	39	2.6%
	false reports (includes impersonation)	5	.4%	5	1.4%	10	.7%
	weapons (sales, possession)	16	1.4%			16	1.1%
	disorderly conduct (inc. loitering, prostitution)	14	1.2%	15	4.1%	29	1.9%
	arson	14	1.2%	2	.6%	16	1.1%
	murder	12	1.1%	3	.8%	15	1.0%
	conspiracy, contempt	95	8.4%	25	6.9%	120	8.0%
	endangering wel. of child	3	.3%	4	1.1%	7	.5%
	criminal failures (pay, report, register, resisting arrest)	15	1.3%	1	.3%	16	1.1%
	reckless endangerment	15	1.3%	2	.6%	17	1.1%
	motor vehicle deaths/assaults	2	.2%			2	.1%
	CRIM. NEG. HOMICIDE/MANSLAUGHTER	5	.4%	3	.8%	8	.5%
other	19	1.7%	7	1.9%	26	1.7%	
Total	1132	100.0%	362	100.0%	1494	100.0%	

**Violent Crimes**

Mentally ill offenders committed mostly (75%) non-violent crimes. In order to compare our results with the latest national research, we have based our definition of violent crime on the U.S. Department of Justice’s, Bureau of Justice Statistical crime categories, which divides crimes into four areas: Violent Offenses, Property Offenses, Drug Offenses and Public-order offenses. **Violent offenses** include murder, negligent manslaughter, kidnapping, sexual assault, robbery and other face-to-face assaults, while **Property**

**offenses** include burglary, larceny/theft, and fraud. **Drug offenses** include possession and trafficking while **Public-order offenses** include weapons possession and drunk driving.. (Refer to “Mental Health and Treatment of Probation” by Paula M. Ditton, U.S. Department of Justice, Bureau of Justice Statistics, July 1999, NCJ 174463, p. 4.)

Although based on BJA’s crime categories, the current study expanded the definition of violence to include arson and weapon offenses and other minor face-to-face crimes such as menacing moderately expanded to include a larger range of violent offenses. Even this definition is not identical to the definition of violence by New York State’s Penal Law but the reader is invited to categorize violent and non-violent crimes in the manner most relevant to his/her purposes.

The offenses were categorized as either violent or non-violent. See table 41. We also identified the offenses accorded to severity (felony/ misdemeanor/violation of probation). Over one-half (842 or 55%) of offenders committed a felony. See tables 42 and 43.

**Table 41.**

**Categories of Offenses and Violent Crime**

		violent crime		Total
		violent	non-violent	
categories of offenses	DWI (includes BWI)		297	297
	motor vehicle (not including deaths/injuries)		96	96
	sex offenses (not prostitution)	76		76
	crimes against another person (asslt., menacing, harassment)	154		154
	theft (not robbery or burglary)		180	180
	burglary and criminal trespass		112	112
	robbery	85		85
	drugs (sale, possession, includes paraphenalia)		176	176
	forgery (includes poss. of instruments, fraudulent acts)		39	39
	false reports (includes impersonation)		10	10
	weapons (sales, possession)	16		16
	disorderly conduct (inc. loitering, prostitution)		29	29
	arson	16		16
	murder	15		15
	conspiracy, contempt		120	120
	endangering wel. of child		7	7
	criminal failures (pay, report, register, resisting arrest)		16	16
	reckless endangerment		17	17
	motor vehicle deaths/assaults	2		2
	CRIM. NEG. HOMICIDE/MANSLAUG HTER	8		8
other		26	26	
Total		372	1125	1497

**Table 42.**

**Categories of Offenses and Felony/Misdemeanor/Violation Status**

Count		FELONY/MISDEM		
		FELONY	MISDEMEANOR	VIOLATION
categories of offenses	DWI (includes BWI)	123	129	2
	motor vehicle (not including deaths/injuries)	40	44	
	sex offenses (not prostitution)	57	9	
	crimes against another person (asslt., menacing, harassment)	72	55	11
	theft (not robbery or burglary)	98	55	
	burglary and criminal trespass	101	4	2
	robbery	78	1	
	drugs (sale, possession, includes paraphenalia)	107	44	2
	forgery (includes poss. of instruments, fraudulent acts)	32	3	
	false reports (includes impersonation)		7	
	weapons (sales, possession)	11	4	
	disorderly conduct (inc. loitering, prostitution)	2	15	10
	arson	15	1	
	murder	15		
	conspiracy, contempt	64	45	
	endangering wel. of child		7	
	criminal failures (pay, report, register, resisting arrest)	3	10	
	reckless endangerment	11	4	
	motor vehicle deaths/assaults	2		
	CRIM. NEG. HOMICIDE/MANSLAUGHTER	8		
other	3	9	12	
<b>Total</b>		<b>842</b>	<b>446</b>	<b>39</b>

**Table 43.**

**Violent Crime and Felony/Misdemeanor/Violation Status**

			FELONY/MISDEM				Total
			FELONY	MISDEMEANOR	VIOLATION	UNKNOWN STATUS	
violent crime	violent	Count	258	70	11		339
		% within violent crime	76.1%	20.6%	3.2%		100.0%
non-violent	Count	584	376	28	3	991	
	% within violent crime	58.9%	37.9%	2.8%	.3%	100.0%	
Total	Count	842	446	39	3	1330	
	% within violent crime	63.3%	33.5%	2.9%	.2%	100.0%	

Offenders with diagnoses of schizophrenia (29.5%) and ADD (27.3%) were more likely to commit violent crimes than offenders with other diagnoses. See table 44.

**Table 44.**

**Primary Diagnosis and Violent Offense**

			violent crime		Total
			violent	non-violent	
primary diagnosis	schizophrenia	Count	33	79	112
		% within primary diagnosis	29.5%	70.5%	100.0%
	depression	Count	121	411	532
		% within primary diagnosis	22.7%	77.3%	100.0%
	bipolar	Count	18	112	130
		% within primary diagnosis	13.8%	86.2%	100.0%
	anxiety disorder (includes panic dis.)	Count	13	56	69
		% within primary diagnosis	18.8%	81.2%	100.0%
	ADD	Count	12	32	44
		% within primary diagnosis	27.3%	72.7%	100.0%
	PTSD	Count	4	17	21
		% within primary diagnosis	19.0%	81.0%	100.0%
	OCD	Count		5	5
		% within primary diagnosis		100.0%	100.0%
	no dx indicated	Count	171	413	584
		% within primary diagnosis	29.3%	70.7%	100.0%
Total		Count	372	1125	1497
		% within primary diagnosis	24.8%	75.2%	100.0%

Substance abuse use did not appear to make any difference in whether or not a violent crime was committed. See table 45.

**Table 45.**

**Violent Crime and Substance Abuse**

			violent crime		Total
			violent	non-violent	
substance abuse	yes	Count	218	752	970
	substance abuse	% within substance abuse	22.5%	77.5%	100.0%
	no known	Count	154	373	527
	substance abuse	% within substance abuse	29.2%	70.8%	100.0%
Total		Count	372	1125	1497
		% within substance abuse	24.8%	75.2%	100.0%

## 2. Overview of Special Populations within Sample

The characteristics of three special populations (individuals with psychotic disorders, depression, and bipolar disorder) that comprised 53.7% of the sample are summarized in the tables below.

### A. Psychotic Disorders

(Schizophrenia = 115, Psychotic Disorder NOS = 25)

N = 140

V. Number with a History of Treatment for Mental Illness	Number Known to Have Been Prescribed Psychotropic Medications	Number Charged with Violent or Non-Violent Crimes		Number with Histories of Substance Abuse
		Violent	Non-Viol.	
128 = 90%	119 = 83.8%	33 = 29.5%	79 = 70.5%	102 = 71.8%

### B. Bipolar Disorder

N = 134

Number with a History of Treatment for Mental Illness	Number Known to Have Been Prescribed Psychotropic Medications	Number Charged with Violent or Non-Violent Crimes		Number with Histories of Substance Abuse
		Violent	Non-Viol.	
108 = 80.6%	99 = 73.9%	18 = 13.8%	112 = 83.6%	99 = 73.9%

### C. Depression

N = 548

Number with a History of Treatment for Mental Illness	Number Known to Have Been Prescribed Psychotropic Medications	Number Charged with Violent or Non-Violent Crimes		Number with Histories of Substance Abuse
		Violent	Non-Viol.	
404 = 73.7%	306 = 55.8%	121 = 22.7%	411 = 75%	420 = 76.6%

**D. Violent Offenders**  
**N = 372 = 25% of Sample**

<b>Number with a History of Treatment for Mental Illness</b>	<b>Number Known to Have Been Prescribed Psychotropic Medications</b>	<b>Number with Histories of Substance Abuse</b>
261 = <b>70.2%</b>	156 = <b>41.9%</b>	154 = <b>41.4%</b>

**Diagnostic Categories of Violent Offenders**

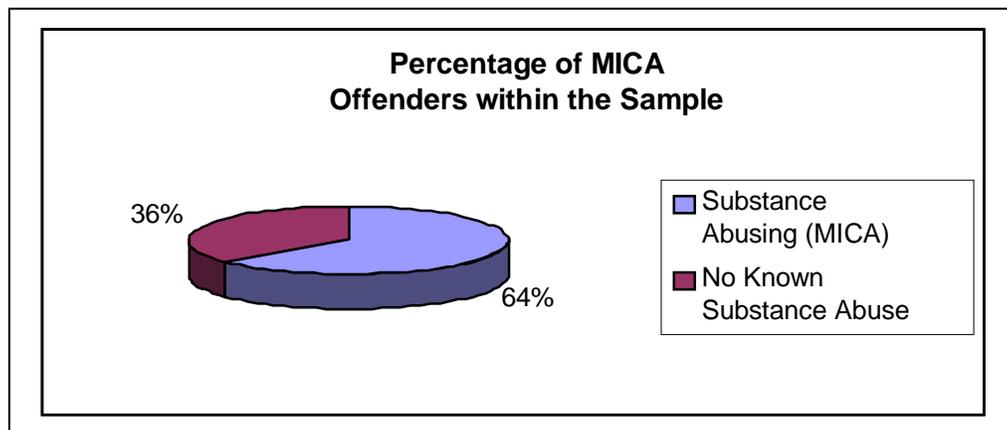
<b>Diagnostic Category</b>	<b>Number of Cases</b>	<b>Percent of Violent Crimes</b>
<b>Adjustment Disorder</b>	14	3.8%
<b>Anxiety Disorder</b>	17	4.6%
<b>ADD</b>	12	3.2%
<b>Dissociative Disorder</b>	1	0.3%
<b>Eating Disorder</b>	1	0.3%
<b>Impulse Control Disorder</b>	7	1.9%
<b>Mood Disorders</b>	139	37.4%
<b>Personality Disorders</b>	9	2.4%
<b>Psychotic Disorders</b>	47	12.6%
<b>Disorders of Sexual Behavior</b>	20	5.4%
<b>Conduct Disorder</b>	1	0.3%
<b>Past Treatment is Only Indicator</b>	65	17.4%
<b>Past Hospitalization is Only Ind.</b>	19	5.1%
<b>Medications are Only Indicator</b>	4	1.1%
<b>Behavior is Only Indicator</b>	7	1.9%
<b>Suicide attempts/idea. Only Ind.</b>	7	9.9%
<b>Other Indicators</b>	2	0.5%

Twenty-five percent of the mentally ill offenders were identified as having committed a violent offense. Over one-third (36%) were undiagnosed based upon other indicators (past treatment, medication only, behavior only, suicide attempt only). Offenders with mood disorders committed the highest number of violent offenses (139). However, as noted earlier in Table 35, offenders with diagnoses of schizophrenia and ADD had a slightly higher rate of committing violent crime than those in other diagnostic groups.

## E. MICA/CAMI Population

The terms "mental illness and chemical abuse" (MICA) or "chemical abuse and mental illness" (CAMI) have been used to describe the population of mentally ill who have co-occurring disorders. The term "co-occurring disorders" does not connote a single problem with a simple solution. People with co-occurring disorders are a heterogeneous group with multiple medical and social problems. Many individuals with co-occurring mental health disorders are in jails and prisons, where they may receive treatment that is inappropriate, if they receive any treatment at all (NASMHPD, 1998)<sup>1</sup>.

According to National Association of State Mental Health Program Directors (NASMHPD), the substance abuse and mental health communities must be clear in the terms and definitions used to identify the population of individuals with co-occurring disorders. Phrases such as "dual diagnosis", "co-occurring disorders", "mental illness and chemical abuse (MICA)", "dual disorders", and "co-morbidity" are apparently intended to describe the same clinical phenomenon. They can lead to confusion between the fields of mental health and substance abuse (NASMHPD, 1998)<sup>2</sup>.



### Prevalence of Substance Abuse within the Sample

Almost two thirds (64%) of the mentally ill offenders, in our sample, were identified as substance abusing. Offenders in jail (83.8%) and on parole (82.9%) had a higher rate of substance abuse than offenders on probation. Those in the ROR group could not be

<sup>1</sup> National Association of State Mental Health Program Directors (NASMHPD), National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders, June, 1998 Washington, DC.

<sup>2</sup> National Association of State Mental Health Program Directors (NASMHPD), National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders, June, 1998 Washington, DC.

identified according to use of substances due to the limited time and information available at ROR.

### **Type of Substances Used**

Alcohol was identified as the most used substance among the sample (48.7%). Those in the jail were the most likely to be identified (65.6%) as abusing alcohol. Cocaine use was high among the parolees (62.4%). Not many offenders were identified as abusing marijuana (24.3%) or heroin (7%).

### **Who are the MICA Offenders?**

While 64% of all mentally ill offenders used substances, a higher percentage of those with depression (76.6%) bipolar disorder (73.9%) and schizophrenia (73%) were more likely to be identified as substance abusers. Males and females did not differ use of substances.

Offenders with schizophrenia (63.5%), bipolar disorder (63.4%) and depression (58%) were most likely to abuse alcohol. Marijuana use was higher for those with ADD (42.6%) and depression (31.1%) than the rest of the sample group (24%).

Over one quarter (28.9%) of the offenders used cocaine. Those with schizophrenia (41.7%) were the more likely to use cocaine. Heroin use was low and did not appear to differ among the diagnostic groups.

## **F. Multiple Admissions to the Mental Observation Unit at the Jail**

### **a. 1991-4/27/99 Census**

- ❑ **Between 1991 and April 27, 1999 there were 10,168 admissions to the jail mental observation unit in Suffolk County.**
- ❑ The total numbers of **admissions** to the Mental Observation Unit in 1998 was 1,320 *(an individual may have been admitted more than one time during the year).*
- ❑ The total number of **individuals** admitted to the Mental Observation Unit in 1998 was 1,052 *(the individual is only accounted for one time, regardless of how many admissions to the Mental Observation Unit in 1998).*

### **MULTIPLE ADMISSIONS:**

- ❑ 77 offenders were admitted to the mental observation unit one or more times in 1998.
- ❑ 372 offenders admitted to the mental observation unit in 1998 had at least one other prior admission in another year *(1991-1998).*
- ❑ 128 offenders with an admission to the mental observation unit in 1998 had 4 or more admissions between the years 1991-1998, 92 of these offenders had 5 or more admissions.
- ❑ 21 offenders seen for the first time in the mental observation unit in 1998 had at least one other admission in 1999.

## A Profile of Selected Offenders in the Jail Mental Observation Unit

This section contains data on 10 defendants randomly selected who had five or more jail admissions (incarcerations) during the years 1991-1998. All of the defendants profiled in this section were seen in the mental observation unit during each of the incarcerations. All of the 10 defendants profiled were admitted to Riverhead Jail in 1998 and have 5 or more prior admissions (incarcerations) and were also seen in the mental observation unit in 1998. The legal history for these defendants is limited to involvement in the Suffolk County Criminal Justice system. *\*\*This profile includes jail admissions only if seen in the mental observation unit while incarcerated, however the defendant profiled may have additional incarcerations (jail admissions) not listed here since this profile pertains only to incarcerations and evidence of mental illness. Information on criminal justice system involvement outside Suffolk County is not included in this report These 10 defendants are not in our original sample group (n=1541), subjects in our sample were selected from cases in 1999 and diagnosis for these individuals was not included on the list provided by prison officials.*

Case #1

A is a 42 year old female with 20 prior incarcerations (jail admissions). All of the crimes she committed are non-violent offenses.

<b>Date of admission</b>	<b>Age</b>	<b>Offense</b>	<b>Type of charge</b>	<b>Bail Sentence</b>
<b>1992</b>	35	Prostitution	EX	\$150
	35	Unauthorized use of a motor vehicle	EX	\$150
	35	UUMV	EX	\$1000
	35	Prostitution	EX	\$50
	35	VFCA	EXCIV	\$1000
	35	Burg 2 <sup>nd</sup>	EX	\$10,000
	35	Prostitution	EX	\$250
	<b>1993</b>	36	Loit/f/prostitution	Misdemeanor
36		Prostitution	Misdemeanor	\$250
36		Prostitution	Misdemeanor	\$250
36		Prostitution	Misdemeanor	\$500
<b>1994</b>	37	Loit/f/prostituiton	Misdemenor	\$100
	37	Prostitution	Misdemeanor	\$250
<b>1996</b>	39	Loit prostitution	T	45 days
	39	Prostitution	Misdemeanor	\$50
<b>1997</b>	40	Loitering 1	Misdemeanor	\$250
	40	UUMV 3	Misdemeanor	\$1000
	40	Prostitution	Misdemeanor	\$100
<b>1998</b>	40	Prostitution	Misdemeanor	\$250
	40	CPCS 7	Misdemeanor	\$1000

Case # 2

B is a 26 year old male with 5 prior incarcerations. These five incarcerations ( jail admissions) resulted from property and drug related offenses.

<b>Date of admission</b>	<b>Age</b>	<b>Offense</b>	<b>Type of charge</b>	<b>Bail sentence</b>
<b>1992</b>	19	Criminal Possession Controlled Substance	EX	\$500
<b>1993</b>	20	Petit Larceny	AMT	60 days
<b>1995</b>	22	Burglary 3	Felony	\$1,000
		Criminal Possession Stolen Property 4	Felony	\$1,000
<b>1998</b>	24	Criminal Possession of Controlled Substance 3	Felony	\$10,000

Case # 3

C is a 33 year old female with 8 prior incarcerations (jail admissions). Her charges consist of public disorder and property offenses and drug related offenses.

<b>Date of admission</b>	<b>Age</b>	<b>Offense</b>	<b>Type of charge</b>	<b>Bail Sentence</b>
<b>1991</b>	25	Prostitution	EX	\$100
<b>1992</b>	26	Violation of probation	WARR	NB
	26	Violation of probation	GJ	\$500
<b>1994</b>	28	Loitering F/Prostitution	Misdemeanor	\$100
<b>1997</b>	31	Prostitution	Misdemeanor	\$50
	31	Petit Larceny	Misdemeanor	\$1000
<b>1998</b>	32	Resisting Arrest	Misdemeanor	\$200
	32	Criminal Possession of a controlled substance 3	Felony	\$50,000

Case # 4

D is a 33 year old male with 7 prior incarcerations. D committed a variety offenses both violent and non - violent. The nature of the offenses were property, public disorder and violent.

<b>Date of admission</b>	<b>Age</b>	<b>Offense</b>	<b>Type of charge</b>	<b>Bail Sentence</b>
<b>1991</b>	24	Conspiracy 2	Ex	\$2500
<b>1992</b>	25	Petit Larceny	Ex	\$100
	26	Agg. Harassment	Misdemeanor	\$100
<b>1993</b>	26	Kidnapping 2	Felony	\$2500
<b>1996</b>	29	Violation of Parole	Par	N/A
<b>1997</b>	30	Violation of Parole	Par	N/A
<b>1998</b>	31	Violation of Parole	Par	N/A

Case # 5

E is a 42 year old female with 6 prior incarcerations over a two year period. All but one of the jail admissions were due to drug related charges.

<b>Date of admission</b>	<b>Age</b>	<b>Offense</b>	<b>Type of charge</b>	<b>Bail Sentence</b>
<b>1997</b>	40	Criminal Sale of a Controlled Substance 3	Felony	\$3,500
	40	Prostitution	Misdemeanor	\$250
	40	Criminal Sale of a Controlled Substance 3	Felony	\$1,000
<b>1998</b>	41	Criminal Sale of a Controlled Substance 3	Felony	NB
	41	Criminal Sale of a Controlled Substance 3	Felony	NB
	41	Criminal Sale of a Controlled Substance 3	T	365 days

Case #6

F is a 33 year old female with 12 prior incarcerations over a two year period. All of the charges are drug related and public disorder offenses.

<b>Date of admission</b>	<b>Age</b>	<b>Offense</b>	<b>Type of charge</b>	<b>Bail sentence</b>
<b>1997</b>	29	Criminal Possession of a Controlled Substance 7	Misdemeanor	\$75
	29	Criminal Possession of a Controlled Substance 7	Misdemeanor	\$150
	29	Prostitution	Misdemeanor	\$175
	29	Criminal Possession of a Controlled Substance 7	Misdemeanor	\$1,000
	29	Prostitution	Misdemeanor	\$50
	29	Criminal Sale of a Controlled Substance 3	Felony	\$1,000
	29	Prostitution	Misdemeanor	\$250
<b>1998</b>	30	Criminal Sale of a Controlled Substance 3	Felony	No bail
	30	Prostitution	Misdemeanor	\$500
	30	Criminal Sale of a Controlled Substance 3	Felony	\$25,000
	30	Criminal Sale of a Controlled Substance 3	Felony	No bail
	30	Criminal Sale of a Controlled Substance 3	Felony	No bail

Case # 7

G is a 32 year old male with 21 prior incarcerations over a 7 year period. Almost all of his incarcerations resulted from committing property offenses.

<b>Date of admission</b>	<b>Age</b>	<b>Offense</b>	<b>Type of charge</b>	<b>Bail Sentence</b>
<b>1991</b>	24	Pettit Larceny	Ex	\$25
<b>1992</b>	25	Petit Larceny	Ex	\$500
		Agg. Unlicensed Operation of a motor vehicle	T	\$500/60 DAYS
<b>1994</b>	27	Assault 3	Misdemeanor	\$50
		Petit Larceny	Misdemeanor	\$1000
<b>1995</b>	28	Petit Larceny	Misdemeanor	\$250
		Petit Larceny	Misdemeanor	\$100
		Petit Larceny	Misdemeanor	\$125
		Petit Larceny	Misdemeanor	\$250
		Pettit Larceny	Misdemeanor	\$100
		Petit Larceny	Misdemeanor	\$125
		Petit Larceny	Misdemeanor	\$250
		Petit Larceny	Misdemeanor	\$250
<b>1996</b>	29	Petit Larceny	Misdemeanor	\$1,000
		Petit Larceny	Misdemeanor	\$100
		Petit Larceny	Misdemeanor	\$250
		Petit Larceny	Misdemeanor	\$750
<b>1997</b>	30	Agg. Unlicensed operation of a motor vehicle	T	180 DAYS
		Petit Larceny	Misdemeanor	\$1,000
		Grand Larceny 4	Felony	\$10,000
<b>1998</b>	31	Petit Larceny	Misdemeanor	\$1,000
		Petit Larceny	Misdemeanor	\$250

Case #8

H is a 37 year old male with 6 prior incarcerations. Almost all of his incarcerations were due to violent offenses.

<b>Date of admission</b>	<b>Age</b>	<b>Offense</b>	<b>Type of charge</b>	<b>Bail Sentence</b>
<b>1993</b>	31	Burglary 2	Felony	\$5,000
<b>1994</b>	32	Unauthorized Use of a Motor Vehicle 3	Misdemeanor	\$1,000
<b>1996</b>	34	Violation of Parole	Par	N/A
<b>1997</b>	35	Assault 2	Felony	\$5,000
<b>1998</b>	36	Criminal Possession of a weapon Assault 3	Misdemeanor T	\$150 180 days

Case #9

I is a 31 year old male with 5 prior incarcerations in one year.

<b>Date of admission</b>	<b>Age</b>	<b>Offense</b>	<b>Type of charge</b>	<b>Bail Sentence</b>
<b>1998</b>	30	Criminal Possession Stolen Property 4	Felony	\$5,000
	30	Loitering 1	Felony	\$25,000
	30	Criminal Contempt 1	Felony	NB
	30	Criminal Possession of a Weapon 3	Writ	NB
	30	Criminal Possession of a Weapon 3	Writ	NB

Case # 10

J is a 41 year old female with 5 prior incarcerations.

<b>Date of admission</b>	<b>Age</b>	<b>Offense</b>	<b>Type of charge</b>	<b>Bail Sentence</b>
<b>1992</b>	34	Petit Larceny	Ex	\$100
1993	35	Loitering 1	Misdemeanor	\$500
	35	Criminal Possession of a Controlled Substance 7	Misdemeanor	\$200
1997	39	Criminal Possession of a Controlled Substance 7	Misdemeanor	\$100
1998	40	Robbery 2	Felony	NB

## **VI. STRENGTHS AND WEAKNESSES OF THE CURRENT CRIMINAL JUSTICE AND MENTAL HEALTH SYSTEMS**

***Handling the mentally ill is perhaps the single most difficult type of call for law enforcement officers. Today these encounters are becoming more frequent... Regardless of disposition, police officers usually found themselves saddled with sole responsibility for suspected mentally ill persons whose public behavior warranted some form of social intervention.***

***-- Peter E. Finn and Monique Sullivan  
National Institute of Justice***

***There are now far more mentally ill in the nation's jails and prisons (200,000) than in the state hospitals (61,700). With 3,000 mentally ill inmates, Rikers Island in New York has, in effect, become the state's largest psychiatric facility.***

***-- Michael Winerip***

***Being in jail or prison when your brain is working normally is, at best, an unpleasant experience. Being in jail or prison when your brain is playing tricks on you is often brutal.***

***-- E. Fuller Torrey***

The New York State Office of Mental Health estimated in 1995 there were 60,959 individuals with serious and persistent mental illnesses in New York State. In Suffolk County there were 9,164 such persons (OMH, 1998 and 1999).

Current estimates indicate that 4,707 individuals with a serious mental illness will have been incarcerated, detained, or supervised by Probation, Parole, Jail or Pretrial Services in Suffolk County in 1999. This estimate has been made based on the research sample, after controlling for multiple admissions and multi-agency duplication and indicates that 9.5% of individuals in contact with the criminal justice system are seriously mentally ill.

On an annual basis, 10.4% of the probation population, 7.7% of the pretrial population, 7.1% of parolees and 16% of the jail population are seriously mentally ill based on the current sample.

All of these individuals came into the criminal justice system after an encounter with the police. The data provided by the Suffolk County Police Department indicates that police officers are being called upon with steadily increasing frequency to deal with emotionally disturbed persons and suicides (see figures 1 through 5). These numbers represent one aspect of the aftermath of deinstitutionalization on Suffolk County. Because many mentally ill individuals are not receiving consistent adequate treatment for a variety of reasons, the law enforcement and criminal justice systems have, by default, become care providers.

The three most frequently cited reasons for the increasing numbers of offenders with mental illnesses in the criminal justice system are an insufficiency of appropriate community mental health services, failure of individuals to comply with treatment (i.e., take prescribed medications), and substance abuse.

The issue of insufficient community mental health services has been an ever-present problem since the advent of deinstitutionalization some thirty years ago, and has been well-documented (see, for example, Torrey, 1997 and Issac & Armat, 1990). This

problem has received widespread attention in both the mental health literature and in the media.

Failure to consistently take prescribed psychotropic medications and the impact of substance abuse on the symptoms of serious mental illnesses have also been cited with increasing frequency in recent years as reasons why many mentally ill individuals enter the criminal justice system and why some of them become violent (Torrey, 1997; Link et al, 1992; Swanson et al, 1990).

It was not within the scope of this study to investigate the present system of public and private mental health care in Suffolk County in order to comment on its strengths and weaknesses. The study was conducted within the criminal justice system in the area where there is overlap between the two systems of criminal justice and mental health and where there should exist strong linkages. The data suggests that existing linkages may be limited.

The fact that 66.8% of subjects were receiving care for their mental illnesses while in the criminal justice system and that 47.4% of them were known to have been prescribed psychotropic medications (see tables 12 and 13) was a positive finding, indicating that these individuals had access to treatment. Indeed, actual diagnoses were known for 70.2% of the subjects, indicating that there was communication between the criminal justice and mental health systems in order for criminal justice personnel to be aware of exact diagnoses. However, the fact that these subjects entered into the criminal justice system suggests weaknesses within the mental health system that need to be investigated further. This is not to imply any deficiency in the quality of services rendered; rather, it raises questions regarding the ease of accessibility, continuity of care, and support for treatment compliance. The fact that for 28% of subjects no diagnoses were known and the only indicators of mental illness were histories of past hospitalizations or treatment strongly suggests problems with accessibility, continuity of care, and treatment compliance.

The frequency of substance abuse was found to be high across all diagnostic and offense categories in the present study (overall rate = 64%), which raises questions regarding the availability of specialized MICA treatment. Within the larger population of mentally ill individuals known to be receiving mental health care in Suffolk County the frequency of substance abuse has been steadily increasing. In 1991 13.4% of individuals receiving treatment for mental illnesses were identified as MICA clients. In 1993 this figure increased to 16.4%; and it increased again in 1995 to 19.6% (OMH, 1999). These numbers indicate that substance abuse by mentally ill individuals is increasing. If the rate of increase (approximately 3% every two years) seen between 1991 and 1995 (the last year for which OMH had available statistics) continued from 1995 to the present, it could be estimated that approximately 25% of individuals receiving services in the mental health system in Suffolk County today have problems with substance abuse. This frequency is much lower than the rate found in the population within the criminal justice system, which suggests a possible relationship between the abuse of substances and criminal activity. It also raises questions regarding the availability of specialized MICA treatment programs for this population. Even for those individuals who are receiving mental health care and who have not come into contact with the criminal justice system, the steady increase in substance abuse suggests a need for greater access to MICA treatment. This problem may have been further complicated in the past by the fact that substance abuse treatment and mental health treatment have traditionally been rendered by two completely separate systems of care.

In 1991 a task force convened by the New York State Office of Mental Health investigated the growing problem of mentally ill individuals entering into the criminal justice system throughout the state. Rock and Landsberg (1998, pg. 328) summarized the findings of the task force as follows:

1. Forensic clients throughout the criminal justice system are seriously underserved in terms of mental health services.
2. Even where some mental health services are provided, the range of necessary services is limited.
3. The planning process for this population is inadequate and fails to integrate the needs of both the criminal justice and mental health systems.
4. There is limited to no coordination between mental health and criminal justice staff. Responsibilities and communications between the two systems are often unclear.
5. There is a lack of family participation and input into planning for services and discharge options.

In 1995, Rock and Landsberg undertook a survey of local mental health care directors throughout the state to assess the impact of recommendations the task force had made in 1991. They found that, in general, there was a heightened awareness of the needs of this unique population, but there also existed a lack of resources to follow through with specialized services. They noted that this was especially true for forensic MICA clients and sex offenders.

While gathering data for the present study, some evidence of formal linkages between the two systems of mental health and criminal justice were noted. The focus of this research was to investigate the size and characteristics of mentally ill individuals within the criminal justice system in Suffolk County and not to assess the quality and quantity of communications between the two systems per se. The data nevertheless suggested that communications between the two systems was somewhat informal. Indeed, many of the comments written by probation and parole officers indicated that they were functioning as advocates for their clients in recognizing the symptoms of mental illnesses and attempting to obtain treatment services for them. The apparent lack of formalized communications and responsibilities between the two systems undoubtedly makes their work harder to perform. The problem of probation and parole officers having to navigate between two systems that have no incentives to cooperate with each other has been recognized nationwide (see, for example, Davidson, 1996; Steadman, et al, 1994 and 1995; Finn and Sullivan, 1988). The fact that probation and parole officers are so willing to extend themselves in service to their clients and to the community at large is a clear strength in Suffolk County that can be increased with more formalized relationships between mental health service providers and the criminal justice system. The significantly high rate of substance abuse suggests a lack of specialized MICA services and/or problems with accessibility and support for treatment compliance. The problem is further exacerbated by the fact that substance abuse treatment is an entity separate from mental health treatment, making it yet another system through which criminal justice personnel have to navigate in order to obtain needed services for their clients.

The large number of mentally ill offenders, the fact that 28% of them do not appear to be receiving consistent mental health care, and the fact that 64% of them have

histories of substance abuse suggests additional demands on and weaknesses in the treatment systems that need to be addressed. Some of these weaknesses may be due to the lack of formalized communication and structures of responsibilities between systems that interfere with consistency of care or that enable individuals to remain outside of treatment. A jail diversion program can function to close the existing gaps between these systems, facilitate communication between them, and ensure that each is appropriately responsible to the other and to the needs of the mentally ill individuals who fall into the criminal justice system.

## VII. PROGRAM IMPLEMENTATION CONSIDERATIONS

*We have too many high-sounding words,  
And too few actions that correspond with them.*

Abigail Adams (1744-1818)

### 1. An Overview of Exemplary Models

Over the past twenty years, various jurisdictions throughout the United States have developed programs to deal with mentally ill persons who have become involved with the criminal justice system. With the closure of many of the nation's institutions housing the mentally ill, many of the persons who would formerly have been "committed" through the actions of the mental health community are now being handled as defendants by the criminal justice community. There are two main reasons why the criminal justice community has been seeking alternative methods for dealing with this population. The first reason is a financial one: the costs of dealing with the mentally ill population have skyrocketed along with the space they are occupying in the nation's jails. The second reason is humane: there is an increasing perception that the mentally ill who commit crimes should not be given the same treatment as the general criminal population.

At the same time that criminally involved mentally ill offenders have become an increasing problem, the number of offenders who are drug involved has continued to increase. There are many programs throughout the country which treat drug abusers who enter the criminal justice system. However, many of these programs are closed to drug-involved offenders who also suffer from mental illness. Certainly not all mentally ill offenders are drug involved. However, a significant number of mentally ill offenders are also chemically addicted giving us a large MICA (Mentally Ill Chemically Addicted) population. This is probably not surprising given that many of the mentally ill have fallen through the cracks and are not receiving necessary psychiatric and psychological treatment within the community. Instead, this population becomes involved in self-medication; they use alcohol and drugs to alleviate symptoms of depression, anxiety, and confusion. The programs described hereafter generally treat both the mentally ill offender who is drug-involved and the offender who is not. When mentally ill offenders are mentioned hereafter, it should be presumed that both groups are included.

The programs which have been developed fall into several different major types. Generally speaking, they can be classified as **pre-booking diversion programs**, **post-booking diversion programs**, and programs providing specialized services for the **mentally ill** within the probation and jail population. Several of the more interesting of these programs will be discussed.

In the first category, **pre-booking diversion**, the thrust is to avoid arresting the mentally ill. In **Memphis, Tennessee**, a program has been developed through a

partnership between the police department and the local chapter of the Alliance for the Mentally Ill (AMI). Officers from each precinct volunteer for the Crisis Intervention Team. They receive 40 hours of training from AMI in dealing with the mentally ill. The CIT officers provide 24-hour, seven-day-a-week coverage in every precinct. They respond to all crisis calls involving a mentally ill person. Police may bring persons requiring immediate attention to a Psychological Emergency Services hospital where all potential patients are accepted from the police without restriction if they meet the minimum criteria. Police are guaranteed that this will be accomplished within 15 minutes. Persons with less severe needs can be placed in residential or respite care, or released to case managers or other responsible persons.

Police in **Hillsboro County, Florida** use a similar scheme in which “emotionally disturbed persons” are brought to a center (which includes a secure ward) designed specifically for the mentally ill instead of to the County jail. There, police are guaranteed that they will not spend more than 20 minutes in arranging for the placement of these offenders in the facility. Police in Montgomery County, Pennsylvania do not have a specialized group of police officers who deal with “emotionally disturbed person” calls. However, police officers in that jurisdiction carry a “cop card” with instructions on how to deal with the mentally ill.

**These measures are obviously not intended to deal with very serious or violent offenders. However, for misdemeanor offenders and “nuisance-type” offenders, these methods divert persons whose anti-social behavior is driven not by criminal tendencies, but by mental illness.**

In many cases, of course, an arrest by the police officer is indicated. It is at that point that post-booking diversion programs are being employed in many jurisdictions. Some of these programs rely on diversion which takes place within the arraignment court. **Model programs in Hartford, Bridgeport, New Haven, and Norwich/New London Counties in Connecticut rely on mental health staff operating within the court of first appearance.** The diversion staff receives a daily list from the Bail Commissioner’s Office of persons appearing for arraignment. They cross-reference this against their own client database and also take referrals from court personnel who recommend that a defendant be screened for their program. For appropriate defendants, a diversion plan is developed in lieu of the traditional arraignment procedure.

Other jurisdictions screen for the mentally ill from those who have been sent to jail following arraignment. In **Fairfax County, Virginia**, Pretrial Services staff do an initial screening before the arraignment judge on those defendants who can’t make bond. Within three working days after the arraignment, PTS staff interviews the defendant and makes an appropriate alternative recommendation to the judge allowing the defendant to be released from jail.

In **Honolulu, Hawaii**, arrestees are interviewed by the Oahu Intake Service Center at 3 a.m. Those who are determined to show signs of mental illness are transported to the district courthouse at 6 a.m. They are seen there by a Diversion Case Coordinator who will then make a recommendation to the judge regarding a diversion program if this is deemed appropriate.

In **Maricopa and Pima Counties of Arizona**, a forensic unit within the jail identifies appropriate clients for diversion. There is a multi-tiered approach to diversion within these counties. "Release from Jail with Conditions" allows a defendant to be released with special conditions related to the need for further evaluation and treatment. If the conditions are violated, the court is notified and the defendant is remanded back to the court. "Deferred Prosecution" involves an agreement between the Prosecutor's office and the Health Authority specifying treatment conditions. Time frames usually involve four to six months. In the case of a compliant offender, the charges are dropped; otherwise, prosecutors resume the case.

In **King County, Washington (Seattle)**, the Jail Alternative Service operates a program whose aim is to cut down on county costs in bed and jail days. The county assembles a list of persons with three incarcerations and three hospitalizations. Anyone in this category who is arrested can participate in Intensive Case Management, a program run by three persons with 10 cases each. This program provides a broad range of supervision. Managers go out on all crisis calls, with 24-hour per day coverage. Those potential clients who are slated to go to jail can trade jail days for time with this program. These clients attend a daily program with a very structured routine.

**In various jurisdictions, treatment programs have been developed which can deal with a mentally ill offender either through a pretrial procedure or as the result of an adjudication and sentence to probation.** One such program is the **Milwaukee, Wisconsin Community Support Program**. The program, run by a non-profit agency, operates out of a small clinic in a predominantly residential neighborhood. It employs nurses, a part-time psychiatrist, pharmacy staff, four case managers with caseloads of 60 each, a financial services staff, and a housing staff. At any given time, 250 persons are treated within the program. It administers medical and therapeutic services five days a week with a pharmacy on the premises to distribute medication. **Urine samples are taken to monitor possible drug use.** The center's money management program is the legal recipient for the client's social services and disability benefits. Fixed expenses are paid by the program. The remainder is distributed to the client as a daily allowance after the client has taken his/her medication. One element of the program is a **Day Reporting Center** open from Monday to Friday where program participants spend the day in treatment and therapy. The use of the Day Reporting Center is applied on a selective basis.

Programs have also been developed for the mentally ill who have been adjudicated and are currently on probation or otherwise sentenced to participate in a specialized treatment program. One example is a program in **Summit County, Ohio**. Here, specialized caseloads are formed for offenders on probation and parole. The probation officer serves as an intensive case manager working on relapse prevention. The program employs progressive sanctions in an attempt to avoid an “all or nothing” approach.

**In Maricopa County, Arizona (Phoenix), six specialized Mental Health Probation Officers each supervise 40 clients.** As part of the facilities available for treatment of the mentally ill, the Probation Department operates a Transitional Living Center which is a residential program for those requiring psychiatric intervention. Housed within the program at any given time are 25 seriously mentally ill probationers awaiting community placement. The program is housed in a church; the average stay is 60 days. A local non-profit agency runs the daily operations of this program which is seen as a bridge toward independent living for these probationers.

In addition to the community-based programs for sentenced defendants, **several jurisdictions have jail-based programs. These programs are operated for those defendants who have been sentenced to incarceration and who also have serious mental health problems.** In **Alabama**, one facility operates a 62-bed unit for the mentally ill within the jail. Inmates admitted to this facility receive 30 hours per week of treatment services for an average of 18 weeks. Aftercare plans are developed with some inmates going on to correctional substance abuse programs.

In **Delaware**, a **Chronic Care Program** operates a 25-bed unit within the correctional institution. The program was originally designed for inmates with mental retardation and mental illness, but specialized services for dually diagnosed persons were developed as greater numbers of substance abusers were admitted to the program.

**In New York City, the New York City Link program is operated at Rikers Island. Linkage planners meet potential clients while they are still at Rikers. For clients determined to be at need, a comprehensive discharge plan is developed. These clients are then transferred to the community-based Transition Management team prior to their release from confinement.** These counselors provide case management services and advocate for the client within the community. This program addresses a problem that has been widely perceived. This is the lack of smooth transition for an inmate with mental health issues being released from the jail. It often takes weeks for that inmate to be seen by the community mental health office and by drug treatment counselors. In the interim, inmates often stop taking the medication that had stabilized them within the jail setting.

In each of the programs cited above, a major factor was the desire to develop an alternative approach to the “in and out” (of the jail) policies that have developed since the deinstitutionalization of the mentally ill. While placement (although perhaps not sufficient placement) has been available for drug and alcohol offenders, very few facilities have been willing to accommodate the mentally ill or those with a dual diagnosis of mental illness and substance abuse. The programs mentioned above began with the intention of addressing this serious problem. As noted from the brief program descriptions, each of the programs has attempted to address the issue from a different angle. In fact, it seems likely that in a large jurisdiction, the issue of mentally ill and MICA offenders may need to be addressed at several different points with the criminal justice system. The programs cited provide some guide into different methods that Suffolk County might be able to adapt to its own needs.

## **2. Common Problems Encountered by Probation and Parole Officers in Dealing with Mentally Ill Offenders**

A survey of the methods by which probation and parole departments throughout the country have responded to managing the needs of mentally ill offenders (American Probation and Parole Association, 1995) indicates that these programs often encounter difficulty working with this unique population. The most frequently cited problems are:

- 1) inadequate quality and quantity of available mental health services;**
- 2) resistance on the part of individuals to receive treatment;**
- 3) reluctance on the part of providers to render treatment to a population perceived as undesirable;**
- 4) role conflict experienced by probation/parole officers who must simultaneously function in the roles of surveillance and advocacy.**

These difficulties flow from the inability of the mental health system to meet the needs of all of its target population and unreasonable expectations on the criminal justice system to compensate for this failure.

One advantage of jail diversion programs is the fact that they can mandate treatment, usually as a condition of probation or parole. However, mandating an individual to enter into treatment is ineffective if appropriate mental health services to address a person’s needs do not exist, or if that individual is resistant to participating in treatment. Under these conditions, jail diversion programs simply attempt to recycle individuals through a system that has already failed to effectively serve them. The problem is further exacerbated if there are waiting time delays, reluctance on the part of providers to accept a forensic client, delays due to an individual’s lack of benefits and inability to pay for services, or fragmented services that necessitate referrals to more than one provider in order to obtain all the kinds of treatment that an individual may need (such as substance abuse services and psychiatric care for MICA clients). Additionally, these kinds of problems are especially difficult for probation and parole officers, because they are

responsible for protecting the community against the kinds of behaviors that result from untreated mental illness while at the same time they are attempting to obtain treatment from a fragmented system. Thus, while the criminal justice system has the advantage of being able to mandate treatment, existing problems in the mental health system—often makes this advantage meaningless.

### Effective Jail Diversion

In order to work effectively, then, jail diversion programs need to function to bridge the two systems of criminal justice and mental health, and they need to be able to expeditiously link individuals to appropriate services and help individuals to engage and remain in treatment. Doing this successfully can help to ensure an individual's compliance with the requirements of probation/parole supervision and decrease the probability of future recidivism. To do so requires a program that works from the perspective of mental health in terms of its recognition of the needs of the mentally ill while it also appreciates the role and responsibilities of the criminal justice system. Such a program can then coordinate and enhance the functions of both systems in service to the needs of a very unique population.

The vision statement of the National Coalition for Mental and Substance Abuse Health Care in the Justice System advocates for community based programs for forensic clients that coordinate the work of multiple disciplines within the mental health and criminal justice systems. **Suffolk County has pioneered in developing the Correctional/Treatment model which is a multi-disciplinary approach that is currently used in the Day Reporting Center, DWI Jail Program, Drug Court, and Sex Offender Programs.** These programs are for people already deeply entrenched in the criminal justice system. Another component is needed that will effectively keep mentally ill people out of the justice system entirely.

Davidson (1996) advocates for a multisystem approach that fosters the collaboration of mental health and criminal justice through the use of intensive case management. In Davidson's model, case managers function as brokers and advocates between multiple systems (mental health, medical care, social services, criminal justice).

Solomon and Draine (1995) have pointed out that the difficulties associated in serving forensic clients involve fragmented services, lack of communication and coordination between systems, stigma, and mental health system values that sometimes tend to work against clients. These are the kinds of issues that a case management model can address. By linking a case manager and an individual early in the process of the individual's contact with the criminal justice system, there is an advocate who can function to coordinate care and communication within and between systems. A case manager can transition an individual from incarceration to supervised community release and expedite linkages with care providers to avoid delays, maintain contact with an individual to ensure that appointments are kept, and to ensure that basic living needs are provided.

A program that uses a case management approach can bridge the gap between the mental health and criminal justice systems and address the issues

identified by the National Coalition for Mental Health and Substance Abuse Health Care in the Justice System. Effective jail diversion can and should be undertaken by the mental health system as a specialized program that targets individuals it previously failed to serve. As a specialized program, it can function as a liaison between the two systems, and, with the support of mandated treatment by the criminal justice system, it can use interventions that are designed to engage clients who were previously resistant to entering treatment.

### Jail Diversion in an Era of Devolution and Managed Care

The notion of creating a new service within the public mental health system might seem moot in an era of devolution when the responsibility for social services is rapidly being passed down to local counties, a level of government that is least able to afford the provision of any new service. This may appear to be especially true with the advent of a managed care approach to the provision of public mental health services. However, because the counties will be taking on the responsibility for providing mental health services under managed care arrangements, they will be funding the care of mentally ill individuals whether they are in the mental health system or in the criminal justice system. The advent of managed care may, in fact, increase the cost of their care in the criminal justice system. Because mentally ill individuals who fall into the criminal justice system tend to have more complex treatment needs, and because they may be more resistant to treatment and difficult to serve, local providers may be reluctant to take them on due to the financial risk they pose. Thus, without specialized services, they are more likely to fall into a “revolving door” cycle between jail and the mental health system, all of which will be funded at county expense.

Morrissey (1996), in a discussion of the potential impact of managed mental health care on the criminal justice system makes the following points:

- 1. Cost shifting by public mental health providers will take the form of defining more cases as “bad” rather than “mad” and therefore increase the responsibility of police and the criminal justice system. This will lead to more detention of mentally ill offenders in jail; alternate secure treatment settings at the state or local level will become harder to access and subtle and not so subtle efforts will be made to further criminalize the mentally ill thereby transferring responsibility to the criminal justice system.**
- 2. Jails may become the only available secure setting for the short term management of disturbed and disturbing individuals, for the growing number of persons in crisis who are seen as inappropriate for local hospitals and residential treatment settings or unable to be served in units that are already at maximum utilization.**
- 3. There will be less receptivity by mental health providers operating under managed behavioral health care arrangements to agree to jail diversion, early release, or probation on condition of participation in community based mental health treatment, especially for cases that are seen as overly complex or costly.**

4. **It will become more difficult to arrange continuity of care with community agencies upon release for mentally ill/substance abusing offenders.**
5. **There will be growing pressures and conflicts between state departments of corrections and mental health over the care and treatment of mentally ill offenders within the prison system; each will try to shift (dump) responsibility and costs to the other.**
6. **Increasing responsibility for persons with disabling mental illnesses will strain the abilities of probation and parole officers to manage them. Officers might find it more difficult to link probationers and parolees to public mental health services, or these services, if available, will not be as intense or comprehensive as may be necessary. This will create pressures for more behavioral health training and management of probation and parole officers and more crisis management by law enforcement officers.**

The number of mentally ill individuals who fall into the criminal justice system in the future is more likely to increase, rather than decrease, under a managed care approach to the provision of public mental health services. Given this probability, carefully planned diversion programs operated within the mental health system that recognizes and meets the needs of mentally ill individuals who come into contact with the criminal justice system can be cost-effective alternatives. By meeting the needs of this population, moving them out of a revolving cycle between the two systems and successfully integrating them into the mental health system, such a program can ultimately reduce the cost of their care

### **3. Elements of a Successful, Cost-Effective Jail Diversion Program**

The ability to integrate mentally ill offenders into the mental health system will be key to their success. Most jail diversion programs and efforts by probation/parole departments to deal with the mentally ill focus on simply referring them over to the mental health system for services. They do not necessarily emphasize *integrating* them permanently into this system. *Integration* of an individual into the mental health system requires understanding and overcoming the obstacles that prevented the system from successfully serving them in the first place. Failure to do this merely recycles an individual through a system that has nothing to offer them with the likely result that they will ultimately return to the criminal justice system.

The National Coalition for Mental and Substance Abuse Health Care in the Justice System (Lurigio, 1996) has outlined what they view as a comprehensive vision of care for mentally ill individuals in the criminal justice system, the goals of such care, and what they see as the obstacles to achieving such comprehensive care are outlined below. The design of a program that meets these standards is then discussed.

### **Comprehensive Vision of Care**

- Lasting bridges between mental health and criminal justice system
- Client involvement in treatment decisions
- Ensure client and public safety
- Promote client responsibility and self-sufficiency
- Enable equal access to health care services
- Reduce stigmatization due to mental illness/criminal history
- Culturally competent care that is sensitive to needs of women and people of color
- Strong encouragement of family involvement
- Services specific to client needs
- Increased public awareness of mentally ill individuals in the criminal justice system

### **Goals of Comprehensive Care**

- Reduced rate of recidivism
- Cost savings attributable to reductions in incarceration
- Fewer self-reports of criminal behavior
- Fewer clients “falling through the cracks” between mental health and criminal justice system
- Fewer clients dropping out of treatment
- Reversal in the trend of incarcerating more people of color
- More reliable and accurate data on persons with mental illnesses in the criminal justice system
- Increased sharing of resource between mental health and criminal justice systems
- Diminished stigma associated with mental illness and drug abuse
- Great client satisfaction with services

### **Obstacles to Achieving Comprehensive Care**

- “Turfism” and disputes between and among mental health and criminal justice agencies
- Poor communication between systems due to different “languages” used by each system
- Lack of awareness of the significant cost of failing to treat mentally ill individuals who are in the criminal justice system
- No transitional programs for individuals released from jail or prison into the community
- Assessment and treatment techniques that are insensitive to the needs of women and people of color

The comprehensive vision of care outlined by the National Coalition of Mental and Substance Abuse Health Care in the Justice System is of a program that essentially transitions individuals out of the criminal justice system and integrates them into the mental health system. As the obstacles they identified indicate, simply referring individuals to the mental health system does not in and of itself facilitate an individual's integration into the system. Without an intervening program that understands the "languages" of both systems, and that understands and appreciates the unique needs of each individual, clients are not likely to be directed to appropriate services or to receive the advocacy and support they need to use the services. In addition to communication difficulties between systems, there exist differences in values and perspectives within each system that need to be understood and negotiated on behalf of clients. A program that works from a mental health recovery perspective and that utilizes an intensive case management approach can overcome the communication and values differences between and within systems. Intensive case managers can assess individuals' psychosocial needs, identify existing services to address these needs, advocate on behalf of clients to receive the services, and ensure strong linkages with appropriate services by functioning as a support to both clients and service providers. Additionally, case managers can help to ensure compliance with the conditions of probation/parole supervision by enabling clients to keep appointments and understand what is expected of them. Through regular frequent contact with clients in the community and 24 hour program accessibility arrangements, case managers can intervene early on in instances in which client may become symptomatic, begin abusing substances, or encounter stressors that may trigger a decline in their ability to function.

Intensive case management, however, is only one piece of a comprehensive program of care. **Mentally ill individuals in the criminal justice system need immediate availability of services, and they need housing.** Thus, in order to serve this population effectively, a comprehensive program would need to be able to offer transitional treatment in the interim before linkages to the mental health system are established. A transitional treatment component would enable an individual to be temporarily housed in a supervised facility while undergoing a complete psychiatric evaluation and psychosocial assessment and receiving stabilizing interventions. Short-term transitional treatment provides necessary time to assess individuals, identify needs, and link clients to appropriate services. It provides safe housing away from the criminal justice system until suitable residential care can be arranged and until the financial and medical benefits needed to enable clients to use community mental health services can be activated.

#### **4. Operation and Funding of Comprehensive Care**

Comprehensive care involves both the ability to follow and support clients in the community as well as transitional care in the interim period between the criminal justice system and integration into the mental health system. Such an endeavor might not appear viable as the responsibility for public mental health care devolves from the state down to the county level. However, it is important to keep

in mind that mentally ill individuals in the criminal justice system are ultimately served by the public mental health system. If they are served ineffectively, the cost of their care simply increases as they move back and forth between the criminal justice and mental health systems, both of which will be funded by the county. Thus, the county has a strong interest in developing an effective program that decreases the long-term costs of caring for this population and one that also decreases recidivism and increases public safety. A comprehensive program that utilizes intensive case management and transitional treatment can satisfy these requirements.

Through the use of continuous quality assurance techniques such a program can be both effective and viable in a managed care environment. Using continuous quality assurance techniques such a program can engage in ongoing monitoring and evaluation and generate data that will serve to increase knowledge and understanding of this special population. In addition, the county can help to ensure the availability of services to this population and reduce the amount of time it takes to integrate them into the existing system by requiring that all providers in contract with Special Needs Plans accept a requisite number of clients from this program and work cooperatively with the program's case managers. To help ensure the success of this arrangement, the program can reciprocate by offering training to service providers in how to meet the needs of forensic clients to service providers and by guaranteeing the ongoing support and cooperation of program case managers. Offering providers training and support will ultimately result in their increased comfort and competence in serving this population and enable case managers to transition and integrate clients into the community mental health system.

Developing a comprehensive care program for mentally ill individuals who enter the criminal justice system involves developing a specialized program that enables a cost-effective integration of this population into the existing system. Because the county will incur the expense of caring for the mentally ill regardless of which system they happen to be in at a particular time, there is, in essence, no new expense involved in offering a comprehensive care program. There is, however, an opportunity to decrease the long-term cost of their care by diverting them out of the cycle between systems, and an opportunity to increase the safety and quality of life for this population and the community at large.



## VIII. ANALYSIS

### How the Findings of the Present Study Compare with the Current Mental Health Literature Discourse on the Mentally Ill in the Criminal Justice System

The failures of the deinstitutionalization movement that transferred hundreds of thousands of mentally ill individuals into the community without adequate services have by now been well-documented (Torrey, 1997; Gaylin and Jennings, 1996; Blau, 1992; Issac and Armat, 1990). The inadequate availability of community mental health services and the ability of mentally ill individuals to reject services and remain untreated has been cited as a reason why many of them fall into the criminal justice system (Torrey, 1997; Gaylin and Jennings, 1996; Issac and Armat, 1990). Torrey (1997) points out that most of the severely mentally ill persons who are incarcerated have been charged with misdemeanors stemming from delusional thinking and bizarre behavior in public that are due to individuals not having received treatment.

The data from the present study of mentally ill individuals in the criminal justice system in Suffolk County tends to be consistent with Torrey's assertion. Most of the subjects in this study (75%) committed crimes that were non-violent in nature, while 25% of them engaged in clearly violent offenses. There is, however, a significant group (29%) that committed crimes which can be categorized as dangerous and/or possibly violent (DWI=297, criminal conspiracy/contempt=120, endangering the welfare of a child=7, reckless endangerment=17). The exact details of the circumstances of each of their offenses are unknown. Thus, the degree of danger or violence in these cases cannot be determined with certainty. Of the felonious crimes committed, 31% were violent, while 69% were non-violent in nature. In the misdemeanor category 84% of the offenses were non-violent, and 16% were violent.

Torrey also asserts that a strong relationship exists between untreated mental illness and the likelihood of violent behavior. When mentally ill individuals refuse treatment, they are at greater risk of becoming symptomatic and thus more likely to engage in bizarre behavior or violence that leads to their arrest.

The data from this study suggests that many of the subjects may not be receiving consistent treatment for their illnesses, or, indeed may not be under any care at all. A significant group (28%) of subjects did not have diagnoses listed, suggesting that they were not receiving mental health care at the time of the survey. These individuals were identified as mentally ill based solely on a history of past treatment (219), a history of hospitalization for a mental illness (122), a history of having taken psychotropic medications (19), a history of suicide attempts (21), exhibiting unusual behavior (38), or other indicators such as self or family reports of mental illness (13). This finding suggests that 28% of the subjects may, in fact, have entered the criminal justice system due to a lack of treatment for their illnesses immediately prior to their arrests. Although most of their offenses were non-violent, they were serious enough to be classified as felonies. Some of the comments written by probation and parole officers about these subjects indicated

that the officers had recognized the existence of mental illness in these individuals and were attempting to obtain services for them.

Link et al (1992) demonstrated that the most accurate predictor of violence by mentally ill individuals is the degree to which an individual is psychotic. The risk of violent behavior by individuals with major mental illnesses has also been shown to be influenced by the degree of severity of an individual's illness and that person's use of illegal substances (Swanson, et al, 1990). The data from this study did not show any immediate pattern of association between substance abuse and/or severity of illness and violent crimes. It did indicate, however a high rate of substance abuse histories across all diagnostic and offense categories.

In the present study the degree to which subjects known to be diagnosed with psychotic disorders engaged in violent crimes did differ slightly from subjects diagnosed with other illnesses. Subjects suffering from psychotic disorders comprised 9.3% of the sample and were responsible for 12.6% of the violent crimes. The largest diagnostic category in the sample was Mood Disorders. This group comprised 44.5% of the sample and was responsible for 37.4% of violent crimes. While some psychosis may be associated with mood disorders, the degree to which these individuals may have actually experienced episodes of psychosis was not known. Individuals in other diagnostic categories committed the remaining 50% of the violent crimes. The number of violent offenses within each of these diagnostic groups is fairly proportional to the size of the group. Thus, while it did appear that individuals with psychotic disorders were slightly over represented in the violent crimes category, an association between psychosis and violence could not be clearly seen. Overall, offense categories were fairly evenly distributed across diagnostic categories and appeared to be fairly proportionate to the size of each diagnostic group.

Substance abuse also did not appear to be associated with violence. The data simply showed that substance abuse was prevalent in all offense types. The overall frequency of substance abuse for all diagnostic categories was 64%. In the Mood Disorders and Psychotic Disorders categories the rates of substance abuse were 75.8%, and 71.8% respectively. The rate of substance abuse in individuals diagnosed with ADD was 70.8% (a diagnostic group that also had a high rate of violent crime). Known substance abuse histories were also seen more frequently in subjects diagnosed with personality disorders (80%) and subjects diagnosed with Conduct Disorder (70%). The prevalence rate of substance abuse among incarcerated individuals who are also diagnosed with mental illnesses has been found to range from 44% in individuals incarcerated in metropolitan jails (Abram, 1990) to as high as 90% in state prison inmates who are also diagnosed with Schizophrenia, Bipolar Disorder, and Anti-Social Personality Disorder (Goldstrom, Mandersheld and Rudolph 1992). The number of individuals in the criminal justice system in Suffolk County falls within the range of these findings. In the present study, subjects diagnosed with psychotic disorders, mood disorders and personality disorders ranged from 71.8% to 80%.

Overall, the characteristics of the population of mentally ill individuals within the criminal justice system in Suffolk County appears to be consistent with the assertions in the mental health literature that most mentally ill individuals come

into contact with the criminal justice system after committing non-violent offenses and that their crimes are related to substance abuse and to a lack of consistent treatment.

## **IX. SUBCOMMITTEE RECOMMENDATIONS**

1. **Further research is needed concerning available program statistics in order to determine suitable levels of diversion, and where that diversion should occur** (i.e. pre-booking, post-booking).

A systemic analysis is required with an accompanying description of cases at each diversion discretionary decision point. This study must include a review of existing protocols of the police and others in the criminal justice system.

In addition, an in-depth analyses of the C.P.E.P. (Comprehensive Psychiatric Emergency Program) population transported by the police and EDP (emotional disturbed person) responses by the police is required. Analysis of those requiring 730 and 508 exams, as well as those granted insanity defenses is also needed.

2. **Develop and implement a Jail Linkage Program for mentally ill inmates detained at Suffolk County's Correctional Facilities.**

Linkage case managers meet potential mentally ill clients while they are incarcerated and develop a comprehensive discharge plan prior to their release from confinement.

3. **Increase services for MICA (Mentally Ill Chemical Abusers) individuals at all levels of the Criminal Justice System.**

4. **Develop and implement specialized intensive supervision caseloads for seriously mentally ill probationers and parolees.**

Suffolk Probation implemented a successful correctional-treatment model for Special Offenders in 1985 which received partial federal funding for this population. Expansion of this highly accountable community-based model is strongly recommended.

5. **Expand available housing for mentally ill offenders including the MICA population.**

Transitional housing is an integral part of most successful programs nationally and clearly is an identified need in Suffolk County.

6. **Develop and implement a specialized training program for all relevant members of the criminal justice and treatment systems regarding the appropriate response to and intervention with the seriously mentally ill.**
7. **Identify alternative funding sources and secure additional funding for systems improvement with this population.**
8. **Continue to conduct empirical research and statistical analysis of the nature and prevalence of the mentally ill in Suffolk County Criminal Justice System.**

Areas requiring immediate analysis include:

- A.) **A systemic analysis of the flow of mentally ill persons throughout the entire criminal justice system.**
- B.) **Identify Developmental Pathways of mentally ill violent felony offenders.**
- C.) **Identification of successful approaches for appropriately responding to the mentally ill in criminal justice.**

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## APPENDIX 1

### CRITERIA FOR SEVERE AND PERSISTENT MENTAL ILLNESS AMONG ADULTS

To be considered an adult diagnosed with severe and persistent mental illness *A must be met*. In addition, *B or C or D must be met*:

#### **A. Designated Mental Illness Diagnosis**

The individual is 18 years of age or older and currently meets the criteria for a *DSM-IV psychiatric diagnosis* other than alcohol or drug disorders (291.xx-292.xx, 303.xx-305.xx), organic brain syndromes (290.xx-294.xx, 310.xx), developmental disabilities (299.xx, 315.xx, 317.xx-319.xx), or social conditions (Vxx.xx). ICD-9-CM categories and codes that do not have an equivalent in DSM-III-R are also not included as designated mental illness diagnoses. **AND**

#### **B. SSI or SSDI Enrollment due to Mental Illness**

The individual is currently enrolled in SSI or SSDI *due to a designated mental illness*. **OR**

#### **C. Extended Impairment in Functioning due to Mental Illness**

The individual must meet 1 or 2 below:

1. The individual has experienced *two of the following four functional limitations due to a designated mental illness over the past 12 months* on a continuous or intermittent basis:

- a. **Marked difficulties in self-care** (personal hygiene; diet; clothing; avoiding injuries; securing health care or complying with medical advice).
- b. **Marked restriction of activities of daily living** (maintaining a residence; using transportation; day-to-day money management; accessing community services).
- c. **Marked difficulties in maintaining social functioning** (establishing and maintaining social relationships; interpersonal interactions with primary partner, children, other family members friends, neighbors; social skills; compliance with social norms; appropriate use of leisure time).
- d. **Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings** (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings; individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).

2. The individual has met criteria for ratings of 50 or less on the Global Assessment of Functioning Scale (Axis V of DSM-III-R) *due to a designated mental illness over the past twelve months* on a continuous or intermittent basis. **OR**

#### **D. Reliance on Psychiatric Treatment, Rehabilitation, and Supports**

A documented history shows that the individual, at some prior time, met the threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder, e.g., hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and, thereby, minimize overt symptoms and signs of the underlying mental disorder.



## APPENDIX 2

### CRITERIA FOR SERIOUS EMOTIONAL DISTURBANCE AMONG CHILDREN AND ADOLESCENTS

To be considered a child or adolescent with serious emotional disturbance *A must be met*. In addition, *B or C must be met*:  
*must be met*:

#### **A. Designated Emotional Disturbance Diagnosis**

The youngster is younger than 18 years of age and currently meets the criteria for a *DSM-IV psychiatric diagnosis* other than alcohol or drug disorders (291.xx-292.xx, 303.xx-305.xx), organic brain syndromes (290.xx, 293.xx-294.xx, 310.xx), developmental disabilities (299.xx, 315.xx, 317.xx-319.xx), or social conditions (Vxx.xx). ICD-9-CM categories and codes that do not have an equivalent in DSM-III-R are not included as designated diagnoses. **AND**

#### **B. Extended Impairment in Functioning due to Emotional Disturbance**

The youngster must meet 1 and 2 below:

1. The youngster has experienced functional limitations due to emotional disturbance *over the past 12 months* on a continuous or intermittent basis. *The functional problems must be at least moderate in at least two of the following areas or severe in at least one of the following areas.*<sup>3</sup>
  - a. **Self-care** (personal hygiene; obtaining and eating food; dressing; avoiding injuries).
  - b. **Family life** (capacity to live in a family or family-like environment; relationships with parents or substitute parents, siblings, and other relatives; behavior in family setting).
  - c. **Social relationships** (establishing and maintaining friendships; interpersonal interactions with peers, neighbors, and other adults; social skills; compliance with social norms; play and appropriate use of leisure time).
  - d. **Self-direction/self-control** (ability to sustain focused attention for long enough periods of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability).
  - e. **Learning ability** (school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).
2. The youngster has met criteria for ratings of *50 or less* on the Children's Global Assessment Scale (CGAS) *due to emotional disturbance for the past 12 months* on a continuous or intermittent basis.<sup>4</sup> **OR**

#### **C. Current Impairment in Functioning with Severe Symptoms**

The youngster must meet 1 *and* 2 below:

1. The youngster *currently* meets criteria for a rating of 50 or less on the Children's Global Assessment Scale (CGAS) *due to emotional disturbance.*<sup>4</sup>
2. The youngster must have experienced at least one of the following within the past 30 days:
  - a. Serious suicidal symptoms or other life-threatening, self-destructive behaviors.
  - b. Significant psychotic symptoms (hallucinations, delusions, bizarre behavior).
  - c. Behavior caused by emotional disturbances that placed the youngster at risk of causing personal injury or significant property damage.

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<sup>3</sup> It is intended that the clinician *assess the youngster's functioning* in at least these five domains in consideration of assigning a single numerical rating on the CGAS.

<sup>4</sup> While the CGAS is recommended, ratings of *50 or less* on the *Global Assessment of Functioning Scale (Axis V of DSM-IV)* may be substituted. The CGAS is described in *Shaffer, D. et al. (1983) "A Children's Global Assessment Scale (CGAS)." Archives of General Psychiatry 40:1228-1231.*

