

Mental Health and the Criminal Justice
System in Suffolk County:
A Progress Report

May 2003

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 individuals with mental illness 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 individuals with mental illness 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 reviewed 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 individuals with mental illness 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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Table of Contents

Introduction	1
Accomplishments	4
Chapter 1	
Literature Review	6
A Historical Analysis of the Individuals with Mental Illness In the Criminal Justice System	6
The Criminal Justice and Mental Health Systems Today	14
Adolescents with Mental Illness and the Criminal Justice System	19
Chapter 2	
Current Research in Suffolk County	
Stony Brook University Hospital Comprehensive Emergency Program (CPEP) Study	22
Suffolk County Police Department: Emotionally Disturbed Persons Incidents, Suicide Attempts and Suicides	41
Mental Illness & Female Offenders Arrested for Prostitution	44
Suffolk County Mental Health Project	51
Chapter 3	
Current Programs	

FEGS Overview	68
Probation Mental Health Unit	68
Probation Day Reporting Center	69
Medication Grant	70
M.O.O.R.E Program	70
The CAMERA Unit	70
Chapter 4	
Training	
Overview of Agenda	71
Evaluation	75
New Training Initiatives	76
Chapter 5	
Systemic Analysis	
Gaps in the System	77
Sub Committee Recommendations	78

INTRODUCTION

Suffolk County continues to address the problem of crime and violence in the County committed by individuals with mental illness. One initiative involved the creation of the MICA subcommittee of the Criminal Justice Coordinating Council in 1998. We documented the nature and prevalence of individuals with mental illness in the criminal justice system and we also developed effective responses that would reduce crimes committed by this population and to provide them with the treatment necessary to address their mental illnesses. Suffolk County has made significant progress in understanding the nature of the crimes committed by individuals with mental illness and how to best to reduce those crimes.

The criminal justice system continues to cope with a growing number of offenders who have mental illness. Frequently these offenders have multiple problems and are often multiple recidivists. At the onset we began with the belief that this population presented serious problems to the criminal justice system, and utilized an inordinate amount of resources. It was necessary to validate this belief and as such we undertook a systemic analysis to initiate informed planning and system improvements.

Our continued goals are as follows:

- To promote public safety through the reduction of crimes committed by individuals with mental illness in Suffolk County;
- To develop initiatives aimed at identifying, preventing, and responding to criminal activity committed by individuals with mental illness in Suffolk County.
- To improve **the** treatment of individuals with mental illness within the criminal justice system.

- To enhance cooperative and collaborative law enforcement efforts to suppress criminal activity by individuals through the development of a strategic planning process and information-sharing system among criminal justice agencies.
- To foster better treatment of the individuals with mental illness within the criminal justice system by developing a multi-disciplinary interagency strategy.

Consistent with the aforementioned goals, in the year 2000, we completed an empirical study on the nature and prevalence of the individuals with mental illness in Suffolk County's Criminal Justice System and produced our first report: *The Nature and Prevalence of Individuals with Mental Illness in Suffolk County's Criminal Justice System*. As a result, the empirical data confirmed what we already suspected, we had significant numbers of individuals with mental illness within our local criminal justice system. Our findings were consistent with the problems faced at a national level. Some major findings from the our first report included:

- In one year, (1999), there were over 1,320 admissions to Suffolk County's jail mental observation unit
- On an annual basis, 10.4% of the probation population, 7.7% of the pre trial population, 7.1% of parolees and 16% of the jail population are individuals with mental illness
- 75% of those in the criminal justice system committed non-violent crimes
- Over 35% were charged with alcohol or drug related charges
- Almost 65% of the individuals with mental illness individuals were identified as substance abusing

- Approximately, 50% of all individuals with mental illness offenders have been in a hospital for a mental disorder at some time in their life.
- Over 50% were identified as either individuals with psychotic disorders, depression, or bipolar disorder.
- Over 50% of individuals with mental illness offenders are taking medication for a mental disorder.

Clearly, the Mentally Ill Chemically Addicted(MICA) population is a significantly large population, a population that would be better served with treatment rather than incarceration. Once we established the nature and prevalence of the problem, we proceeded onward, planning and ultimately developing programs in response to the documented needs of the county. Listed below are the accomplishments of the county's response to the identified problems.

Accomplishments

Research/Planning

- An in depth analysis of the Stony Brook University Health Science Center Comprehensive Psychiatric Emergency Program (CPEP) population and their involvement in the criminal justice system and a review of Police Emotional Disturbed person responses is being conducted. This study also includes studying the population which requires 730 and 505 exams as well as those granted the insanity defense. (*see Chapter 3*)
- A study of female offenders with mental illness who were convicted of prostitution was completed (*see Chapter 3*)
- A study of the relationship between mental illness, substance abuse, and encounters with the criminal justice system was completed using data from the Suffolk County Mental Health Project (*See Chapter 3*).
- A literature review of mental illness and individuals within the criminal justice system was completed (*See chapter 2*)

Services

- A jail linkage program connecting individuals with mental illness to services in the community when they are released
- Services for the Mentally Ill Chemically Addicted (MICA) population were expanded. Even with this expansion, services are still needed, due to the magnitude of the problem.

- Probation established a specialized unit to serve probationers with serious mental illness offenders.

Training:

- We developed a training entitled: **Working with Individuals with Mental Illness**. Six training sessions were held in 2001 and in total, 298 people attended the trainings (see chapter 4)
- In 2002, we developed a training entitled: **Working with the Individuals with Adolescents with Mental Illness in the Criminal Justice System** and in May 2002 one training session was held and 40 people attended.

The following report is consistent with the overall goals set forth by the MICA subcommittee and accordingly contains: a review of the most current literature about this population, current research that was and is being conducted in Suffolk County, an overview of programs which have arisen from identified needs of the county, and training initiatives within the county. Finally, we conclude our report with a systemic analysis of the gaps within the system and new recommendations for the upcoming year.

Chapter 1

Literature Review

The only good is knowledge and the only evil is ignorance.
Socrates

The following chapter consists of three parts, first a review of the history of individuals with mental illness in the criminal justice system. Secondly, we review the most contemporary literature on the topic. Lastly, we include a special review of the most current literature on adolescents with mental illness and the criminal justice system.

A Historical Analysis: Individuals with Mental Illness and the Criminal Justice System

Prisons and Jails are now the largest mental institutions within the United States. The emptying of mental hospitals and the reduction of community mental health centers has resulted in a large increase in the number of inmates with serious mental disorders. According to a 2001 Department of Justice report, at least 16 percent (300,000) of the total jail and prison population have a serious mental illness. It is estimated that the correctional system is responsible for more individuals with mental illness people than all of the psychiatric facilities, at a cost of almost 15 billion dollars a year.

The aforementioned statistics might lead some to believe that individuals with mental illness are involved in more criminal activity than the general population. In fact, criminality is only one factor influencing the rising number of individuals with mental illness within the criminal justices system. While the individuals with mental illness are involved in criminal activity, research has shown that a greater proportion of individuals with mental illness are arrested compared to the general population not because they are involved in more criminal activity but because they have a greater probability of arrest. Teplin (1984) discovered that people with mental illnesses have a 65% greater chance of being arrested than those who are not mentally ill committing the same offense.

Historically, perceptions or misperceptions of individuals with mental illness, and systemic changes within the mental health and criminal justice system have all influenced the status of the individuals with mental illness. Moreover, societal attitudes and perceptions about individuals with mental illness influence public policy and laws; they also influence social movements which prompt treatment trends such as institutionalization and deinstitutionalization.

In the past, many of the social movements had unintended negative results due to their failings. These include insufficient community treatment facilities and insufficient funding for inpatient treatment facilities (Lamb & Weinberger, 1998). Over the years the treatment of the individuals with mental illness has fluctuated, although most often they were treated poorly. The trend continues and currently jails and prisons are often

the “treatment of choice” for persons with mental illness. This chapter will examine the historical factors leading up to the present situation.

Fear is the main source of superstition, and one of the main sources of cruelty. To conquer fear is the beginning of wisdom.
Bertrand Russell (1872 - 1970)

Early Views and Treatment of the Mentally Ill

Throughout history, individuals with mental illness have been misunderstood. As such, it is important to review historic views of individuals with mental illness because these perceptions influence treatment protocols and governing laws. The following is a condensed history of the overall public perceptions and treatment of individuals with mental illness. (*For a more comprehensive account see: Grob (1994) The Mad among Us: A History of the Care of America's Mentally Ill.*)

In early history, mental illness or deviant behavior was viewed as the product of supernatural forces. This idea endured for many centuries. References of possession can be found in ancient records of the Chinese, Egyptians, Greeks and the Hebrews. The accepted cure was to force or coax the evil spirits out by exorcism. Exorcism often involved techniques ranging from mild to brutal. Such treatments included confinement and prayer to being submerged in water or burned, in order to make the body inhospitable for the demonic spirit. During these times individuals with mental illness were afforded no rights or legal protections (Allderidge,1985).

Around 460 BC, Hippocrates, set out to prove that mental illness was due to natural causes and he developed one of the first biogenic theories of mental illness. In the first century, B.C. Asclepiades first differentiated between chronic and acute mental illnesses. In the second century, Galen, codified the organic theories and made significant advances in anatomical research. He was the first to postulate that arteries contained blood and not air. This discovery led to the practice of bleeding individuals with mental illness, in order to restore the proper balance in the body (Allderidge,1985).

During, the middle ages the idea that insanity or mental illness was controlled by supernatural forces was resurrected. Again, this led to varying types of treatments ranging from prayers to starvation, all which were believed to expel the devil. This persisted through the renaissance (Kemp, 1990).

Although some historians suggest that many individuals with mental illness were burned as witches during the Witch Hunts, others suggest that the Witch Hunts had less to do with persecuting those with odd behavior and more to do with political and economic pursuits (Grob,1994).

During the fifteenth century, individuals with mental illness were kept in houses for the poor and others in general hospitals. Historical accounts of this time indicate that Bethlem Hospital in London was given almost exclusively to the individuals with mental illness. The poor laws of the seventeenth century required “lunatics” and other disabled be provided for by the local government or parish. During this time, many of the insane were institutionalized in public hospitals and privately owned madhouses. Many of the institutions did not aim to cure, but to isolate (Scull, 1993).

In the late, 1700's, a movement toward more humane treatment of individuals with mental illness was initiated. Jean-Baptiste Pussin, a superintendent of Le Bicetre Hospital in Paris forbid the staff to beat the patients. In 1793, Pinel extended Pussin's reform adding that to treat the individuals with mental illness like animals not only was inhumane but also impeded their recovery. In 1796, William Turke began similar reforms, he was convinced that the most therapeutic environment for individuals with mental illness was a quiet supportive religious environment. The view that the individuals with mental illness were simply ordinary people with extraordinary problems was the concept behind moral therapy. However, at the same time many of the individuals with mental illness were still being housed in prisons, under dismal conditions (Maher & Maher, 1985).

In the 1800's, Dorothy Dix, a social reformer, advocated for the removal of individuals with mental illness in prisons and initiated reforms in the United States. As a result of her efforts new hospitals were built, regrettably the government did not view mental health as a priority, consequently these institutions were not sufficiently funded. Insufficient funding left these hospitals without proper staff and in essence they became warehouses for individuals with mental illness (Viney & Zorich, 1982).

Moreover, these institutions that seemed like fortresses, perpetuated the notion that the mentally disturbed were freakish and dangerous. The situation remained relatively unchanged until the mid 1900's with the advent of psychotropic medications and the deinstitutionalization movement (Grob,1994).

Although the modern perspective of mental illness has evolved and most people believe in a biological basis for mental illness, fears still loom about the individuals with mental illness. Historically, persons with serious mental illnesses have been construed as violent and dangerous (Shellenberg & Wasylensk, 1992). Currently, this belief continues and many people still believe violence is strongly linked with mental illness.

Public opinion and policy that surrounds mental illness tends to be affected by misperceptions promoted by the media. The sensationalized media coverage when a "former mental patient" commits a violent act and the misuse of psychiatric terms such as psychotic and psychopathic contribute to public misperceptions (Monahan, 1992). Additionally, the sensationalized media coverage of violent crimes committed by a few individuals with mental illness leave the public to believe that these cases are representative of the majority of the individuals with mental illness in the criminal justice system, when in fact they are not. In reality, numerous studies (Mulvey,1994, Monahan,1992, Grisso, 1992, & Silver, 2000) found that there is no significant difference in rates of violence between the individuals with mental illness and those who are not mentally ill, who are not substance abusers.

Another common misconception that persists is that criminals who commit violent acts use the insanity defense for lenient sentencing. In reality, when the individuals with mental illness do use the insanity defense rarely do they receive lighter sentences. Studies find that the insanity defense is used in less than 1 percent of felony indictments, and succeeds in only one quarter of these cases (Callahan, & Steadman, McGreavy, Robbins, 1998). These misperceptions create a fear based belief system that drives both formal policies and laws directed towards those persons with mental illnesses and are reflected in governing laws pertaining to the insanity defense.

Criminal Responsibility and the Individuals with Mental Illness

Through the years the insanity defense has reflected societal attitudes about the criminal responsibility of individuals with mental illness. The concept of mens rea (guilty mind) is fundamental to Western ideas of criminal responsibility and Plato was one of the first to address insanity as a legal defense. Plato insisted that the care for individuals with mental illness should be a family responsibility and that they should not be held accountable or punished in any way for their irrational acts.

In 1583, William Lambard articulated that “If a man or natural fool or a lunatic in the time of his lunacy, or a child who apparently had no knowledge of good or evil do kill a man, this is no felonious act for they cannot be said to have an understanding of will.” (Brooks, 1990, 58) In the early 1700’s, Rex vs. Arnold, more emphasis was placed on the word “know” and the “wilde beast” test was set forth. This excluded blameworthiness of the defendant if he did not know what he was doing, no more than a wilde beast. These were the precursors of the most universally accepted and enduring test of sanity the M’Naghton Rule (Brooks, 1974).

The M’Naghton rule derives from an assassination attempt, in 1843, by a Scot, Daniel M’Naughten, who had delusions of persecution toward the Prime Minister of England. M’Naughten attempted to shoot the Prime Minister, but his bullet ended up killing his secretary instead. After a lengthy trial, he was found not guilty because of “insanity”. The legal basis of this decision was based upon medical information provided by the work of Issac Ray’s (1838) book *The Medical Jurisprudence of Insanity* (Brooks, 1974).

Although, the judge was moved by the medical evidence, Queen Victoria was not. Political pressures forced the judiciary to add a cognitive clause to the formula which amended it and the clause became: “To establish a defense on the ground of insanity, it must be clearly proved at the time of committing the act, the party accused of laboring under such defective reasoning from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it that he did not know what he was doing was wrong.” (Halleck, 1967,132)

At the turn of the century, the Progressive Movement challenged the foundations of criminal law system, a system that they claimed is based upon the view each person should be rewarded for right choices and punished for wrong ones. Their study of the conditions in which people lived suggested that poverty and environment had an undeniable effect, producing criminal behavior. Although the Progressive Movement did challenge the basic philosophy, in the end they believed that offenders are moral agents freely choosing wrong behaviors. Ultimately, they asserted that they (criminals) deserve punishment, however they concentrated reform on turning the punishment system into a corrections system (Allen, 1969). They strove to change the criminal justice system from a punitive to a rehabilitative system.

As times change so do attitudes and from 1960-1990, there were diverse attitudes towards mental health treatment and the law. The period between 1960 and 1980 can be defined as the Liberal Era most notably for the reform made to the mental health system and such reforms paralleled the progressive era. In contrast to this era a Neo Conservative Era, arose which consist of a reaction against these reforms. The latter period is associated with the return to principles of strict moral agency and responsibility of the old criminal law (La Fond & Durham, 1992).

Over the years there have been subsequent variations of the insanity defense. All variations include one of three types of excusability: 1. that the patient did not know

what he was doing or that it was wrong 2. the patient could not resist doing what he did 3. the patient was mentally ill and the crime was a product of his/her illness. Most recently, some states have implemented another concept, “guilty but mentally ill”. This verdict does not excuse the crime because of the mental illness but allows the judge to sentence the perpetrator to a state hospital for a period necessary to undertake the resolution of the illness. Following treatment, the patient is placed back in the correctional system for the completion of whatever sentence was imposed (Reid, 2000).

In 1984, following John Hinckley’s attempt to assassinate President Reagan the United States Congress enacted the Insanity Defense Reform Act. This act eliminated the volitional element, and shifted the burden of proof from the prosecution to the defense, and required the defense to achieve clear and convincing level of probability in its presentation. Thus, the legislature produced a formula which would result in fewer Not Guilty by Insanity verdicts (Finkle, 1989). The publicity surrounding John Hinckley’s assassination attempt helped push public policy and the insanity defense was almost abolished.

Historic Systemic Changes

Dramatic changes within the mental health service delivery system in the country have occurred since 1970. Deinstitutionalization, the advent of psychotropic medications, changing treatment philosophies, activism of the civil rights movements, and federal funding for community mental health centers all contributed to the drastic reduction of patients within state hospitals. In 1955, over a half million people were in state hospitals, in 1991 that number had decreased to 100,000 (National Institute of Mental Health, 1991).

Similarly, the criminal justice system has also undergone major changes. In 1999, the Bureau of Justice Statistics reported that in the last decade, the U.S. jail population increased from 158,394 to 444,584. The prison population increased from 329,000 to 824,133 in the same period. Fully 2.3% of the U.S. adult population is in jail, prison or parole on any day, giving the United States the worlds highest incarceration rate. The surge in corrections populations is attributed to several policy changes including the generally harsher sanctions resulting from the policy of “getting tough on crime” and the “war on drugs”.

As the corrections populations increased so did the number of persons with mental illnesses in jails and prisons. 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. (Abrams & Teplin, 1991)

With the closure of many of the nation’s institutions housing individuals with mental illness, 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.

Presently, the lack of appropriate mental health facilities is cited as one reason for the imprisonment of the individuals with mental illness. Interestingly, the same problem was recognized almost three hundred years ago. In 1773, the Governor of Virginia expressed dismay that he was forced to authorize the confinement of persons with

mental illnesses in the Williamsburg jail, against both his conscience and the law because of lack of appropriate services (Deutsch, 1937). As noted earlier, it was common, in the 1800's, to incarcerate individuals with mental illness individuals. In 1837, a social reformer, Dorothea Dix, began a 30 year campaign to ensure that individuals with mental illness were taken out of the prisons. In March of 1841, she entered the East Cambridge Jail to teach Sundays School class for women inmates. Within the confines of the jail she observed that individuals with mental illness were housed in unheated, unfurnished and foul smelling quarters. At the time, Dix questioned the conditions and was told that the insane do not feel heat or cold. Dix traveled to other prisons and played a major role in founding 32 mental hospitals and 15 schools for the feeble minded (Viney, & Zorich, 1982).

In 19th century New York, the 1894 Lunacy Commission concluded that the presence of individuals with mental illness convicted of criminal offenses and held in prisons was objectionable to the ordinary inmates and suggested that a maximum security hospital for the criminally insane should be built (Steadman and Cocozza, 1974).

In the late 1950's though the 1960's the deinstitutionalization movement was spurred by the advent of effective psychotropic medication and changes in treatment philosophies. This movement resulted in the release of many long term inpatients to community based care and living situations. Subsequently, a movement towards closing of mental hospitals was initiated as states seized the chance to slash hospital budgets, and the number of people in state mental institutions fell drastically (Accordino, Porter, Dion, Torrey, 2001)

During the 1960's the deinstitutionalization movement was reinforced by the emerging social concern of civil rights for people with serious mental illness and a belief that serious mental illness could be prevented and treated. In 1963, the federal government reinforced the movement by initiating the Community Mental Health Centers Act. This act funded the development of comprehensive community based mental health services and shifted treatment for people with serious mental illness to "least restrictive environments" within communities (Accordino et. al., 2001).

Many researchers (Torrey,1997,French, 1987, Accordino et al., 2001) believe that the shift in residency of the individuals with mental illness from hospitals to the criminal justice system is the result of deinstitutionalization. The impetus began in the 60's through the 70's to eliminate the infamous mental institutions. These "warehouses" of the past were known for their sparse living conditions, brutal treatment of patients, and harsh medical procedures and treatments. Concern for the civil rights of individuals with mental illness, a desire to cut costs, and a hope that new medications could replace supervised care all drove the movement to close the institutions.

Although this movement arose from noble intentions, a number of theorists explain the increase in the number of individuals with mental illness in prison as a result of failures within this movement (Bonovitz, Caldwell & Bonvitz, 1981). More specifically, because states lagged in opening the promised network of clinics and halfway houses and obtaining treatment became harder. Health insurers restricted coverage, for profit hospitals often turned away the psychotic and new laws made it more difficult to commit disturbed people (French, 1987).

Unfortunately, funding cutbacks during the subsequent decades have resulted in the reduction of community level mental health services. In many states, the closing of the state hospitals and the laws regulating admission to the hospital are so strict that the

often authorities are left with few options, except to arrest those who are exhibiting bizarre behavior (Accordino et. al, 2001).

During the 80's, the federal government attempted to modify and redesign federal support of mental health treatment through the passing of the Mental Health Act in 1981. However, the legislation was never passed and the federal government repealed and replaced it with the Omnibus Budget Reconciliation Act in 1981. This Act effectively ended federal funding of community treatment and shifted the burden to individual states (Breakey, 1996; Ray & Finely, 1994). The dissipation of federal support has resulted in the closing of many community mental health centers.

With the demise of community mental health centers and the lack of psychiatric facilities often times authorities find themselves without a place for individuals with mental illness. Consequently the lack of appropriate treatment facilities often results in the incarceration rather than the treatment of persons with mental illnesses. Correctional facilities are open 24 hours a day and a person charged with a crime can not be refused admission regardless of his or her mental condition. From a criminal justice perspective the deinstitutionalization movement was one more social movement that added to the already burgeoning prison population (Torrey,1997).

While deinstitutionalization led to problems managing individuals with mental illness in previous years, in the 90's the rise of managed care in community hospitals reduced access to inpatient hospital care in community institutions, resulting in fewer community hospital beds. A fundamental tenet of managed care is to limit costs to the provider (Brokowski & Eaddy, 1994). As a result, community mental health programs transformed the delivery of services to people with serious mental illnesses and this has resulted in limitations of care and poor coordination of services. Researchers (Torrey, 1997, Whitmer, G.E., 1980) hypothesize that this reduction has led to an increase in individuals with mental illness within the criminal justice system.

Prisons and jails have become "housing" for the mentally ill and approximately 29% of jails hold persons with serious mental illness either on misdemeanor charges or no charges at all. Researchers contend that criminalization and incarceration of individuals with mental illness were unintended consequences of the deinstitutionalization movement (French, 1987, Torrey, 1992).

Another factor which contributed to the rise in the mentally ill population in the criminal justice system was the new "war on drugs policy" enacted in the 80's. It is well known that a significant subgroup of the mentally ill has co-occurring substance abuse disorders, they are the Mentally ill Chemically Addicted (MICA) population (Abrams & Teplin, 1991). The co-morbidity that includes drug or alcohol abuse in addition to a mental illness can lead to increased rates of violence and arrest. Higher rates of crime among dually diagnosed people are reflected in arrest rates. Those with co occurring disorders have many more arrests than those without. Drug use itself is illegal, and many people are involved in crimes related to substance abuse. Overall, a substance abuse problem increases the possibility/probability of arrest for substance abuse related crimes (Abrams & Teplin,1991).

Policymakers are recognizing the magnitude of the problem and in 1992, the Center for Mental Health Services was established. This arose from the ADAMH reorganization act (42 U.S.C 290bb 31) requiring the Center for Mental Health Services to produce a report to Congress concerning the most effective methods for providing mental health services

to individuals in the criminal justice system, including obstacles to providing such services.

Conclusion

Various historical factors have contributed to the recent trend of utilizing the criminal justice system to serve the individuals with mental illness. Public perception and attitudes toward mental illness has shaped public policy. These attitudes have been reflected within legislation regarding the insanity defense and funding for treatment of individuals with mental illness. Deinstitutionalization, managed care, substance abuse problems within this population, new get tough on crime laws, the “war on drugs” all have contributed to what some have called the criminalization of the mentally ill.

The Criminal Justice and Mental Health Systems Today

As noted previously, there is a great concern that individuals with mental illness are over-represented in the prison population, and that they are not receiving either appropriate care or long-term treatment planning. Clinical studies suggest that 6 to 15 percent of persons in city and county jails and 10 to 15 percent of persons in state prisons have severe mental illness (BJS, 2001). In addition, these offenders usually have acute and chronic mental illness and a lower ability to function, with a sizeable amount also being homeless (Steadman et al. 1999). It also appears that a greater proportion of individuals with mental illness persons are arrested compared to the general population. Based on the Special Report Mental Health Treatment of Inmates and Probationers (NCJ 174463), at midyear 2000, State prisons held 191,000 individuals with mental illness inmates.

As illustrated in the previous section, many systemic factors contribute to the incarceration of individuals with mental illness. They include deinstitutionalization, more rigid criteria for civil commitment, lack of adequate community support for persons with mental illness, mentally ill offenders' difficulty gaining access to community treatment, and the attitudes of police officers and society (Lamb & Weinberger, 1989). Several researchers offer these suggestions for improving the problem:

- mental health consultation to police in the field
- formal training of police officers
- careful screening of incoming jail detainees
- diversion to the mental health system for individuals with mental illness who have committed minor offenses;
- assertive case management and various social control interventions, such as outpatient commitment, court-ordered treatment
- and psychiatric conservatorship

Linda Teplin (2000), a professor of Psychiatry and Director of the Psycho-Legal Studies Program at Northwestern University Medical School, has done extensive research on this population. After extensive review, Teplin notes an alarming and growing trend towards the "criminalization of mentally disordered behavior" and she asserts that those who were once treated within the mental health system are instead being forced into the criminal justice system. She has several explanations for the higher arrest rate among persons who display signs of serious mental illness. First, to a certain extent, many officers may be deficient in adequate awareness of the signs of severe mental disorder. Secondly, many mental disorders are coupled with a number of alarming symptoms. Although some symptoms such as verbal abuse, hostility, and disrespect, are not themselves against the law, such behaviors may provoke an officer to respond more punitively. Lastly, as a result of the severe reductions in mental health services- both inpatient and outpatient- the criminal justice system may have become the default option for dealing with individuals who cannot or will not be treated by the mental health system.

A report issued by the United States Department of Justice in 1999 reported that 16 percent of all inmates in state and federal jails and prison have schizophrenia, manic

depressive illness (*bipolar disorder*), major depression, or another severe mental illness. This means that on any given day, there are nearly 283,000 individuals with severe mental illnesses incarcerated in federal and state jails and prisons. On the contrary, there are more or less than 70,000 persons with severe mental illnesses in public psychiatric hospitals, and 30 percent of them are forensic patients.

Individuals who are struggling with a mental illness and involved with the criminal justice system often find the experience of incarceration, as a whole, to be a frightening one. The conditions of the jails and prisons are ill suited to stabilize or treat the mental illness and often times they end up exacerbating the illness. Because most often these facilities have few mental health professionals they are unable to effectively treat people with these brain disorders. As such it is difficult for workers to identify and react to the needs of inmates encountering severe psychiatric symptoms. Moreover, inmates with severe mental illnesses generally do not have access to up to date anti psychotic drugs due to the expensive costs of these medications. Federal and state prisons typically do not have sufficient rehabilitative services offered for inmates with severe mental illnesses to assist them in their move back into society. The Bureau of Justice Statistics *2000 Census of State and Federal Adult Correctional Facilities*, found that one in every eight state prisoners was receiving some mental health therapy or counseling at midyear 2000. Additionally, nearly 10% (n= 114,400) were receiving psychotropic medications (including antidepressants, stimulants, sedatives, tranquilizers, or other anti-psychotic drugs), and fewer than 2% (n= 18,900) of State inmates were housed in a 24-hour mental health unit.

People suffering from a mental illness who enter the criminal justice system have complex assistance requirements. The individuals with mental illness who are incarcerated face issues, such as victimization, segregation, and alienation from family (NAMI, 1992). More specifically, people with mental illnesses have trouble defending themselves while incarcerated. Jails and prisons are often unkind, perilous atmospheres for inmates and are even more so for individuals with mental illness. Some regular symptoms of mental illness such as peculiar and disorganized behavior often make individuals with mental illness prisoners a vulnerable population. For these offenders the symptoms of their illness may lead to a myriad of problems. For example, bizarre behavior may irritate correction workers and other inmates and lead to victimization and cognitive disorganization makes prisoners with mental illness simple targets for other confrontational prisoners. Finally, untreated mental illness may make inmates' behavior unpredictable, distressing others and sometimes infuriating violent reactions from guards and fellow inmates.

Yet like the rest of the prison population, inmates with mental illness discover that behaviors that aid them in handling the incarceration, decreases their success in the community once released and may contribute to their re arrest (Hayes, 1997). Some of these behaviors may include aggressiveness and intimidation of others or conversely, extreme passivity, manipulative behavior and reluctance to discuss problems with authority figures.

Moreover, inmates with mental illness may be penalized for troublesome behavior in ways that worsen their illnesses (Rold, 1992). The customary punishment for those who violate prison or jail rules is "punitive segregation" better known as solitary confinement. The punishment stops communication with the general population and forbids partaking in prison programs. Rold (1992) asserts that people

with mental illness are for the most part likely to find themselves in punitive or administrative segregation as a result of conduct that is indicative of their illness. For example, Sloat (1994) found in Ohio in the early 1990s that hundreds of inmates had been put in disciplinary cells for no reason other than mental illness. It was also noted that “acting out” psychotic behavior and even suicide attempts by inmates with mental illness were on occasion considered discipline troubles. The conditions in punitive and administrative segregation generates an enormous amount of psychological pressure and can bring about symptoms of mental illness to emerge even in inmates with no earlier psychiatric problems (Wallace, 1994). Segregated inmates are also at risk for suicide. A recent study of nine suicides that came about within 24 months, at an unnamed large metropolitan jail, found that of the nine suicides, eight were segregated from the general population of the jail at the time of their death (Hayes, 1997).

Kolbert (1998) declared that while those individuals with mental illness are incarcerated, many of them lose their community contacts that are said to be crucial to their ability to achieve success once they are released. It is not easy for even the most loyal family members or friends to sustain contact with an incarcerated person. Under the difficult circumstances associated with being incarcerated, a prisoner’s bonds with family and friends many times become weak and eventually cease. Once released a prisoner returns to their community with neither proper discharge planning, transitional services, nor the support of family and friends. As a result, it increases the likelihood that they will re-offend or violate parole resulting in their return to prison.

In an effort to address some of the problems faced by this population New York State passed legislation in 1999 for the assisted outpatient treatment (*also known as AOT*) of particular individuals with mental illness individuals who, in view of their treatment history and situation, are not likely to endure safely in the community devoid of proper supervision. This new regulation, set forth in Section 9.60 of Mental Hygiene Law, is commonly referred to as Kendra’s Law. “This legislation was created to help make certain that individuals with mental illness persons who are more susceptible to relapse adhere to the treatment programs they rely on to remain safe and stable members of their communities,” said Governor George E. Pataki when he signed the bill into law. The law also obliges the Office of Mental Health to monitor and oversee all AOT programs. The following section describes two laws which have impacted the individuals with mental illness and the criminal justice system.

Laws Affecting Individuals with Mental Illness

Kendra’s Law

In 1999, Governor George Pataki signed New York’s new act for assisted outpatient treatment. Generally the law is known as Kendra’s Law, named after Kendra Webdale, a woman who was pushed to her death by Andrew Goldman, a man with schizophrenia and a history of both repeated hospitalizations and violent acts caused by his untreated mental illness. Despite repeatedly seeking help and he was unable to get it. The act permits courts to issue orders to continue treatment while in the community to specified individuals with mental illness. The Office of Mental Health more specifically describes those specified individuals as those who are in a deteriorating condition, unlikely to

comply with treatment, and have a history of either several hospitalizations or violence as a result of noncompliance with the medications essential to control their illness. The Office of Counsel for the New York State Office of Mental Health believes that Kendra's Law improves New York's treatment system in two significant respects. First, it is said to permit individuals who are instructed to comply with treatment to continue to be outpatients. Consequently, some committed to inpatient facilities could be released earlier and transferred to supervised outpatient treatment while others who previously would have been put in a hospital can now stay in the community under the assisted outpatient treatment orders. Secondly, it is noted that Kendra's Law can be useful to more of the population; instead for those that solely meet the "danger to self or others" standard. Kendra's Law considerably raises New York's capability to care for those who refuse treatment simply due to their mental illness status and often permits care to be administered in a less restrictive environment.

Wyatt v. Stickney (1971)

A landmark case, *Wyatt v. Stickney* established that psychiatric patients have a legal right to individual treatment. This case arose because in 1970, there was a significant financial deficit that resulted in the erosion of mental health care facilities and treatment quality. Ricky Wyatt was a psychiatric patient at the time of the cutbacks and was a victim of the inadequate living conditions and treatment. Breaking through was the idea of an individual having "the right to treatment". Morton Birnbaum, an attorney-physician, believed that psychiatric patients had a legal right to treatment that would give them "a realistic opportunity to be cured or improve his mental condition". The presiding Judge Johnson became the first Federal Judge to opine that "civilly committed patients have a constitutional right to individual treatment." Resulting from the Wyatt case, there was a drastic deinstitutionalization of previously committed patients. Rather than meeting the new court ordered standards for the quality of treatment and conditions, many hospitals closed down. In addition, The Mental Health Law Project was created (now known as the Bazelon Center for Mental Health Law), which further limited the involuntary treatment for a patient and established and developed the right to refuse treatment.

Timeline for Standards of the Insanity Defense:

A common misperception among the public is that criminals who commit violent acts use the insanity defense for lenient sentencing. In fact, studies find that the insanity defense is used in less than 1% of all felony indictments and succeeds in only one quarter of these cases (Callahan et al. 1998).

1600's – Absolute Madness recognized in English common Law

1723- Wild Beast Rule: not guilty by reason of insanity if “mental defect produced the act”

1854- **M’Naghten**: To establish a defense on grounds of insanity, it must be clearly proven that at the time of committing the act. The party accused was laboring under such a defect of reason from the disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it he did not know what was wrong.

1896- **Irresistible Impulse**: “mental disease may impair volition or self control even when cognition is relatively unimpaired”

1954- **U.S. vs. Durham**: An accused is not criminally responsible if his unlawful act was the product of a mental disease or defect.

1972- **ALI Rule**: states a person is not responsible for criminal conduct if at the time such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform to the requirements of law. As used in this article, the terms “mental disease or defect” do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

1984- **The Insanity Defense Reform Act**: To find the defendant not guilty by reason of insanity, the defendant must prove, by clear and convincing evidence, that at the time of the commission of the acts constituting the offense, the defendant, as a result of severe mental disease or defect was unable to appreciate the nature or quality or wrongfulness of his/her acts. Mental disease or defect does not otherwise constitute a defense.

1985- **Guilty but Mentally Ill**: To find the defendant guilty but mentally ill, you must find the defendant had a substantial disorder of thought or mood which afflicted him/her at the time of the offense and which significantly impaired his/her judgment, behavior, capacity to recognize reality, ability to cope with the ordinary demand of life. The effect of the mental illness, though, is such to fall short of legal insanity

An Overview of Mental Disorders and Youth:

Mental health problems affect **one in every five** young people at any given time. Yet, it is estimated that **approximately two thirds** of all young people with mental health are **not getting the help they need**

(U.S. Department of Health and Human Services, 1999).

Historically, children and adolescents' mental health needs have been addressed inadequately in policy, practice, and research. Only recently has the level of their unmet needs been identified. Recent estimates place the rate of serious emotional disturbance among youth in the general population at 9-13% (Friedman et al. 1996). It is notable that mental health problems affect one in every five young people at any given time. Yet, it is estimated that approximately two thirds of all young people with mental health problems are not getting the help they need (U.S. Department of Health and Human Services, 1999). Furthermore less than one

third of the children under age 18 with a serious disturbance receive any mental health services (Childrens Defense Fund, 1999).

Mental Disorders Among Children in the Juvenile Justice System:

There is growing recognition of the high numbers of youth involved with the juvenile justice system with co-occurring mental health and substance abuse problems. Although the prevalence of mental health and substance abuse disorders among youth in the juvenile justice system has not been widely researched, recent studies suggest that these problems are significantly greater for juvenile delinquents than for other youth. It has been estimated that each year, of the youth who come into contact with the juvenile justice system:

- 150,000 meet the diagnostic criteria for at least one mental disorder
- 225,000 suffer from a diagnosable alcohol abuse or dependence disorder
- 95,000 suffer from a diagnosable substance abuse or dependence disorder (Cocozza, 1992).

The juvenile justice system is seen by some as a “dumping ground” for individuals with mental illness, learning disabled, or behaviorally disordered juveniles. Many juvenile offenders have a history of involvement with the mental health system and subsequently migrate to the juvenile justice system because the mental health system has failed to serve their need (Redding, 2000).

Estimates of the percentage of youth with mental disorders in the juvenile justice system vary from study to study, however a consistent picture is beginning to emerge. Despite methodological and instrumentation differences researchers are documenting high rates of mental disorders, including substance abuse disorders and multiple diagnoses, among children incarcerated in juvenile facilities (National Mental Health Association, 1999).

A review of 34 studies (Otto et al., 1992) found that youth in the juvenile justice system experience substantially higher rates of mental health disorders than youth in the

general population. This is consistent with the finding that mental illness prevalence rates in adult corrections populations are two to four times higher than the general adult population (Teplin, 1990).

Researchers have confirmed that a high percentage in the juvenile justice system have a diagnosable mental health disorder but officials have difficulty addressing mental health issues. Part of the problem lies around the varying uses and definitions of the terms “mental health disorder” and “mental illness” and inadequate screening and assessment.

However, it is safe to estimate that at least one out of every five youth in the juvenile justice system has serious mental health problems. Despite methodological problems with previous studies, researchers indicate that prevalence rate of disorders in the juvenile justice system is twice that of those in the general population. Thus a conservative estimate for the prevalence rate of youth in contact with the juvenile justice system is considered to be at least 20% though some studies identified the rate as high as 60%.

Why are children with emotional disorders in the justice system?

While some of these children have committed serious crimes, many of them got in trouble because their local communities failed to provide appropriate services addressing emotional and behavioral problems. These children are disproportionately poor and children of color. Along with their underlying mental disorder, many have histories of other problems that have not been addressed including: physical and/or sexual abuse; parental drug or alcohol use; poor school performance or truancy; family discord, and learning disabilities (*National Mental Health Association, 2000*).

A Summary of Findings

- Along with substance abuse, the most common disorders among youth in the justice system are **conduct disorder, depression, ADHD, learning disabilities, post traumatic stress disorder, and developmental disabilities** (*Garfinkel, 1997*).
- According to a 1994 OJJDP study of juveniles’ response to health screenings conducted at the admission of juvenile facilities, 73 percent of juveniles reported having mental health problems and 57% reported having prior mental health treatment or hospitalizations (*Conditions of Confinement: Juvenile Detention and Correctional Facilities, OJJDP, August 1994*).
- A study (2000) conducted by the Suffolk County Probation Research and Planning Unit found that almost half (48%, n=73) of the all gang members and serious violent offenders assigned to the Gang Reduction Intervention Project had histories of mental health problems. Of those offenders diagnosed, 25% had co-morbid disorders.

- The National Mental Health Association (1999) concludes that the prevalence of **mental disorders among youth in juvenile justice facilities** ranges from **50% to 75%** in multiple, well designed studies which used structured diagnostic interviewing techniques to determine children's diagnoses.

Girls in the Juvenile Justice System:

Adolescent girls who come into contact with the juvenile justice system report **extraordinarily high levels of abuse and trauma**. Incarcerated girls report significantly more **physical and sexual abuse than boys, with more than 70% of girls reporting such experiences**. (Evans, et al, 1996)

Adolescent female offenders exhibit high rates of mental health problems. Girls have higher rates of depression than boys throughout adolescence and are more likely to attempt suicide. A number of prevalence studies done in state juvenile justice systems show females have higher rates of mental health problems than their male counterparts.

A study of juvenile offenders in Georgia Youth Detention Centers revealed that nearly 60% of girls met the criteria for an anxiety disorder, in contrast to 32% among boys 59% of girls had a mood disorder, versus 22% of boys (Marsteller, et al., 1997).

Suicide attempts and self-mutilation by girls are particular problems in juvenile facilities. Characteristics of the detention environment such as seclusion, staff insensitivity, and loss of privacy can add to negative feelings and the loss of control that girls feel and may result in suicide attempts and self-mutilation.

In summary, the literature has established the prevalence of youth with mental health and or substance abuse problems in the criminal justice system, however the literature on treatment issues and the criminal justice system is scant. Compounding the problem, a failure to provide routine standardized screening and assessments results in a less than adequate identification process and often times juveniles are not identified until the problems result in crisis. In addition, oftentimes once juveniles are identified there are inadequate and fragmented services for youth with mental health and substance abuse problems. Finally there seems to be a general lack of communication and coordination across involved systems. Proper mental health services can both prevent children from committing delinquent offenses and from re-offending.

Chapter 2

Current Research in Suffolk County

*The more extensive a man's knowledge of what has been done,
the greater will be his power of knowing what to do.*
Benjamin Disraeli

The following chapter details the most current research projects undertaken since our first report. Consistent with our overall goals we utilize empirical research to inform county-wide planning and program development. The research in the chapter includes: an overview of the Stony Brook University Medical Center Comprehensive Psychiatric Emergency Program (CPEP) study, which is underway, a preliminary analysis of the police department Emotionally Disturbed Incidents, Suicides and Suicide attempts, a profile of mental illness and female offenders arrested for prostitution, and a closer analysis of those individuals with serious and persistent mental illness in the Suffolk County Criminal Justice System.

Profile of the Stony Brook University Hospital Comprehensive Psychiatric Emergency Program (CPEP) Client Population

As noted in the first report, the MICA subcommittee recommended that an in depth analysis be conducted of the CPEP population, specifically, those who are involved in the criminal justice system. The analysis would provide a profile of the CPEP client and would help the criminal justice coordinating council to better plan for programs and services to persons with mental illness in the criminal justice system. Currently, the research team is conducting an assessment of the CPEP client. The following summary outlines some of the preliminary findings.

Purpose of the Study

This study will examine the reasons for patient presentations at CPEP and the outcomes of treatment rendered there (i.e., whether a patient was hospitalized, held for observation and then released, released after a medication adjustment or other treatment, or released after no treatment). The potential relationships between such variables as demographic characteristics (age, gender, ethnicity, socio-economic status), degree of social and family supports, nature of illness, length of illness, substance abuse, criminal justice status, prior treatment histories, and concurrent medical illnesses will be examined to determine the degree to which they may influence the outcomes of treatment.

The findings of this study will be shared with the University Hospital and Medical Center administration and will also be used in future planning of criminal justice and mental health service providers in Suffolk County.

Subject Population

Approximately ten percent of the population of adult patients who presented to CPEP for evaluation and treatment during the year 2000 were randomly selected from the program's admission logbook. A smaller population of children and adolescents were examined. Data was obtained from the medical records of patients who were treated in the Comprehensive Psychiatric Emergency Program (CPEP). Patient names, medical record numbers, and medical encounter numbers were not recorded in the data collection process.

Methods

An in depth review of medical records was conducted by the research team. A data collection instrument was used to record client age, gender, ethnicity, socio-economic status, degree of social and family supports, nature of illness, length of illness, substance abuse, criminal justice status, prior treatment histories, and concurrent medical illnesses. There were no contacts with subjects whatsoever, and there were no discussions of information in patient records with the CPEP staff or anyone who might be directly or indirectly involved with these subjects. Neither the CPEP staff nor anyone with any degree of involvement with a subject were be informed of that person's inclusion as a subject in the study.

Benefits

It is anticipated that the findings of this study will be of practical value to the criminal justice coordinating council MICA subcommittee. The results will assist the planning and policy makers to better understand how clients navigate through the criminal justice and mental health systems in Suffolk County. It is anticipated that the information will be vital to helping the county to better plan for and provide services to persons with mental illness.

Information will also be provided to the CPEP administration, as it may help to reveal the strengths and weaknesses of the services rendered in CPEP. The findings may help to reveal existing problem, to highlight particularly effective interventions, or to suggest new procedures in the development of best practices for psychiatric emergency programs. This, ultimately, will benefit all individuals who require emergency psychiatric care.

It is also anticipated that the findings of this study will contribute to the existing fund of knowledge regarding the social and treatment needs of individuals with serious and persistent mental illnesses.

Description of the Sample Population

The following information is based upon an initial sample of 80 clients, who were admitted to CPEP in 2000.

Gender

Male 54%
Female 46%

Race Ethnicity

White 76%
African American 13%
Hispanic 9%
Other 2%

Age

Mean age = 37 years old
62% were under 40 years old.

Marital Status

Single 52%
Married or living with someone 32%
Separated or divorced 15%

Source of Income

Most of the subjects in the sample had an independent source of income from employment or Social Security benefits. Eighteen percent of subjects were dependent upon their families for support (usually parents or a spouse), and only a small minority was dependent upon Public Assistance benefits.

SSI/SSD 39%

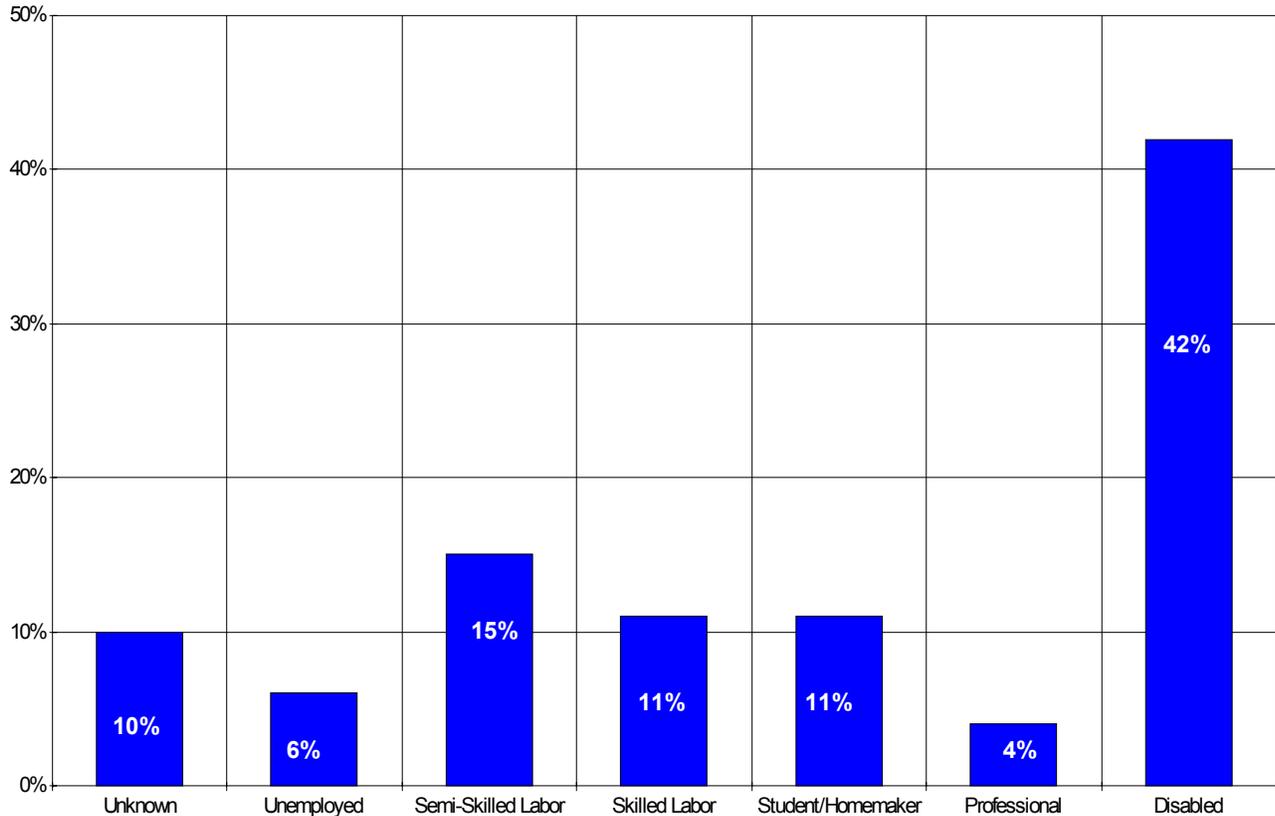
Employment 30%

Family Support 18%

Other/Unknown 10%

Public Assistance 3%

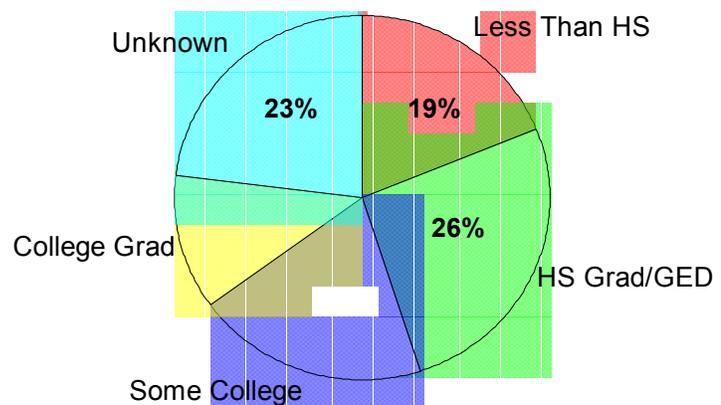
Types of Employment



While 30% of the sample was employed at the time of their first admission in the target period, only 19% reported having skilled or professional employment. Fifteen percent of the sample was employed in lower-wage semi-skilled jobs, and 42% of the sample was unable to work due to disability. Six percent of subjects reported being unemployed, but did not attribute it to a disability. Eleven percent of subjects were not employed outside of their homes because they were students or homemakers.

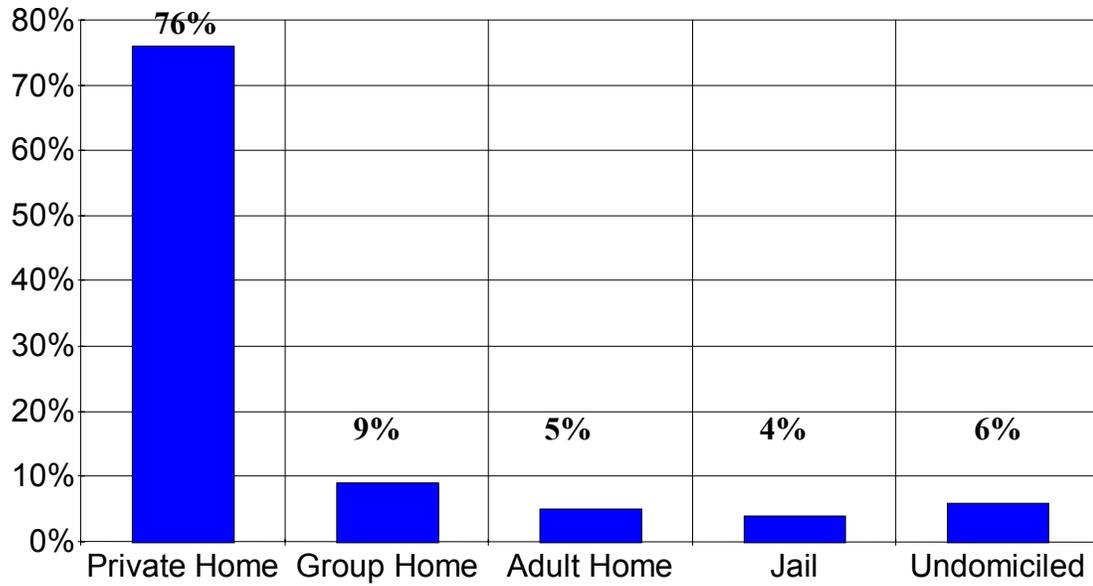
Level of Education

Levels of education were not available for 23% of the subjects. Fifty-eight percent of the subjects reported having at least a high school education, while only 19% reported they had never finished high school.

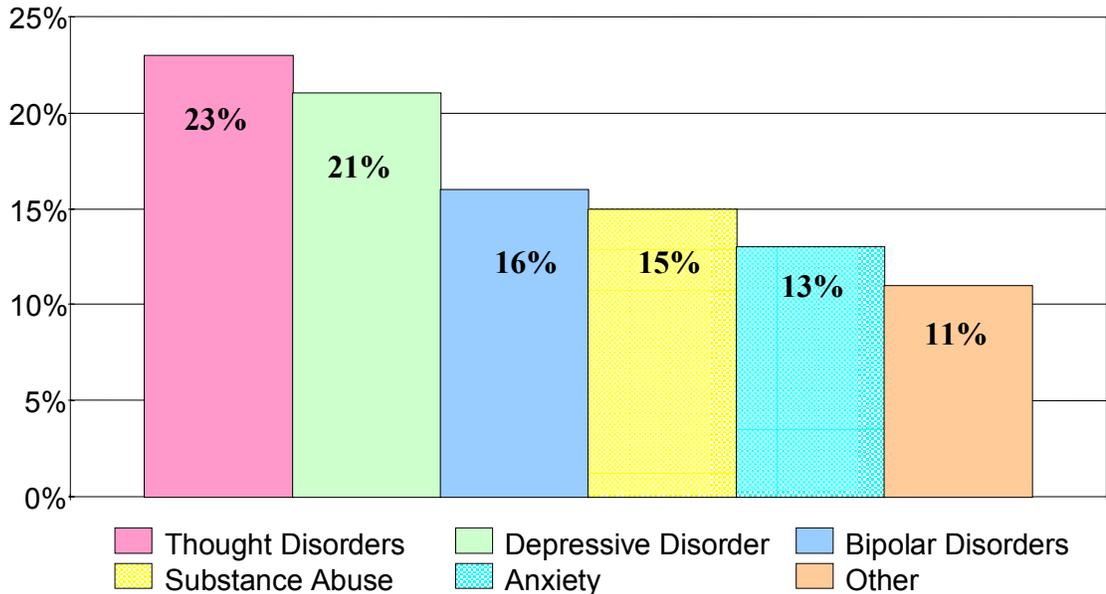


Type of Housing at First Admission in Target Period

The majority of subjects were residing in a private home (house or apartment) either alone, with family, or with friends at the time of their first admission in the target period.



DIAGNOSTIC CATEGORIES OF MENTAL ILLNESSES



Diagnostic categories reported here are the primary Axis I diagnoses indicated in subjects' records. In some cases subjects had concurrent substance abuse diagnoses. Fifteen percent of subjects were diagnosed with substance abuse problems only and no concurrent mental illness.

There were no significant differences between subjects in terms of histories of substance abuse, number of admissions to CPEP, severity of stressors, GAF ratings, or legal system involvement based on diagnoses.

Global Assessment Functioning

GAF ratings were available for 51 of the 80 subjects (64%). The mean GAF rating was 47.1, with a median and mode of 50. *See GAF rating scale and the end of this report*

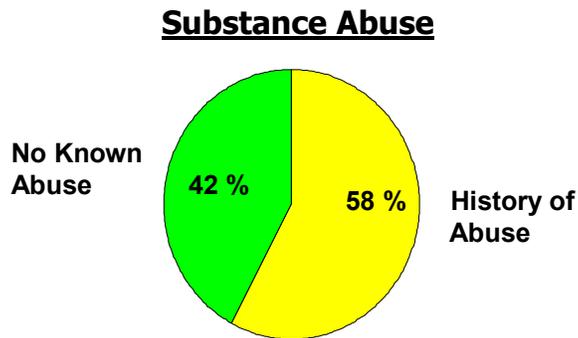
There were no significant differences between subjects in GAF ratings based on diagnostic categories or histories of substance abuse.

SUBSTANCE ABUSE

Subjects were identified as having a history of substance abuse if there was any indication in the CPEP record of past or current abuse of alcohol or drugs (illicit or prescribed). Fifty-eight percent of subjects were found to have a history of substance abuse.

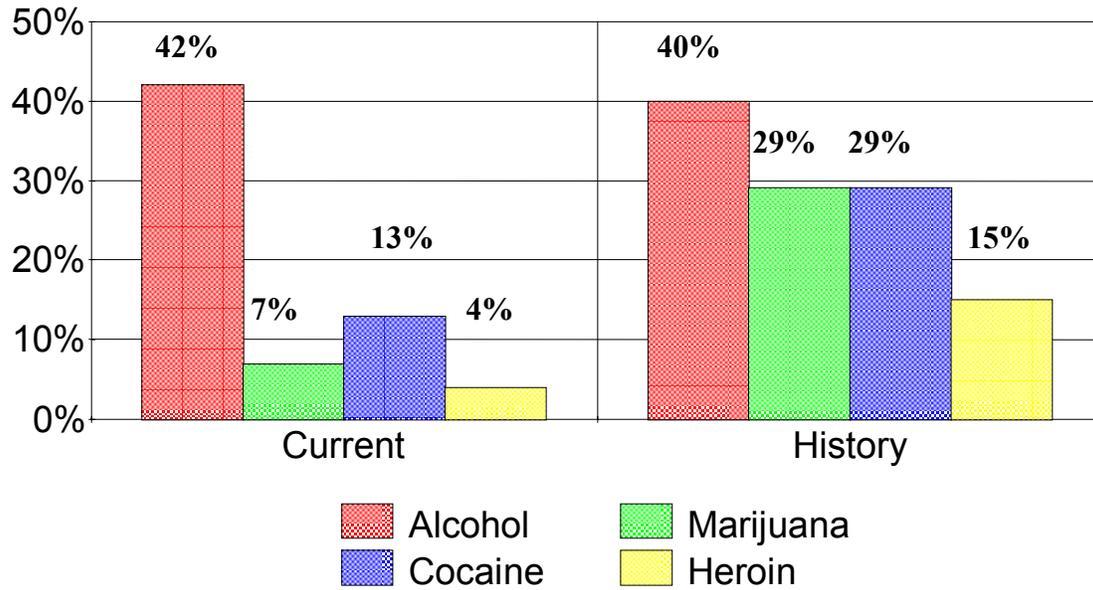
Forty-one percent of subjects had current problems with substance abuse at the time of their admission to CPEP. Subjects were identified as having a current substance abuse problem if at the time of presentation they were intoxicated, if blood tests indicated the presence of alcohol or illicit drugs, or if a subject or significant other reported the abuse of substances.

Although 41% of the sample had a problem with substance abuse at the time of presentation at CPEP, only six of them were receiving services from a substance abuse treatment provider. While some subjects may have been receiving specialized MICA treatment in a mental health clinic, there was no clear indication of this in their records.



Most frequent types of Substance Abuse

Alcohol, marijuana, cocaine, and heroin were the most commonly reported types of substance abuse.

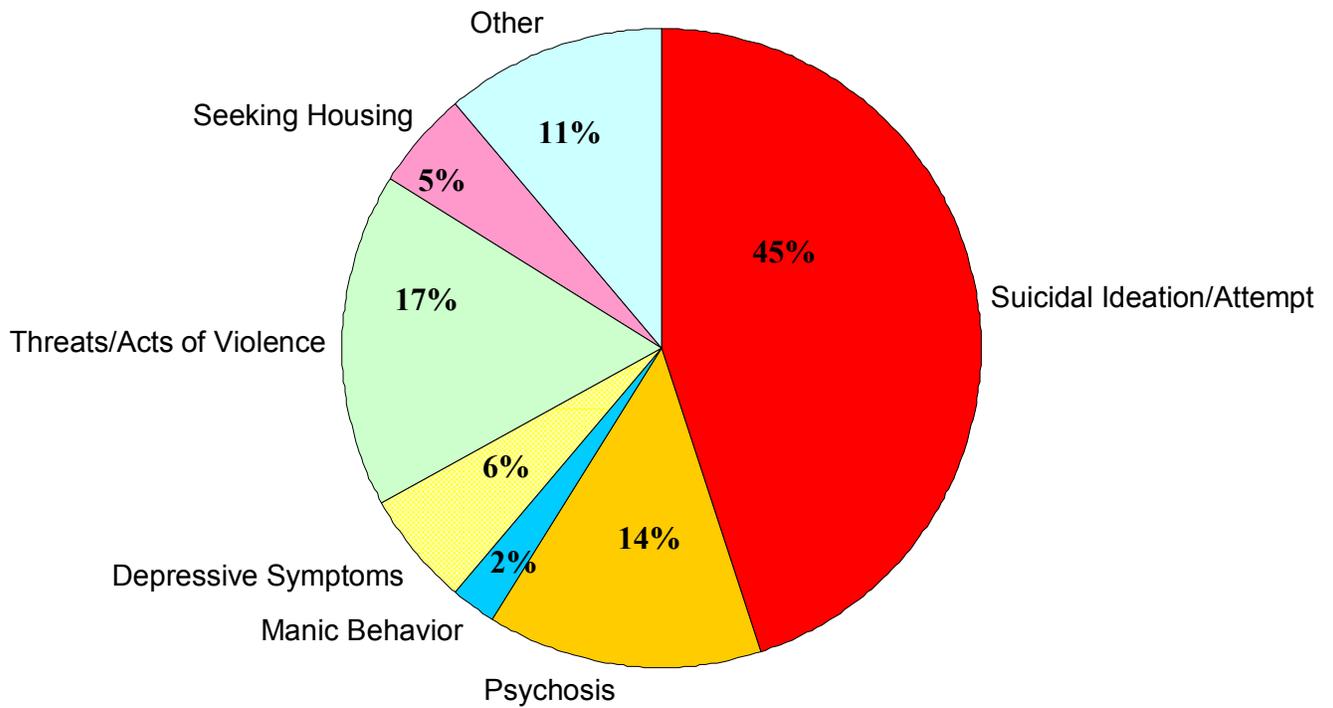


Number of Admissions Per Client

Most clients in the sample were admitted to CPEP one time (82%). The remaining 18% were admitted more than once to CPEP during a one-year period. From 1992 until February 2002, 60% of the sample had only one admission and 40% had multiple admissions to CPEP.

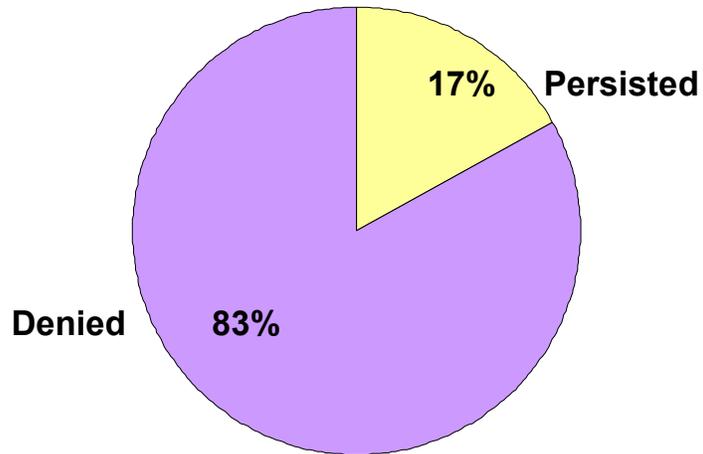
Reasons for Presentations

The most frequent reason for CPEP presentations were suicidal ideation (39%) or attempts (6%). Threats of violence (11%) and acts of violence (6%) were the second most common reasons for presentations. Psychosis was the third most common reason for a CPEP presentation.



Suicidal Ideation

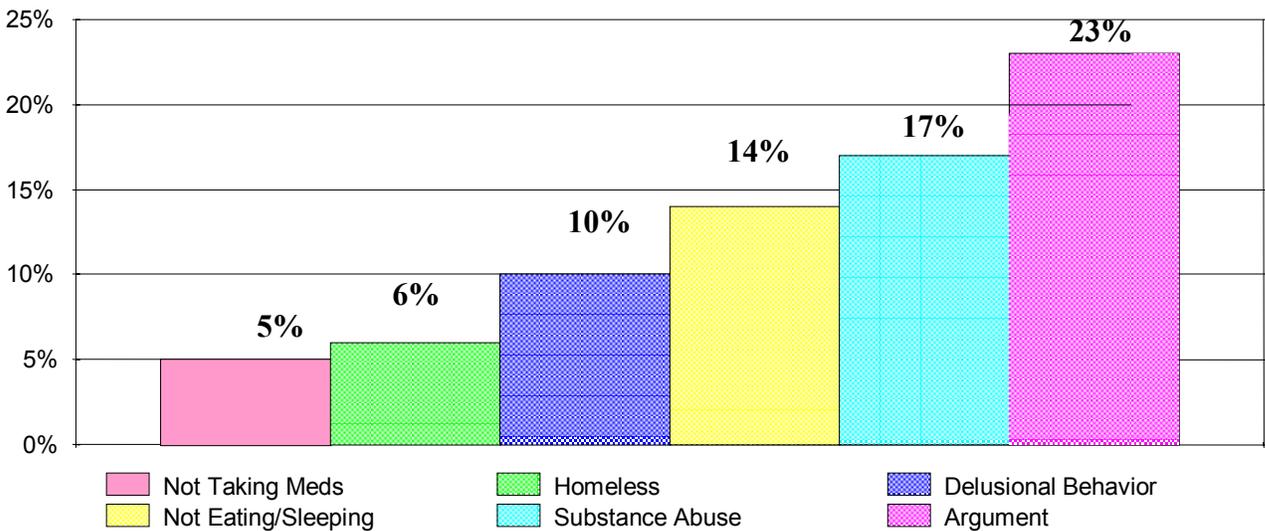
Although Suicidal ideation was the most frequent reason for CPEP presentations, in 83% of cases suicidal intent was denied after admission and persisted in only 17% of cases.



Precipitating Events

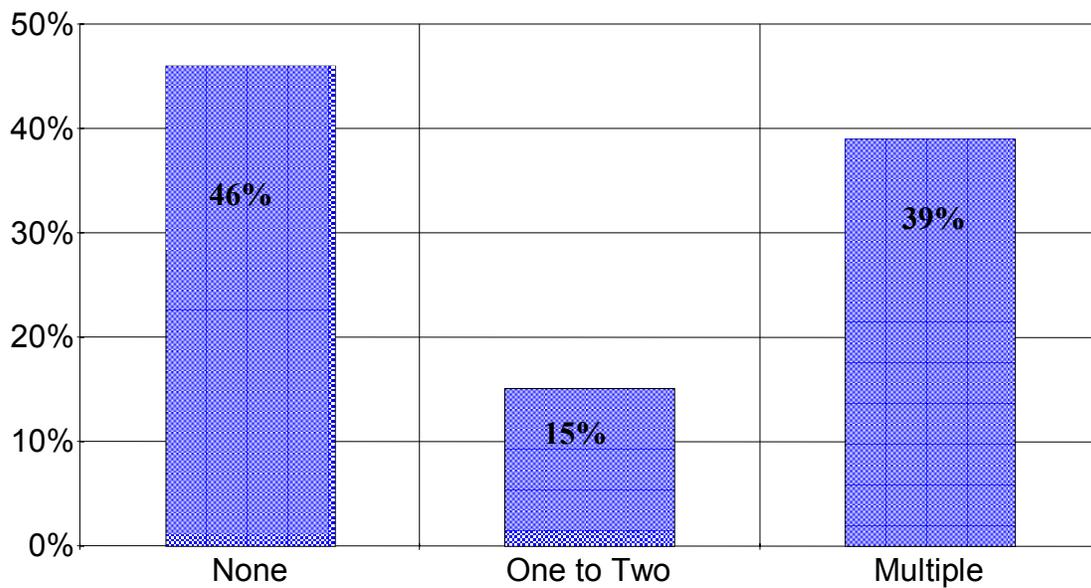
Six Most Commonly Occurring Precipitating Events

The six most frequently occurring events that precipitated CPEP presentations were subjects not taking prescribed psychotropic medications (5% of cases), loss of housing or living undomiciled (6% of subjects), exhibiting delusional behavior (10% of subjects), not eating or sleeping (14% of subjects), abusing alcohol/drugs (17% of subjects), and arguments with others (23% of subjects) that were verbal only (19%) or that involved violence toward others (4%). These behaviors represent what subjects or others reported as the primary event that led to a CPEP presentation. In many cases subjects were concurrently abusing alcohol or drugs as well as exhibiting other behaviors. The abuse of substances is listed here as the precipitating event if it was reported as the *primary* reason for the presentation or the *primary* reason for other behaviors. Thus, for example, if a subject presented at CPEP following an argument with another person and the subject was found to be intoxicated, substance abuse was listed here as the primary precipitating event.

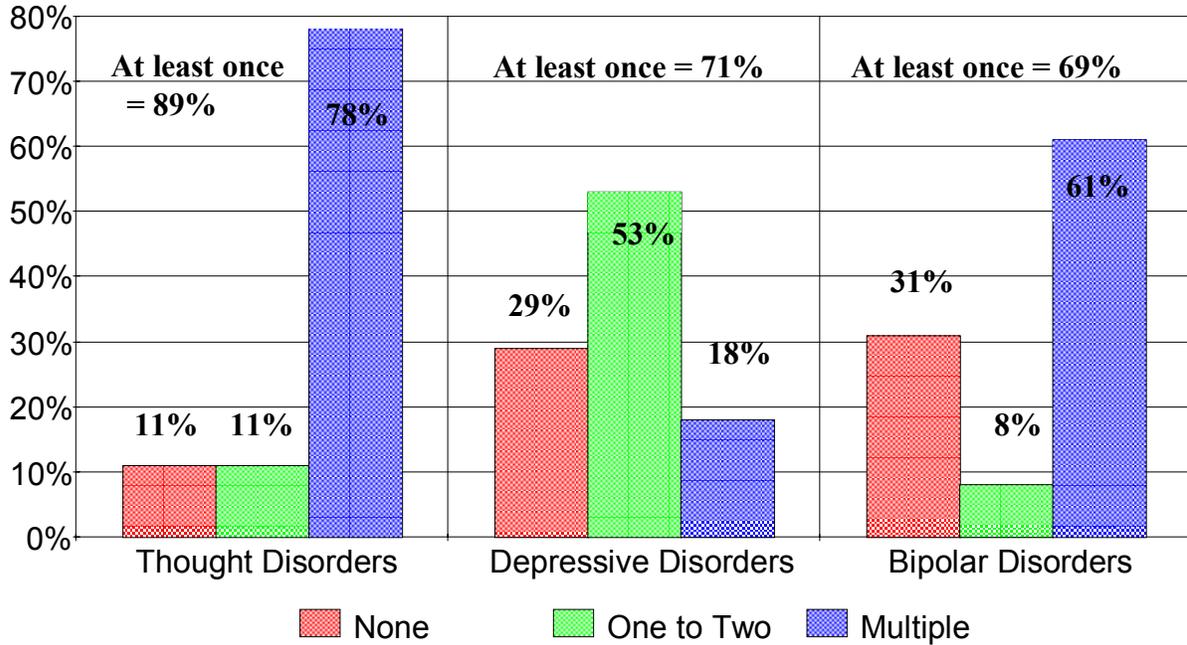


Past Psychiatric Hospitalizations

Fifty-four percent of subjects had at least one psychiatric hospitalization prior to their first admission to CPEP in the target period, while 46% had never been hospitalized. Among those with histories of having been hospitalized, most (71%) had experienced multiple prior inpatient stays. Thirteen percent of subjects had been discharged from a psychiatric unit within 30 days prior to their admission to CPEP.

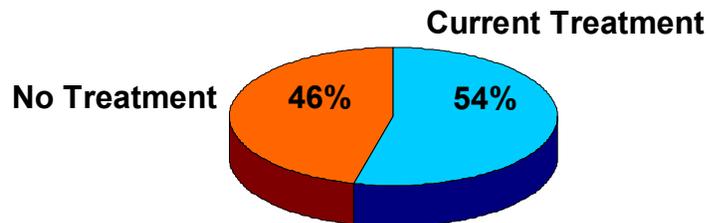


There were significant differences among subjects in the number of prior psychiatric hospitalizations based on diagnostic categories of mental illness. ($\chi^2 = 16.39$, $df = 4$, $p < 0.003$)



Mental Health Treatment

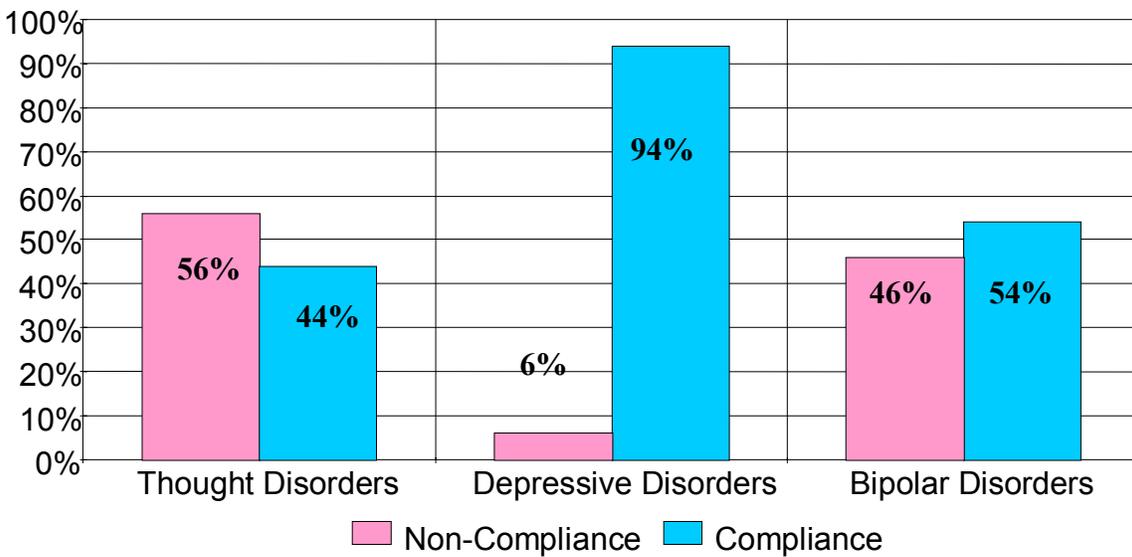
Fifty-four percent of subjects reported having an outpatient mental health treatment provider at the time of their first admission during the target period, while 46% of subjects had no treatment provider.



Histories of Compliance with Outpatient Treatment

History of compliance with outpatient mental health treatment was known for 76 of the 80 subjects. Four subjects had only one CPEP presentation and no history of prior mental health treatment. Twenty-five percent of the subjects, with a known history of prior mental health treatment, had histories of non-compliance with outpatient mental health treatment.

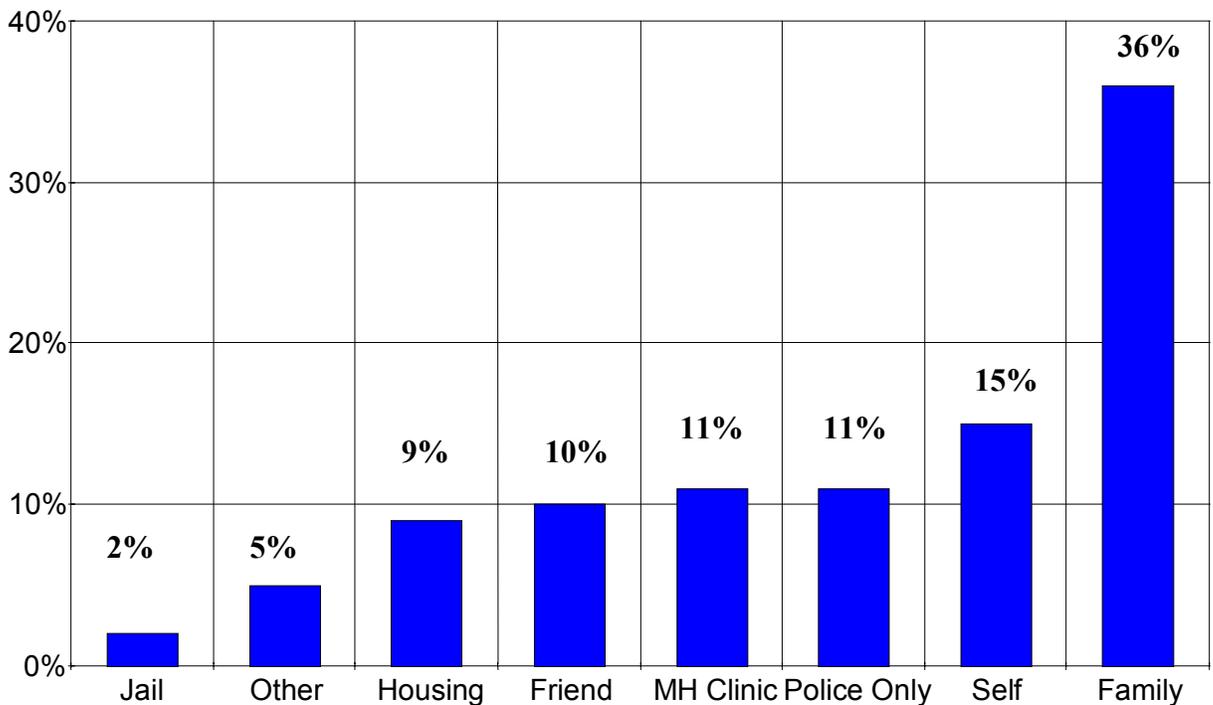
There were significant differences among subjects in the rates of treatment non-compliance based on diagnostic categories of mental illness ($\chi^2 = 10.68$, $df = 4$, $p < 0.03$). Subjects with thought disorders and bipolar disorders were more likely to have histories of non-compliance with outpatient treatment than were subjects with depressive disorders. Among subjects with thought disorders histories of treatment non-compliance occurred more frequently than histories of compliance.



Source of Referral to CPEP

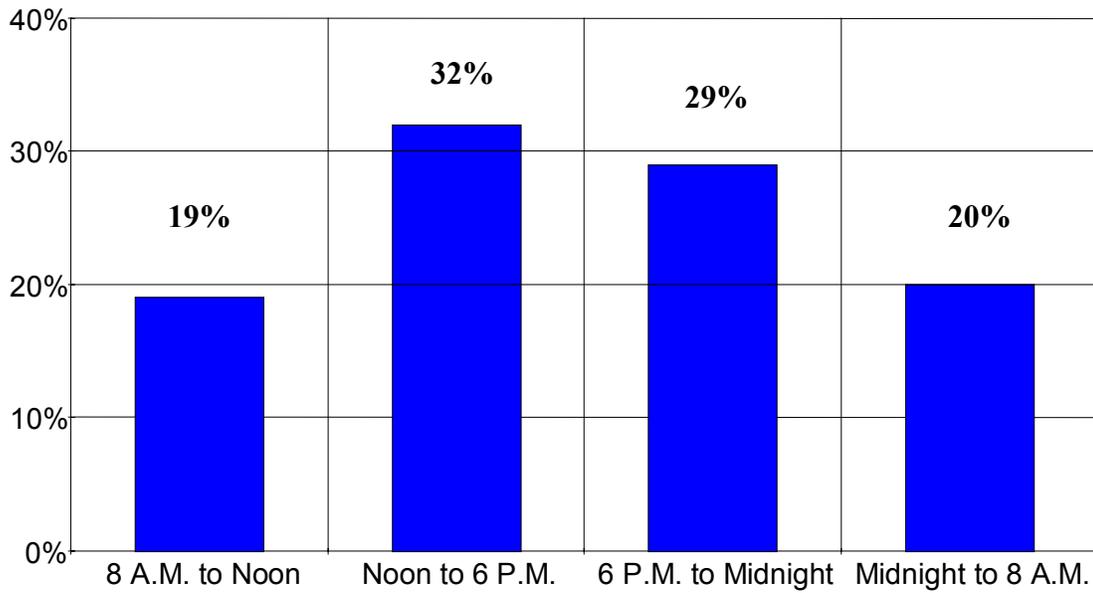
The source of referral is the person or persons who initiated the CPEP presentation. In some cases the referral source may have transported the subject to CPEP or accompanied the subject with a police escort. In other cases the referral source may have called the police to request that the subject be transported to CPEP without accompanying the subject.

- “Police Only” refers to cases in which police responded to a complaint or an incident in the community and determined that the subject required a psychiatric evaluation.
- “Housing” refers to providers of specialized housing (group homes, adult homes).
- “MH Clinic” refers to staff at mental health clinics.



Time of Day of Admissions

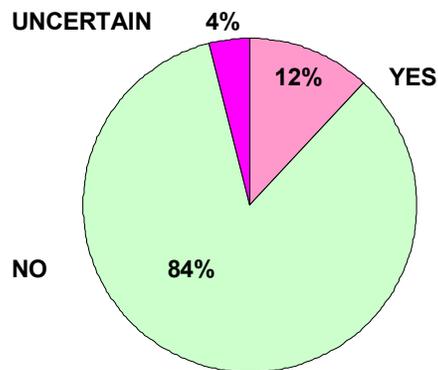
Sixty-one percent of subjects presented at CPEP between noon and midnight. The busiest times of day were noon to 6 P.M. (32% of subjects) and 6 P.M. to midnight (29% of subjects).



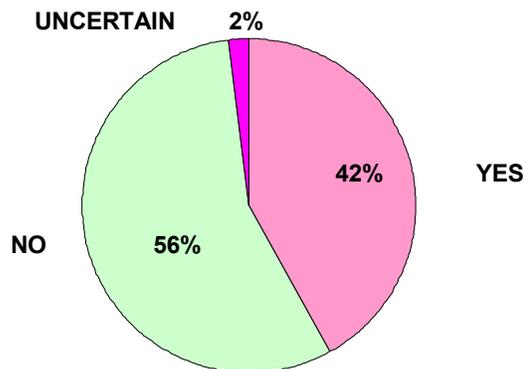
CRIMINAL JUSTICE SYSTEM INVOLVEMENT

Twelve percent of the subjects had some degree of involvement with the criminal justice system (under arrest, awaiting a court action, or under the supervision of probation or parole) at the time of their first admission in the target period. Forty-two percent of the subjects reported having had involvement with the criminal justice system either at the time of their presentation or in the past.

Subjects with Criminal Justice System Involvement at Time of Presentation



Subjects with Criminal Justice System Involvement at Time of Presentation or in the Past

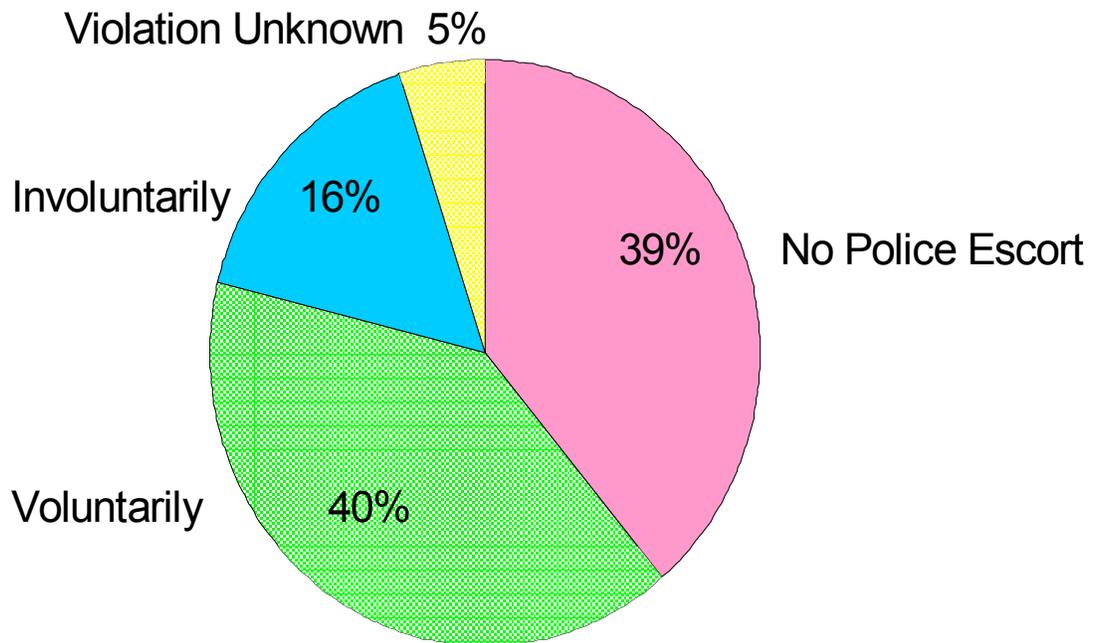


POLICE ESCORTS TO CPEP

POLICE ESCORTS TO CPEP

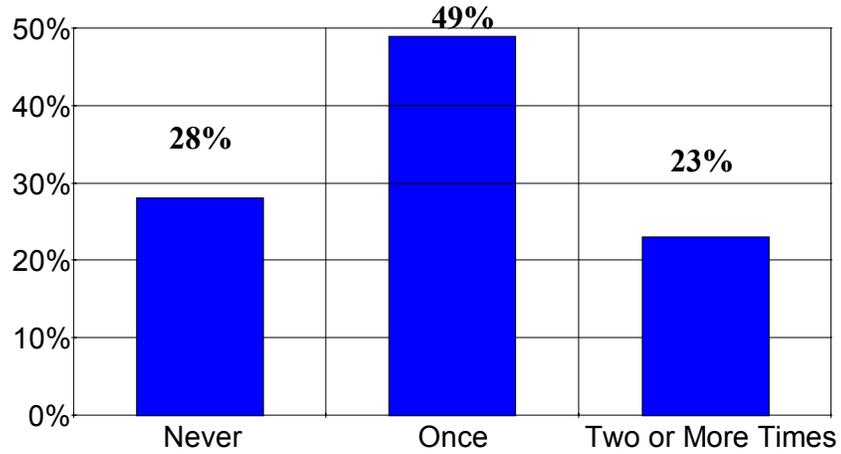
Subjects Escorted by Police at First Admission in Target Period

Sixty-one percent of subjects were escorted by police to CPEP on their first admission in the target period either voluntarily (40%) or involuntarily (16%). In 5% of the cases the police brought subjects to CPEP, but it was unknown whether subjects went voluntarily or involuntarily.



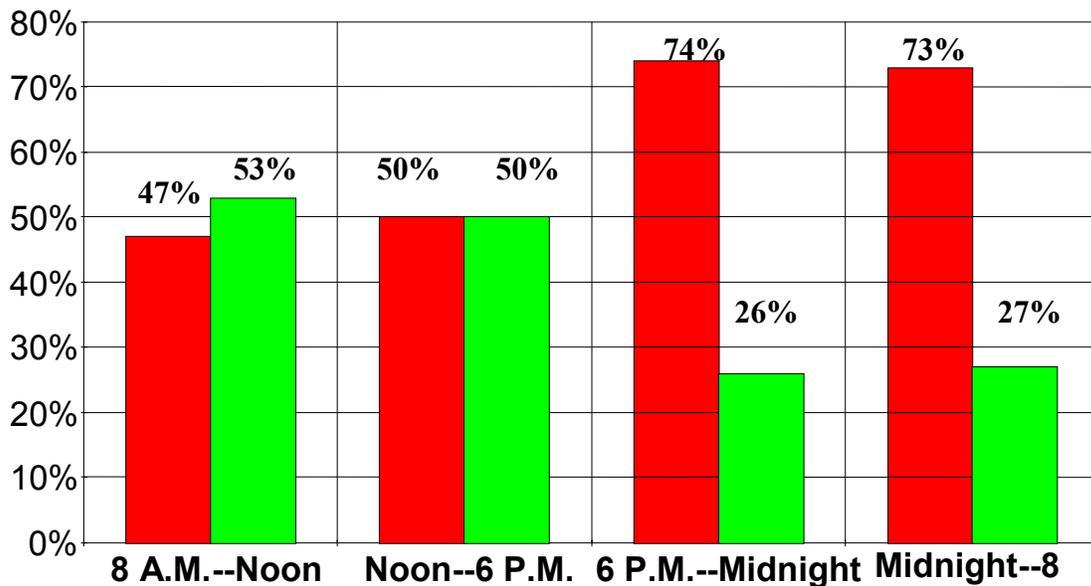
Number of Times Subjects Were Escorted to CPEP by Police Across All Admissions

Only 28% of subjects had never been escorted to CPEP by the police on any admission. Seventy-two percent of subjects had been escorted to CPEP by the police on at least one of their admissions.



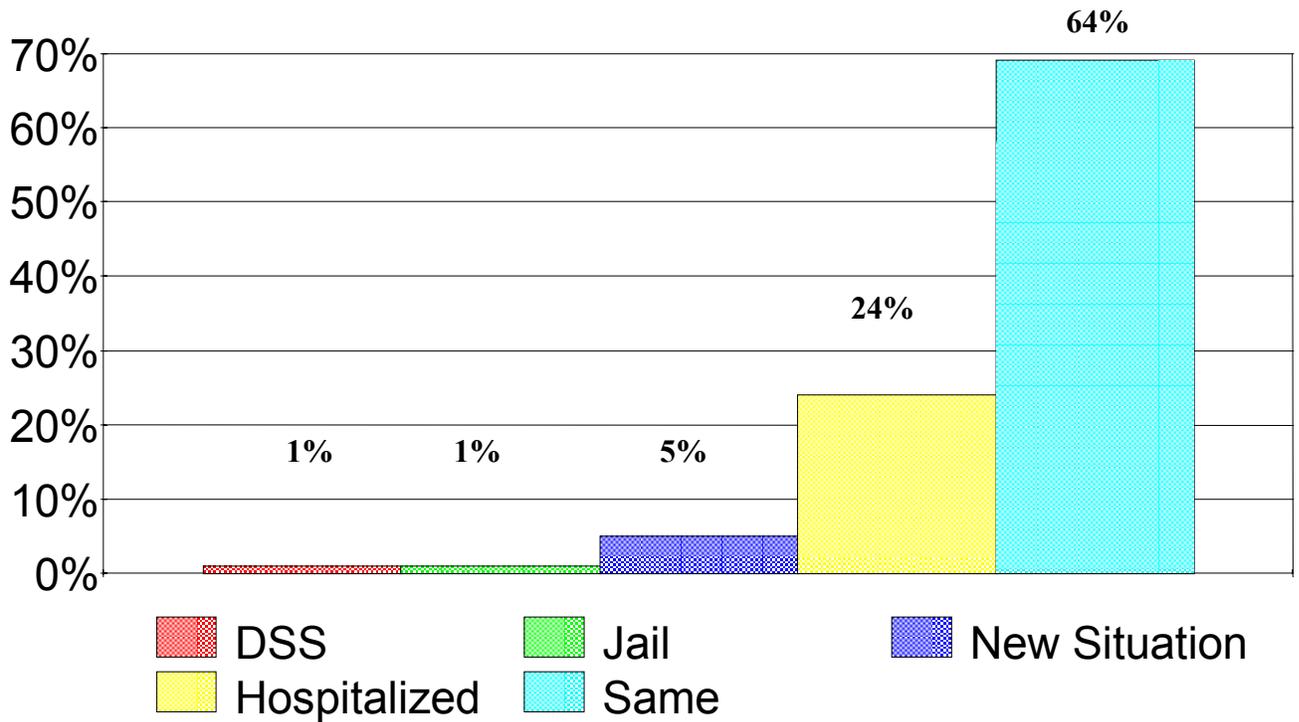
Times of Day When Police Escorts Were Most Frequent

Subjects were most often escorted to CPEP by police during the nighttime and early morning hours.



Discharge Outcomes

In most cases (69%), subjects were discharged to the same living situation they had been in at the time of their presentations. In cases where this occurred, subjects were usually help under observation in CPEP overnight or over a period of hours before being discharged. Subjects who presented in an intoxicated state were detoxified and re-evaluated before discharge. Twenty-four percent of subjects were admitted to psychiatric units in area hospitals. Five percent of subjects were discharged to a new living situation (State-Operated Crisis Residence or a residential substance abuse treatment program). Subjects whose symptoms did not warrant hospitalization and who did not have housing to return to were discharged to DSS emergency housing. Subjects who were under arrest at the time of their presentations were returned to police custody or the custody of the Suffolk County Sheriff's Department.



Suffolk County Police “Emotionally Disturbed Persons” (EDP)
Incidents, Suicide Attempts and Suicides
1988-2001

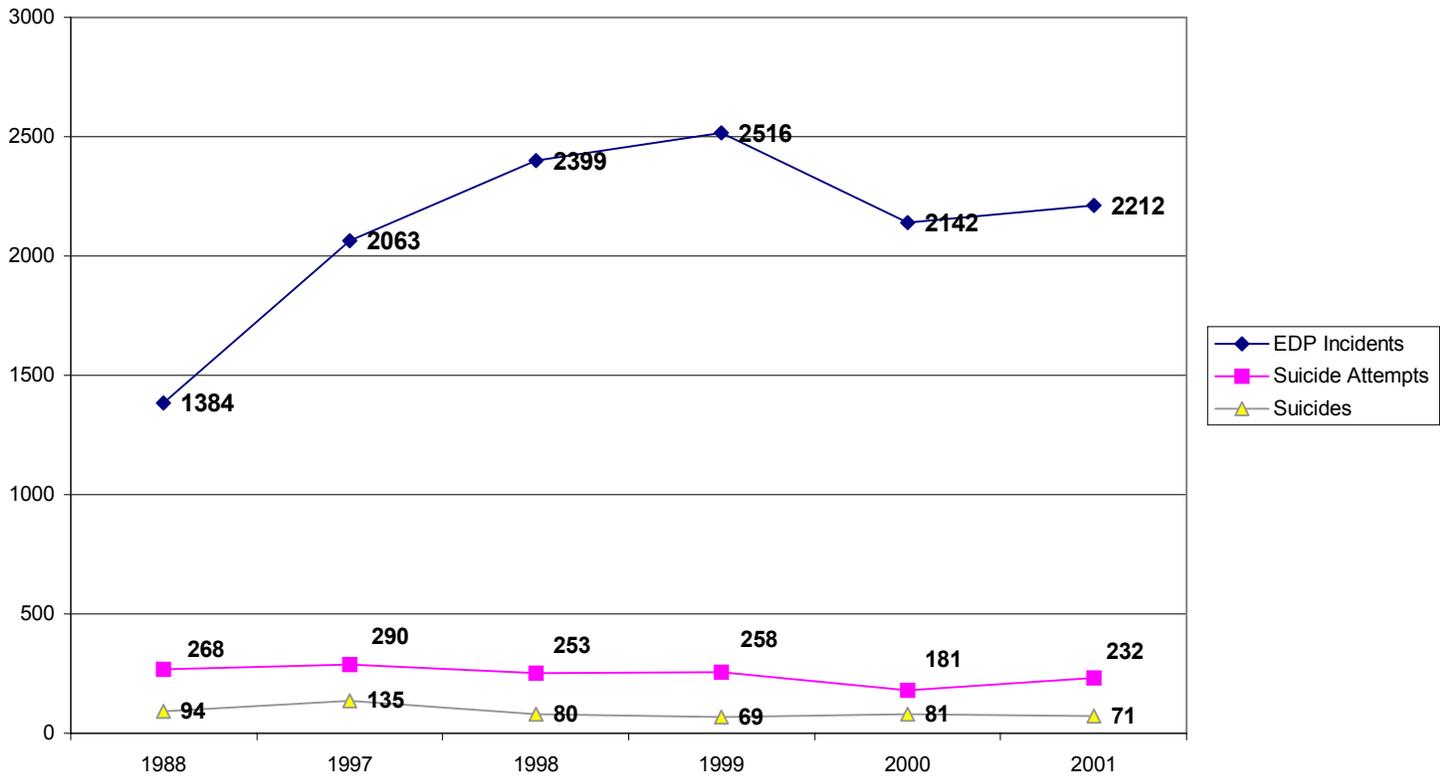
The following represents preliminary statistics provided by Suffolk County Police Department further in depth analysis is underway.

The number of police responses to ‘emotionally disturbed person” (EDP) incidents in Suffolk County increased from 1,384 in 1988 to 2,516 in 1999 or by 1,132 incidents. This represents a 81% increase since 1988. . The number of police responses to EDP incidents rose by 149 incidents since our last analysis, growing from 2063 in 1997 to 2212 in 2001.

**Table 1: Suffolk County Police “Emotionally Disturbed Persons” (EDP)
Incidents, Suicide Attempts and Suicides**

Type of Incident	1988	1997	1998	1999	2000	2001	Number Increase/Decrease 1988-2001	% Increase/Decrease 1988-2001
EDP Incidents	1384	2063	2399	2516	2142	2212	+828	+59.82%
Suicide Attempts	268	290	253	258	181	232	-30	-11.19%
Suicides	94	135	80	69	81	71	-23	-24.46%

Suffolk County Police "Emotionally Disturbed Persons" (EDP) Incidents, Suicide Attempts and Suicides



Mental Illness & Female Offenders Arrested for Prostitution

Social stigma, violence, social exclusion and reduced personal safety are central to the experience of women working as prostitutes. Research validates that women who turn to prostitution are more likely to be victims of abuse than the mainstream population.

Interestingly although prostitutes appear before the courts daily, men who promote prostitution as well as the men who frequent prostitutes are rarely charged. It seems enforcement of the prostitution laws are ambivalent or selective at best. Selective enforcement also takes place among prostitutes so called “high class call girls” and “street workers”. Among these groups arrests seem to be directed at those who are the poorest.

Female offenders who are arrested for prostitution or solicitation are both victims as well as defendants. Current research reveals that approximately 90% of women in the sex trade have been battered by a member of their family, and more than 70% have been sexually abused between the ages of 3 and 14 (Browne, et al. 1999). Another study by Silbert & Pine, (1983) interviewed 200 former and current prostitutes and found that 60% were sexually abused as juveniles by an average of 2 males each. In 81% of the cases, force was used. All but 2% of the subjects reported negative feelings about themselves, men, sex and their mothers. 70% reported that exploitation affected their decision to become a prostitute.

Farley et al. (1998) interviewed 130 people working as prostitutes in San Francisco and found that 82% had been physically assaulted, 83% had been threatened with a weapon and 68% had been raped while working as prostitutes; and 84% reported current or past homelessness. In addition 68% of the people interviewed met DSMIII R criteria for a diagnosis of Post Traumatic Stress Disorder. According to the American Psychiatric Association (1994), Post traumatic Stress Disorder can result when people have experienced “extreme traumatic stressors involving direct personal experience of an event that involves actual or threatened death or serious injury; or other threat to one’s personal integrity; or witnessing an event that involves death, injury, or a threat to the integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.”

Numerous studies found that substance abuse is high among prostitutes and several studies suggest that oftentimes women are lured into prostitution in order to support their drug habit. Farley et al. 1999 reported that 75% of the 130 people working as prostitutes reported having a drug abuse problems.

After reviewing the literature we have found a dearth of information on mental illness and the women working as prostitutes. While the diagnosis of post traumatic stress disorder has been identified as mental disorder frequently experienced by women working as prostitutes (Farley et al. 1999), the nature and prevalence of mental illness within this population has yet to be addressed thoroughly.

Methods & Sample:

The sample consisted of females arrested for prostitution who spent time on the mental observation unit at Riverhead Jail (1989-1999). Prison officials provided researchers with a report of all inmates residing at the mental observation unit, from this list 81 had been on probation. The researchers conducted a chart analysis (probation records) on these 81 offenders.

Demographic Information:

Race/Ethnicity of Female Offenders:

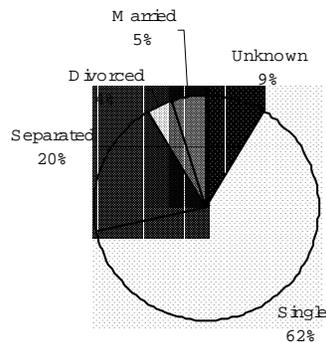
59.3%(n=48)	Black/African American
33.3% (n=27)	White
3.7%(n=3)	Hispanic,
3.7%(n=3)	Unknown racial ethnicity

All offenders with the exception of one spoke English.

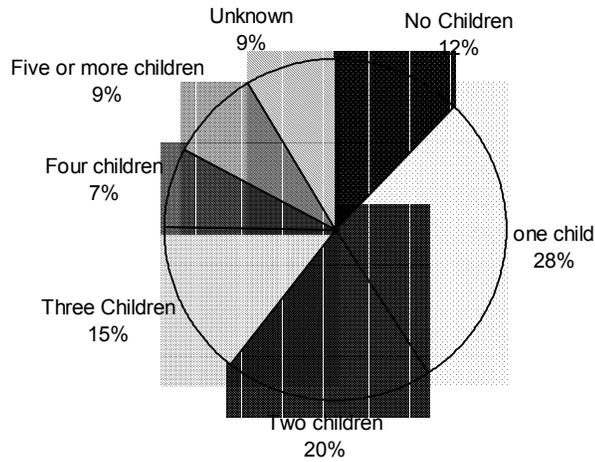
Age of Female Offenders:

Age	% and number
19 or younger	3.7%, n=3
20-25	6.2%, n=5
26-29	12.3%, n=10
30-39	54.3%, n=44
40-51	9.9%, n=8
unknown	13.6, n=11

Marital Status of Female Offenders
who Spent Time on the Mental Observation Unit
at Riverhead Jail
1989-1999

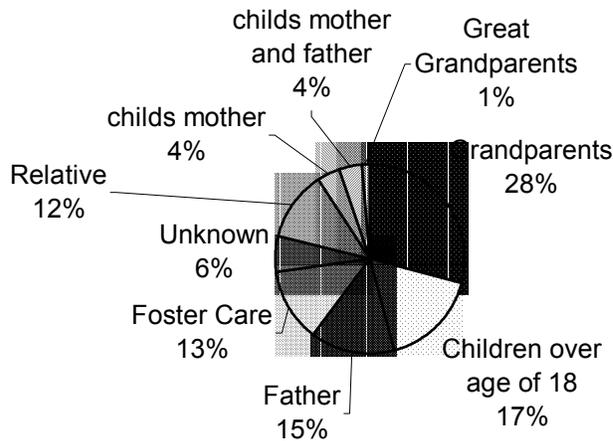


**Female Offenders
who Spent Time on the Mental Observation Unit
at Riverhead Jail 1988-1999
and Number of Children**



Approximately, one third of these offenders had three or more children. Cumulatively, there were 151 children born to these 81 offenders. The following chart consists of who had custody of these children:

Who has Custody of the Female Offenders Child or Children



Education Level of Female Offenders:

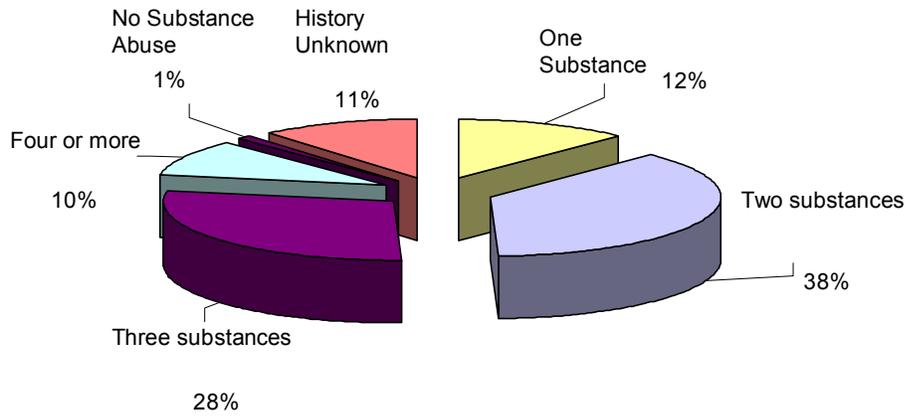
Education Level	Number and % of Sample
Some College or Completed College	11% (n=9)
Completed High School	30% (n=24)
Drop Out	38% (n=31)
GED	9% (n=7)
Unknown	12% (n=10)

Substance Abuse:

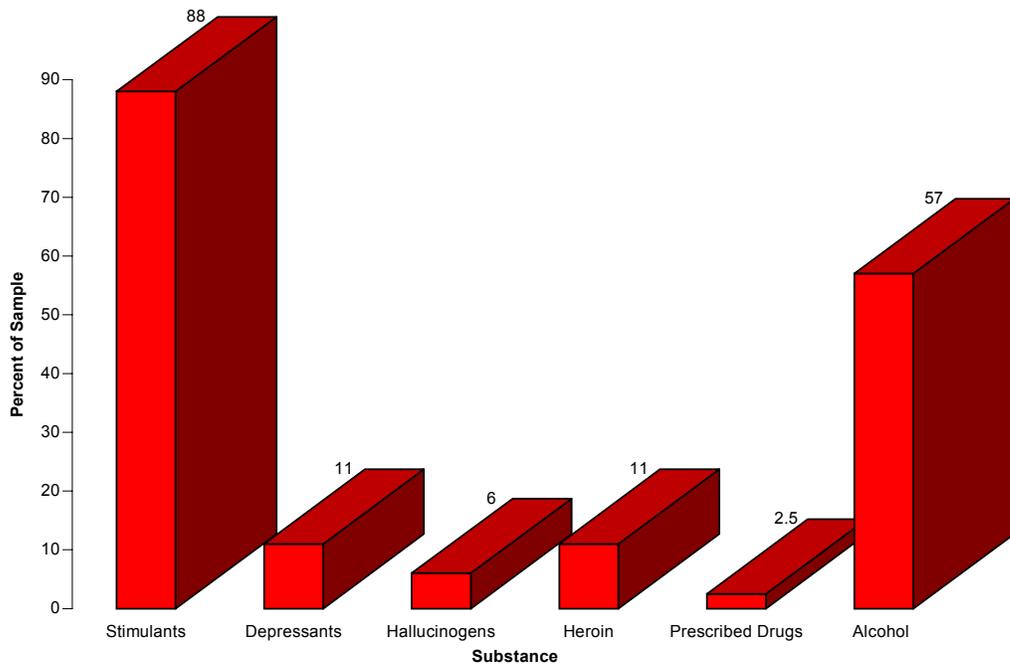
Approximately 90% of the offenders have histories of substance use/abuse.

stimulant use	87.7% (n=71)
depressant use	11.1% (n=9)
other drug use	18.5% (n=15)
hallucinogenic drug use	6.2% (n=5)
heroin use	11.1% (n=9)
prescribed drug abuse	2.5% (n=2)

**Drug Abuse and
Female Offenders arrested for Prostitution
Number of Substances Abused**

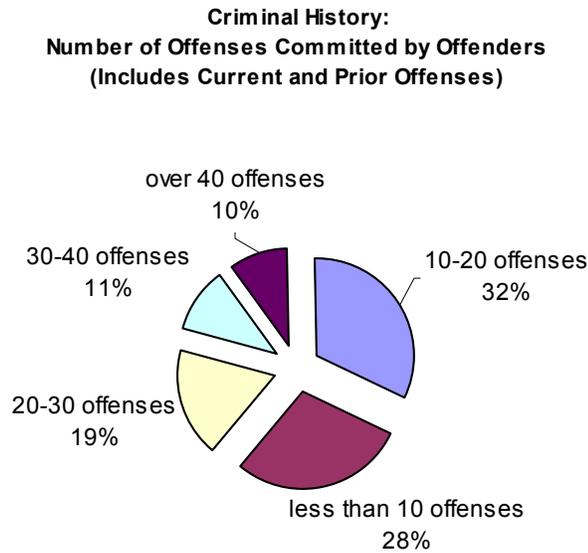


Substance Abuse & Female Offenders Arrested for Prostitution



Criminal Justice Data

Over two thirds (79%, n=64) of the offenders were placed in jail more than one time. The total number of current and prior offenses committed by the offenders is 1,618. These are offenses for which the offenders were arrested; they do not represent final charges after disposition.



Types of Crimes Committed:

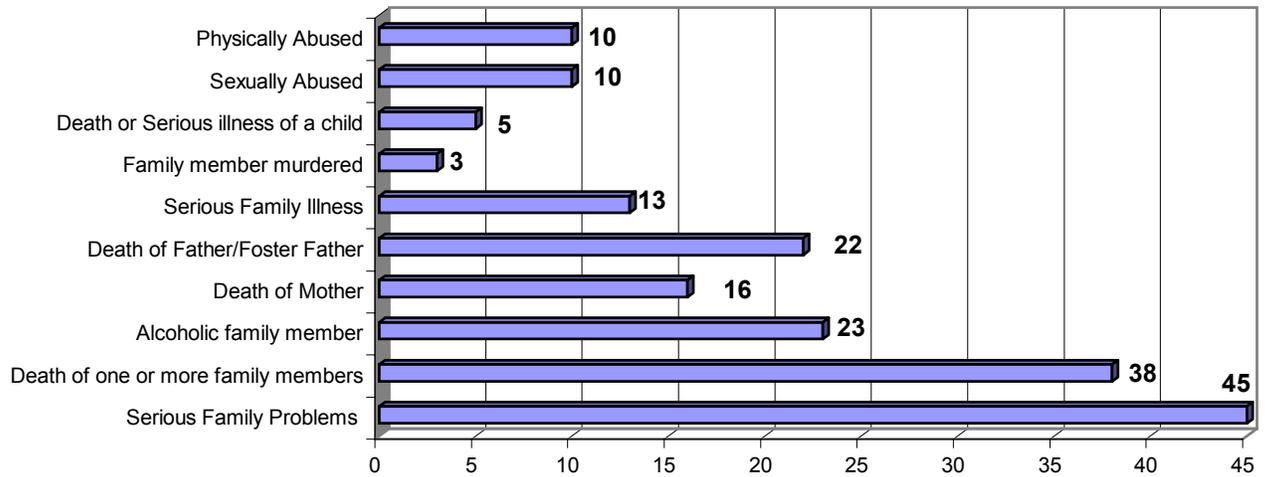
55.8% of all offenses (904) committed by these offenders were in the public disorder category. Of the offenses in the public disorder category, 54.3% (491) were for prostitution; this is 30.3% of all offenses. 18.7% of all offenses (303) were drug related offenses; 17.3% (280 offenses) were property offenses; and 8.1% (131 offenses) were violent offenses.

Almost 40% (n=34) of offenders were arrested for prostitution 6 times or more .

Family Data:

Family data contained in this report are based upon information within the case files. However, *it is likely that these figures are conservative*, given the fact that these are not standard questions within the probation interview. These figures represent only self reported information. Over half of the women, 55.6% (n=45), had serious family problems. Approximately half, 46.9% (n=38), reported one or more deaths of family members. Almost one third report, 28.4% (n=23), that they grew up with a family member who abused alcohol. 25.9% (n=21) were raised by only one parent. 19.8% (n=16) of offenders experienced the death of a mother and almost one third, 27.2% (n=22), reported the death of a father or foster father. 16% (n=13) of these offenders had serious family illnesses.

Stressors and the Female Offender



71.6% (n=58) of the sample had parents who became separated due to divorce, death, etc. The age of the offender when the separation occurred is unknown for 36.2% (n=21) of the subsample. 20.7% (n=12) of the subsample were less than 1 year old at the time. 15.5% (n=9) of the subsample were from 2-9 years old at the time. 12.1% (n=7) of the subsample were from 11-15 years old. 8.6% (n=5) of the subsample were from 20-25 years old, and 6.9% (n=4) were from 27-30 years old.

Mental Health

A majority, 82.7% (n=67), of the offenders had histories of mental health problems. Below are the categories of mental health problems.

Substance Abuse	MOOD Disorder
Psychoactive substance use disorders Marijuana abuse Drug psychosis Poly-substance inhalant PCP abuse PCP intoxication Polysubstance abuse Substance abuse Psychotic disorder probably due to drug use Cocaine dependence	Major Depression Depression
Bipolar Disorder	Adjustment Disorders
Psychotic Disorders: Psychotic Dis. NEC-NOF Psychotic Dis. NEC-schizoaffective Schizophrenia Paranoid R/O Other psychotic disorders	Other Overanxious reaction of adolescence Conduct disorder, socialized aggressive Conduct disorder R/O Organic mental disorder Emotional problems Hyperactivity Emotional problems

Conclusion

Although women represent a small percentage of jail inmates, studies show they are more likely than men to be diagnosed with a serious mental illness. Women are typically under-served in correctional settings in all types of programming. The National Institute of Justice's Drug Use Forecasting program indicates that 67% of female arrestees test positive for drugs. Lifetime prevalence rates of alcohol abuse dependence and drug abuse dependence disorders also reveal that female detainees are more likely than male detainees to be diagnosed with drug disorders. The rates of substance abuse are even higher for persons diagnosed with a mental disorder. In this study, we found that almost 90% of these offenders had histories of stimulant abuse and almost 80% were placed in jail more than once. In fact, 40% were arrested for prostitution six times or more. The cost of repeated incarcerations is great and does not seem to break the cycle. A possible alternative to costly incarceration would be to provide these women with substance abuse and mental health treatment in conjunction with criminal justice supervision.

A Closer Look at Individuals with Serious and Persistent Mental Illnesses in the Suffolk County Criminal Justice System

In our first report (*Assessing the Nature and Prevalence of the Mentally Ill in Suffolk County's Criminal Justice System*) we described individuals with mental illness who were involved in the Suffolk County criminal justice system. We based this upon a sample of 1542 persons with mental illness who were either on probation, parole, or in the jail as of 1999.

Of the 1542 subjects identified in our first study, 797 of them (52% of the entire sample) had known diagnoses of either thought disorders (schizophrenia, schizoaffective disorder, psychotic disorder NOS) or mood disorders (depressive disorders or bipolar disorders). These 797 subjects were selected for the present analysis.

In order to gain further information regarding the relationship between mental illness, substance abuse, and encounters with the criminal justice system, we examined data from the Suffolk County Mental Health Project (SCMHP). The SCMHP is an ongoing longitudinal study of 625 individuals with serious and persistent mental illnesses in Suffolk County. The study is being conducted by Dr. Evelyn Bromet of the Department of Psychiatry at University Hospital and Medical Center at the State University of New York at Stony Brook. This study, which has been ongoing for over ten years, is funded by the National Institute of Mental Health.

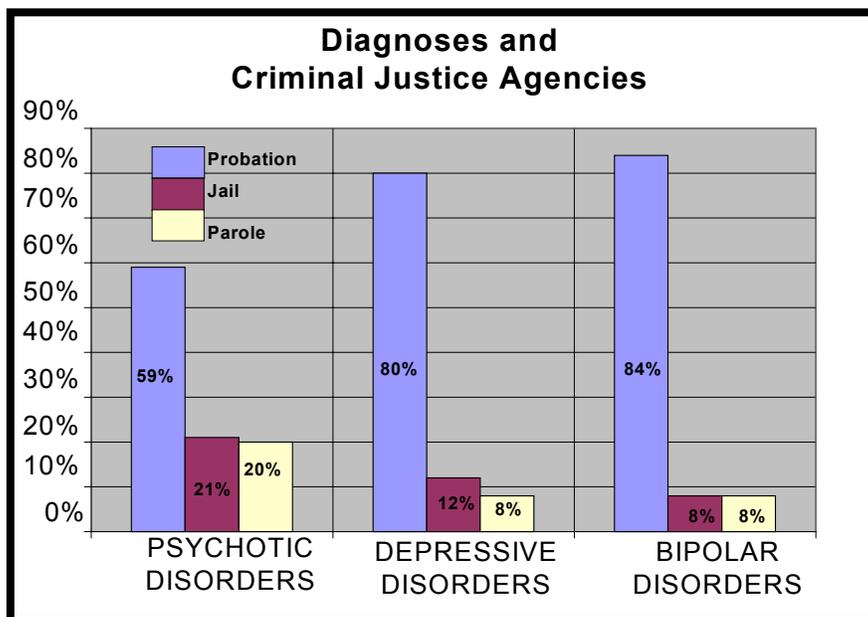
In the SCMHP, all of the subjects were selected for participation following their first ever hospitalization for a mental illness that involved symptoms of psychosis (i.e., thought disorders and mood disorders with psychotic features). Detailed data has been recorded from all of the subjects regarding their race/ethnicity; gender; family, educational, and medical histories; their living situations; the courses of their illnesses; their mental health treatment; and their social support systems. For the purpose of the present analysis, 74 of these subjects who had experienced criminal incarceration during the course of their participation in the study were selected and compared with a control group of 74 subjects matched for age, gender, and race/ethnicity who did not have any histories of criminal justice system involvement. During the selection process, an additional group of 21 subjects who had histories of being arrested but never incarcerated were found. These 21 subjects were held in a separate third group.

The results of the analyses from these two sources of data is summarized below:

- Individuals with histories of criminal justice system involvement were less consistent in receiving mental health treatment than individuals who did not have histories of encounters with the criminal justice system. The lower levels of mental health treatment were not attributable to periods of incarceration.
- Substance abuse was high in all subjects regardless of whether or not they had histories of criminal justice system involvement. For

subjects with histories of involvement in the criminal justice system the rate of substance abuse was even higher.

- Symptoms of mental illness were more strongly correlated with anti-social traits than was substance abuse.
- In spite of the high rates of substance abuse, rates of treatment for substance abuse were low for all subjects with such histories, regardless of whether or not they had involvement with the criminal justice system.

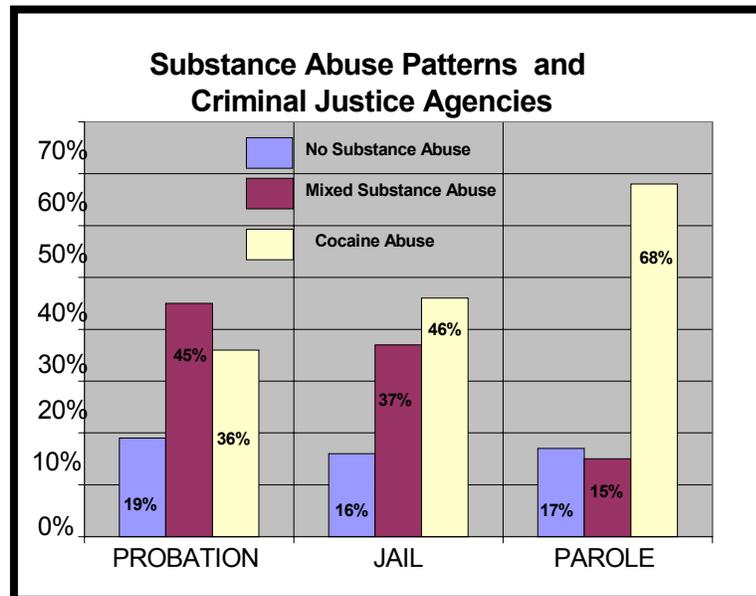


Subjects with psychotic disorders were more frequently found in jail and parole (41%) than subjects with mood disorders. Only 59% of subjects with psychotic disorders were found in probation.

A closer examination of these findings revealed that subjects with mood disorders were more likely to be found in jail and parole when they also had histories of cocaine abuse. In subjects with psychotic disorders, however, there was no association between patterns of substance abuse and the criminal justice agencies in which they were found.

Substance Abuse and Criminal Justice Agency

Cocaine abusers were more likely to have been found in jail or parole and least likely to be found in probation. Subjects in the mixed substance abuse category were most likely to have been found in probation. Subjects with no histories of substance abuse were in the minority and were fairly evenly distributed across criminal justice agencies.



Patterns of substance abuse were classified as follows:

No Substance Abuse: Subjects did not have any histories of substance abuse.

Mixed Substance Abuse: Subjects had histories of substance abuse that involved the abuse of alcohol and/or the abuse of street drugs, but that did *not* include the abuse of cocaine. Most of the subjects in this category had histories of alcohol only abuse or alcohol and marijuana abuse. Some of these subjects also had histories of heroin abuse and the abuse of hallucinogenic drugs.

Cocaine Abuse: Subjects had known histories of substance abuse that included cocaine.

The rates of substance abuse were high in both the SCCJCC study (78% of all subjects) and the SCMHP study (72% of all subjects).

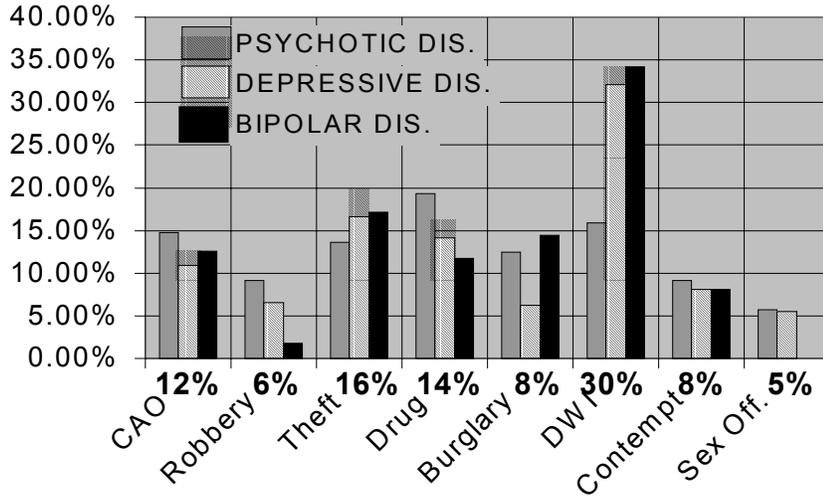
Among the 797 subjects examined in the SCCJCC study, 78% had known histories of substance abuse. In the cohort from the SCMHP study, the overall rate of substance abuse was 72%. Among the subjects with histories of criminal justice system involvement the rate of substance abuse was 84%.

Interestingly, the rates of cocaine abuse in the SCCJCC study and in subjects with criminal justice system involvement in the SCMHP study were each 38%, suggesting a strong association between this substance in particular and criminal justice system involvement.

Among the subjects in the SCMHP study with no histories of criminal justice system involvement, the rate of substance abuse was 57%. This finding suggest that the actual rate of occurrence of problems with substance abuse among individuals with serious and persistent mental illnesses in Suffolk County may be greater than the rate of 20% reported by the New York State Office of Mental Health for 1995 (the most recent year for which OMH has statistics).

The almost identical rates of cocaine abuse among subjects who all have criminal justice system involvement in both studies suggests that this substance is strongly associated with the kinds of anti-social behaviors that result in encounters with the criminal justice system. However, the surprisingly high rate of substance abuse among subjects with no history of criminal justice system involvement suggests that substance abuse alone (at least in the absence of cocaine abuse) does not fully account for encounters with the criminal justice system.

Types of Crimes by Diagnostic Categories



CAO Crimes against others represented 12% of the types of crimes. They represented 15% of the crimes committed by subjects with psychotic disorders, 11% of the crimes committed by subjects with depressive disorders, and 13% of the crimes committed by subjects with bipolar disorders.

Robbery Robberies represented 6% of the types of crimes. They represented 9% of the crimes committed by subjects with psychotic disorders, 7% of the crimes committed by subjects with depressive disorders, and 5% of the crimes committed by subjects with bipolar disorders.

Theft Thefts represented 16% of the types of crimes. They represented 14% of the crimes committed by subjects with psychotic disorders, 17% of the crimes committed by subjects with depressive disorders, and 17% of the crimes committed by subjects with bipolar disorders.

Drug-Related Drug-Related crimes represented 14% of the types of crimes. They represented 19% of the crimes committed by subjects with psychotic disorders, 14% of the crimes committed by subjects with depressive disorders, and 12% of the crimes committed by subjects with bipolar disorders.

Burglary Burglaries represented 8% of the types of crimes. They represented 12% of the crimes committed by subjects with psychotic disorders, 6% of the crimes committed by subjects with depressive disorders, and 14% of the crimes committed by subjects with bipolar disorders.

DWI DWI's represented 30% of the types of crimes. They represented 16% of the crimes committed by subjects with psychotic disorders, 32% of the crimes committed by subjects with depressive disorders, and 34% of the crimes committed by subjects with bipolar disorders.

Contempt Criminal contempt charges represented 8% of the types of crimes. They represented 9% of the crimes committed by subjects with psychotic disorders, 8% of the crimes committed by subjects with depressive disorders, and 8% of the crimes committed by subjects with bipolar disorders.

Sex Offenses Sex offenses represented 5% of the types of crimes. They represented 6% of the crimes committed by subjects with psychotic disorders and 5% of the crimes committed by subjects with depressive disorders. None of the subjects with bipolar disorders was arrested for a sex offense.

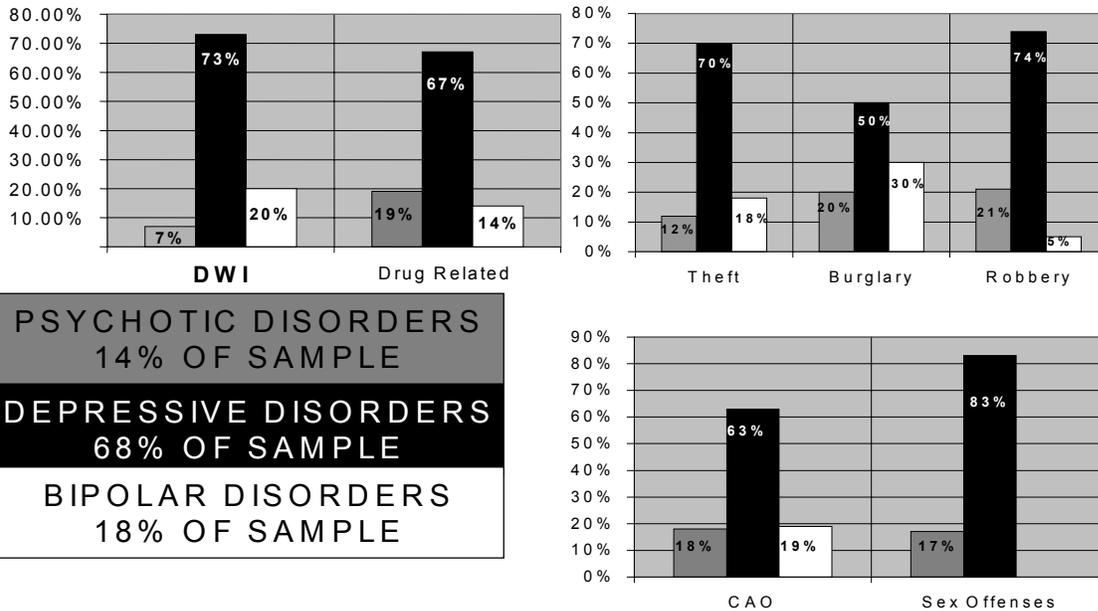
Type of Crime According to Diagnostic Categories

Subjects with **psychotic disorders** represented 14% of the sample. They were under-represented in the DWI category, and over-represented in drug-related crimes, burglary, robbery, crimes against others, and sex offenses.

Subjects with **depressive disorders** represented 68% of the sample. They were under-represented in burglaries and crimes against others. They were, however, over-represented in robberies. They were also significantly over-represented in sex offenses.

Subjects with **bipolar disorders** represented 18% of the sample. They were under-represented in drug-related offenses and robberies. None of the subjects with bipolar disorders had been arrested for a sex offense. Subjects with bipolar disorders were over-represented in DWI's and burglaries.

Percent of Crime Types by Diagnostic Categories



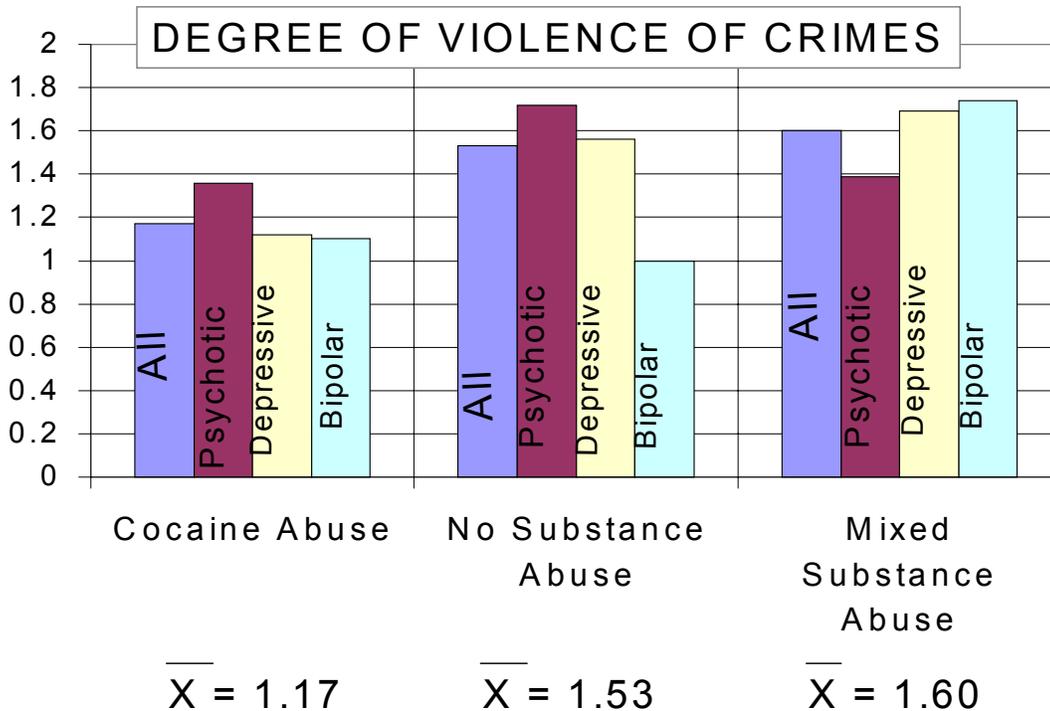
There was a more even distribution in the types of crimes among subjects with **psychotic disorders**. No one particular type of crime represented more than 20% of the subjects in this diagnostic group.

Among subjects with **mood disorders** (depressive disorders and bipolar disorders) DWI's and drug-related crimes represented 46% of the types of crimes committed.

The table below indicates the percentage of crimes directly related to substance abuse (DWI and drug-related crimes) and the percentage of crimes that are often associated with drug-seeking behavior (theft, burglary, robbery) in each diagnostic category.

The smaller proportion of subjects with psychotic disorders who had been arrested for DWI may be a reflection of the possibility that their illnesses prevented them from having access to motor vehicles and drivers licenses. The influence of substance abuse within this diagnostic category can be seen in their over-representation in drug-related crimes, and other crimes, such as burglary and robbery, that may have been associated with drug-seeking behavior.

<i>Diagnostic Categories</i>	<i>Crimes Directly Related to Substance Abuse (DWI & Drug-Related)</i>	<i>Crimes Associated with Drug Seeking Behavior (Theft, Burglary, Robbery)</i>	<i>Total Percentage of Crimes Associated with Substance Abuse</i>
PSYCHOTIC DISORDERS	35%	35%	70%
DEPRESSIVE DISORDERS	46%	29%	75%
BIPOLAR DISORDERS	46%	33%	79%



The degree of violence of the crimes for which subjects had been arrested was assessed on a 4-point scale as follows:

- 1= non-violent crime
- 2= potentially dangerous crime (i.e., dangerous to others)
- 3= potentially very dangerous crime
- 4= violent crime

All crimes that involved aggression toward others were categorized as violent crimes (crimes against others, robberies, sex offenses). Burglaries were scored as potentially dangerous. Crimes such as reckless endangerment were scored as potentially very dangerous.

While scores ranged from 1 to 4, the highest overall mean level of violence for the entire sample did not exceed 1.80.

In general, subjects with histories of cocaine abuse had the lowest mean level of violence score (1.17), while subjects with no histories of substance abuse had the highest mean level of violence score (1.60). While this finding may appear to be inconsistent with the degree of violent behavior that is generally associated with cocaine abuse, this finding may be explained by the fact that cocaine abusers were more frequently convicted of drug-related crimes (sale/possession), which were scored as non-violent crimes.

There was no statistically significant difference in the levels of violence of crimes based on patterns of substance abuse in subjects with **psychotic disorders**, although in this diagnostic category, subjects with no histories of substance abuse had slightly higher level of violence scores.

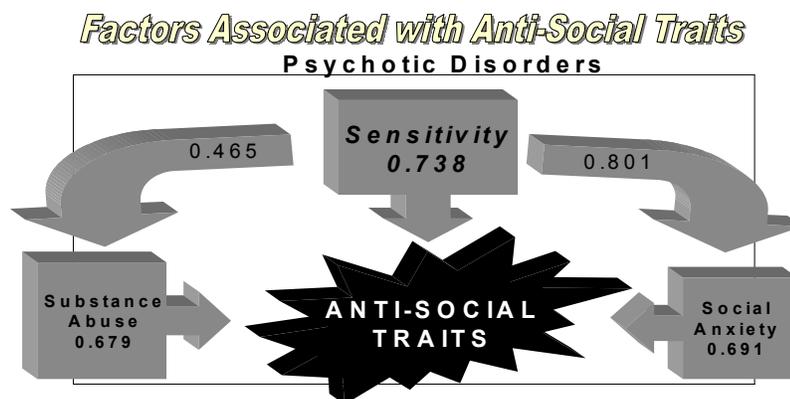
Statistically significant differences in the mean level of violence scores based on patterns of substance abuse were observed among subjects with **mood disorders**.

While there appeared to be a strong association between substance abuse and criminal justice system involvement, further evaluation revealed that symptoms of mental illness were more strongly correlated with anti-social traits than substance abuse.

The symptoms of illness that were most strongly associated with anti-social traits differed according to psychiatric diagnoses, which further supports the probability that substance abuse plays an ancillary role in encounters with the criminal justice system.

In subjects diagnosed with psychotic disorders, sensitivity proved to be the factor that was most strongly associated with anti-social traits. Sensitivity was measured by the SCMHP research team using a Structured Interview for Schizotypy (SIS) in response to questions regarding subject's self-rated assessments of the degree to which they are sensitive to remarks made about them, the amount of time it takes them to get over negative comments, the degree to which they view themselves as "touchy", and the degree to which they experience performance anxiety. The second most strongly correlated factor was social anxiety, which did not prove to have a predictive value due to its strong collinearity with sensitivity. The next most strongly correlated factor was a subject's substance abuse status (no substance abuse, mixed substance abuse, cocaine abuse).

In a stepwise attempt to construct a regression model to predict anti-social traits in individuals with psychotic disorders, sensitivity and substance abuse status proved to be the two factors with the least degree of collinearity ($r = 0.465$) and the greatest predictive value ($R^2 = 68.89\%$). This suggests that symptoms of illness (manifested as sensitivity) are more strongly correlated with the kinds of anti-social behavior associated with encounters with the criminal justice system than is substance abuse in individuals with psychotic disorders. Substance abuse appears to be



In subjects diagnosed with **mood disorders** (depressive disorders and bipolar disorders) irritability proved to be the factor that was most strongly correlated with anti-social traits. Irritability was measured by the SCMHP research team using a Structured Interview for Schizotypy (SIS) in response to questions regarding subjects' self-rated assessments of the frequency with which they lose their tempers, the degree to which they viewed themselves as having a bad temper, how often they felt angry inside, their responses to feelings of anger.

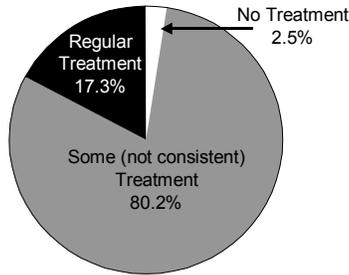
The second most strongly correlated factor was subjects' adolescent anti-social traits. Subjects who had strong anti-social traits as adults tended to also have had such traits as juveniles. Adolescent anti-social traits did not have any correlation with adult irritability.

Subjects' substance abuse status was the third most strongly correlated factor, although its association with adult anti-social traits was much weaker ($r = 0.548$). Cocaine abuse was somewhat more strongly correlated with adult anti-social traits ($r = 0.584$).

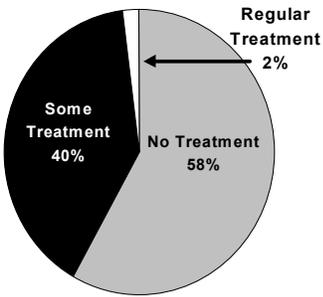
In a stepwise attempt to construct a regression model to predict anti-social traits in individuals with mood disorders, irritability and adolescent anti-social traits proved to be the two factors with the greatest predictive value ($R^2 = 63.20\%$). As was the case in subjects with psychotic disorders, symptoms of illness (as manifested in irritability) proved to be more strongly associated with the kinds of anti-social behaviors that result in encounters with the criminal justice system than substance abuse. In the case of subjects with mood disorders, substance abuse appeared to have a less closely associated ancillary role after irritability.

The levels of consistent mental health treatment received by the subjects in the SCMHP study were low for most subjects. The type and frequency of mental health treatment received had been tracked by the SCMHP research team at six month intervals. A scale that ran from zero (no treatment) to three (consistent participation in treatment across a six-month interval) was used for this study.

Levels of Mental Health Treatment



Levels of Substance Abuse Treatment



When this scale was first developed, consistent treatment was defined as once per month medication visits and/or weekly psychotherapy sessions. Participation in day programs, partial hospitalization programs, etc. was scored as consistent if participation was daily. When this criteria was applied, mean level of treatment scores for the entire sample were extremely low. As it turned out, this definition of regular, consistent treatment was common before 1995, as evidenced by what was recorded in each subject's records. After 1995, subjects who had been receiving consistent treatment were commonly being seen bi-monthly (or even every three months) for medication management and bi-weekly (or only monthly) for psychotherapy sessions. Participation in day programs also seemed to drop to two to three times per week after 1995. Thus, these levels of care were used as the definition of regular, consistent treatment to reflect what appeared to be the commonly offered frequency of treatment after 1995.

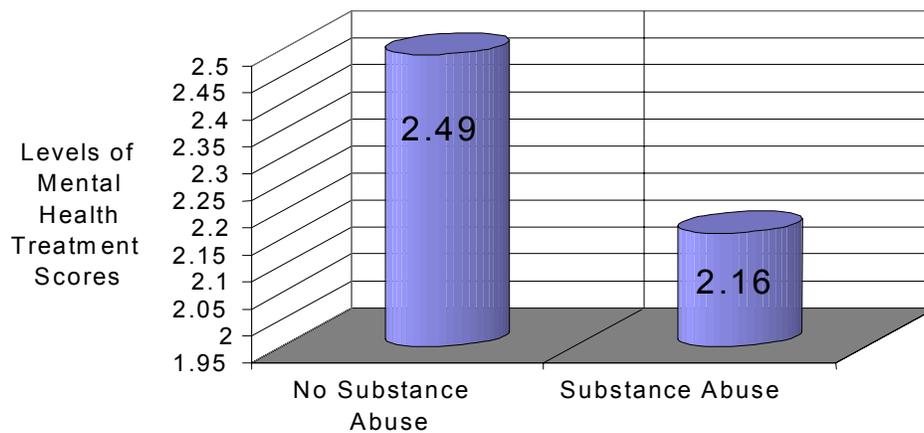
Even with this more liberal definition of consistent treatment, only 17.3% of subjects received a score of 3. For the vast majority of subjects (80.2%) participation in treatment was not regularly consistent across each six-month interval during the four years measured.

Levels of consistent substance abuse treatment were very low for all subjects, regardless of their patterns of substance abuse or degree of involvement with the criminal justice system.

Regular treatment was defined as consistent participation in outpatient counseling, periods of inpatient care, residential treatment, and/or consistent attendance at community AA/NA meetings.

Most subjects who received treatment moved in and out of treatment, staying with it for a month or two and then dropping out for periods of time before returning to treatment. In subjects who had involvement with the criminal justice system, regular treatment seemed to occur following an arrest or a period of incarceration. However, after an initial period of 6 months of regular treatment, most appeared to drop out of treatment altogether, only to re-enter it after another arrest or significant life event (i.e., loss of a job, loss of a relationship, loss of family support, loss of housing, psychiatric hospitalization, etc.).

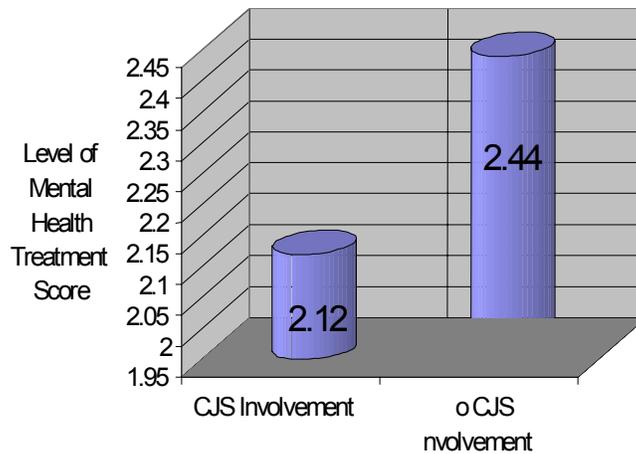
Levels of Mental Health Treatment Differed According to Substance Abuse Status



Subjects with no histories of substance abuse had higher overall levels of treatment scores (mean for group = 2.49).

Subjects with histories of substance abuse had significantly lower levels of mental health treatment scores (mean for group = 2.16). It is unclear why subjects with substance abuse problems seemed to be receiving mental health treatment less consistently than subjects who did not have substance abuse problems. These subjects were also more likely to have had involvement with the criminal justice system as well. It is possible that their substance abuse problems and/or their forensic histories may have made them less desirable to serve in the mental health system. In the absence of formal supervisory oversight to ensure participation in treatment, these subjects may have simply avoided treatment, especially if mental health treatment providers attached a requirement to participate in substance abuse treatment. It is also possible that these subjects were sent into the substance abuse treatment system if their abuse of substances appeared to be primary. However, as will be discussed, overall levels of substance abuse treatment were even lower than overall levels of mental health treatment, suggesting that, if these subjects had been sent to the substance abuse treatment system for care, they did not regularly participate in treatment. Move up text box so page number is not cut off

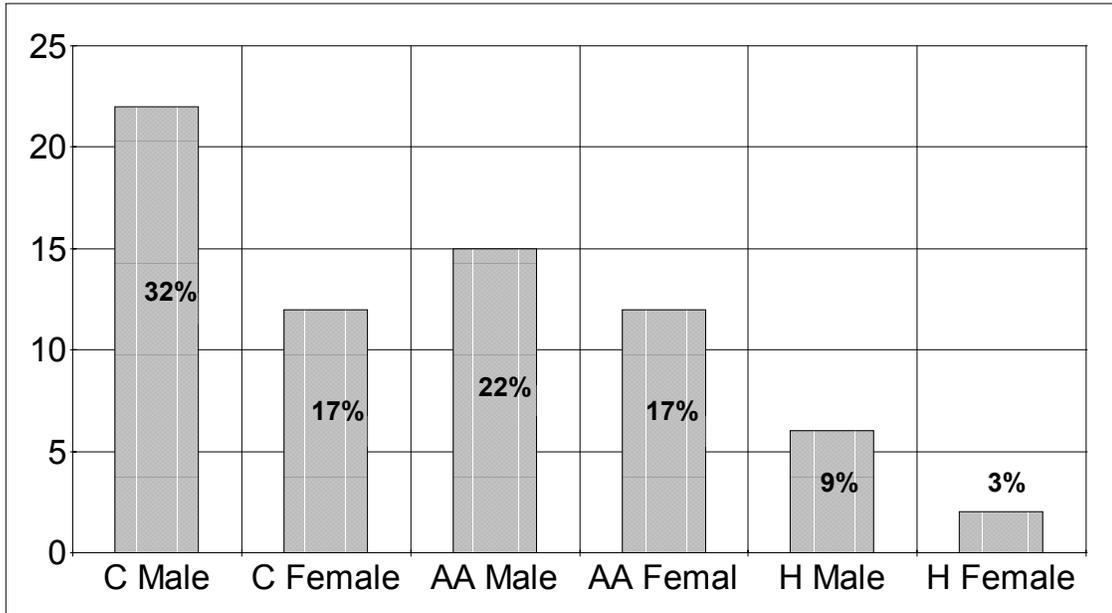
Levels of Mental Health Treatment Differed According to Subjects' Involvement with the Criminal Justice System



Subjects who did not have histories of criminal justice system involvement had higher levels of mental health treatment scores (mean score for this group = 2.44).

Subjects with histories of involvement with the criminal justice system had lower levels of mental health treatment scores (mean score = 2.12). Periods during which these subjects were incarcerated were not counted in the calculation of their scores, because it was not known whether or not they had received treatment while in a correctional facility. Thus, intervals during which they were incarcerated were deleted from the score computation. It was interesting to note that these subjects seemed to enter into consistent mental health treatment in the months following their release from incarceration, suggesting that probation or parole officers may have been requiring and supervising participation in mental health treatment. In ensuing intervals, however, participation in treatment seemed to drop off. In some cases, participation in treatment abruptly stopped the month after release from probation or parole.

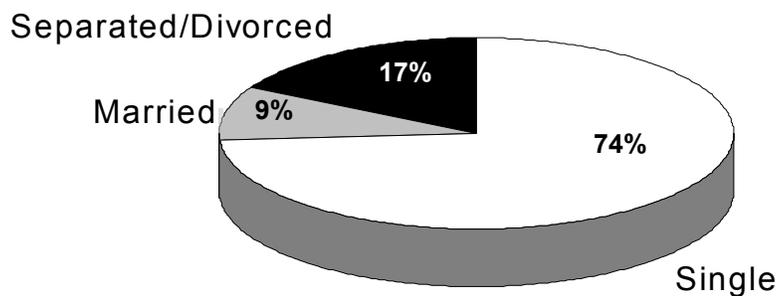
Composite Race/Ethnicity and Gender



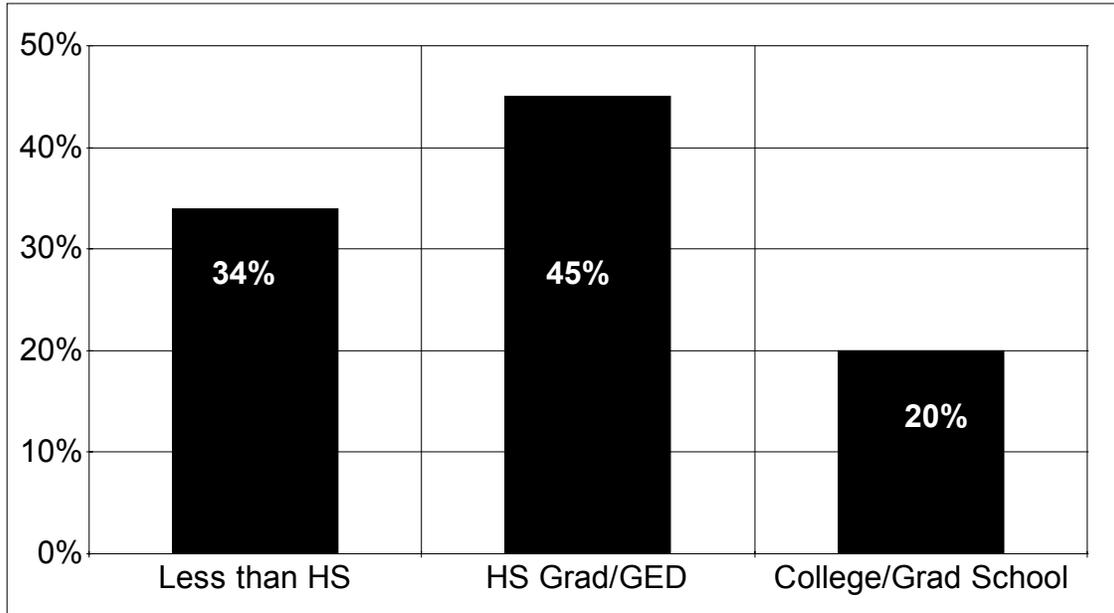
The distribution of gender across this initial group suggests that, in general, males are more likely to become involved with the criminal justice system. However, among African American clients, the distribution of males and females is nearly equal, which suggests that African American women with mental illnesses may be more vulnerable to criminal justice system involvement.

Marital Status

While the vast majority of this initial group of clients was single at entry into the program, 53% of them had at least one child.

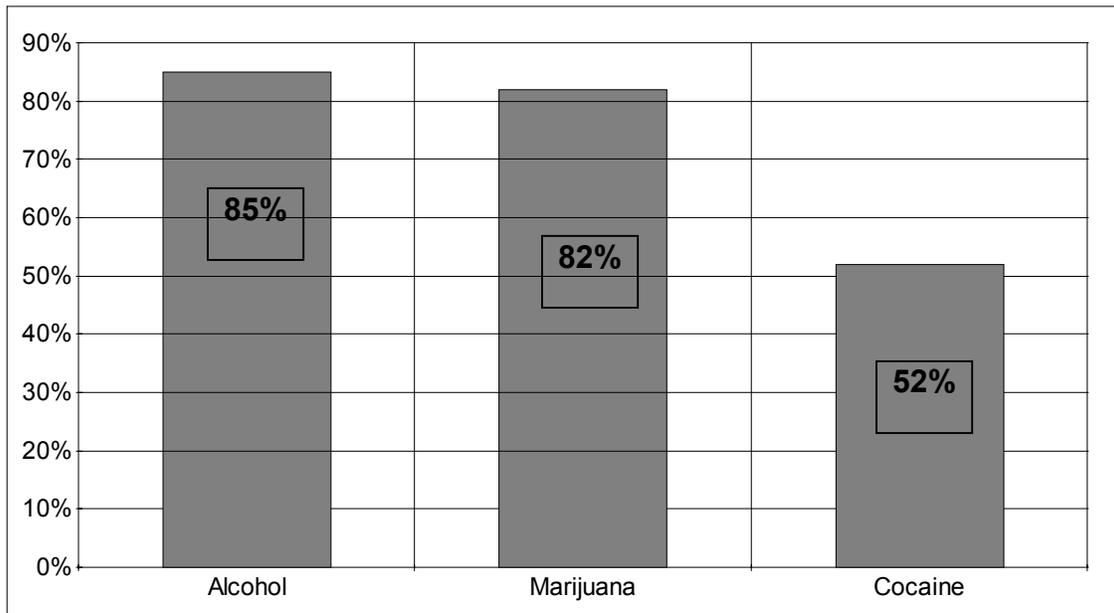


Level of Education



Substance Abuse

The following chart displays the percentage of clients who self-reported abusing alcohol, marijuana, or cocaine.



Chapter 3 Current Programs

The Division of Community Mental Hygiene has a number of program initiatives that it will provide to the Court in order to facilitate treatment rather than incarceration for individuals referred to the Mental Health Court. Among these initiatives are the Transitional Case Management Program; the Medication Grant Program; and, the M.O.R.R.E. Program. In addition, the Probation Department has several specialized programs including the Intensive Supervision Mental Health Unit and the Day Reporting Center.

Transitional Case Management Program

The Transitional Case Management Program was established in December 2000 for the purpose of assisting individuals with serious and persistent mental illnesses who are returning to the community after periods of incarceration in the Suffolk County Correctional Facility and upstate prisons. Case managers are assigned to clients prior to their discharge from incarceration in order to begin a working relationship that involves establishing applications for financial and medical benefits (Public Assistance, Social Security benefits, Medicaid); linking clients to appropriate mental health care, substance abuse treatment medical care, and housing providers; and ensuring that clients will have all needed prescribed medications immediately upon their release.

Case managers have been trained as Medicaid application examiners by the Suffolk County Department of Social Services in order to expedite the process of applying for Medicaid and Public Assistance benefits. The program maintains a close working relationship with the Department of Social Services to help ensure that clients are able to expeditiously obtain and maintain the benefits needed to access treatment and housing services.

The program also maintains a close working relationship with the staff of the Mental Health Clinic within the county correctional facility and with the Suffolk County Department of Probation and the New York State Office of Parole. In addition, case managers work closely with Legal Aid attorneys and the District Attorney's office.

Case managers enroll clients in the Medication Grant Program on the day of release and transport clients to local pharmacies to ensure that there is no lapse in medication treatment during the transition period. Once clients are linked to and active in appropriate treatment services, they are then transitioned to existing long-term case management for ongoing follow up in the community.

Probation Intensive Mentally Health Unit:

The Intensive Supervision Program provides close supervision of probationers with serious mental illness. This helps reduce prison overcrowding and also assists in managing the size of supervision caseloads throughout the department.

Individuals selected for the Mental Health Unit must have a recent Axis I diagnosis and must present serious problems in daily living. The majority of this population also

experiences serious substance abuse problems. The program is intended to serve as an alternative to incarceration by providing for frequent contact between the probation officer and probationer. Minimum contact requirements include eight personal face-to-face contacts per month between the probation officer and probationer. At least two home visits per month are required as well as four collateral contacts. If the probationer is not fully engaged in work or school then it is expected that daily contact with the probation department will be maintained.

Regular drug and alcohol testing are also critical components of the ISP process. In addition to the increased frequency of contacts, this emphasizes programmatic initiatives and planning on the part of the probation officer. This includes referral to treatment agencies for drug and alcohol services, mental health services, as well as employment and education services. The probationer is also given bus tokens on an as needed basis

Needs assessment and evaluation are critical components of the ISP process and are conducted on an ongoing basis. As individuals progress and make successful adjustments some can be reintegrated into regular supervision caseloads and ultimately be successfully discharged.

Probation Day Reporting Center

The concept of day reporting emerged in Great Britain in the early 1970's. It is a holistic correctional treatment approach to reduce offender recidivism by addressing such issues as alcohol and substance abuse, joblessness, educational deficiencies, mental health problems and personal life skills. In recent years, Day Reporting Centers have developed as a means of reducing jail overcrowding and incarceration costs. The main objective is to provide the offender with various community services "under one roof" while, at the same time, preserving public safety. In February 1994, the Suffolk County Probation Department Day Reporting Center began operation. This program combines intensive supervision with comprehensive diagnostic and treatment services, in one central location, for selected offenders who would otherwise be incarcerated. This program provides a one-time opportunity for offenders to reside within their communities while being monitored and supervised on a daily basis. They also receive appropriate counseling, education and diagnostic treatment services, which enable the offender to become a responsible, law-abiding member of the community. The program is divided into four phases, in which participants "graduate" to each successive treatment level. Each phase is designed to last one month but experience has shown that each phase averages one and one-half to two months. The Day Reporting Center operates Monday through Friday during normal working hours and two evenings per week. Probation Officers make unannounced visits at any time, including weekends.

The Probation Department, acting as the lead agency, provides daily intensive supervision and monitoring of the offenders. Comprehensive counseling treatment, educational and medical services are provided by the Department of Health Services – Divisions of Public Health, Community Mental Health, and Alcohol and Substance Abuse Services and the Board of Cooperative Educational Services. Support services are

also provided by the Sheriff's Office, the Department of Labor, the Department of Public Works and the Medical Examiner's Office.

The participant population of the Day Reporting Center has ranged between 110 and 140. On a typical day, if there is such a thing, 35 to 60 participants report to the program. Participant reporting schedules vary with the phase of the program and level of treatment. Latest figures indicate that approximately half of the participants successfully complete the program and the remainder is returned to court.

During 2002, DRC was retooled so that it could provide services to the probationer experiencing more serious mental illness. Further redesign is planned for 2003 so that a greater number of Mentally Ill Chemical Abusers (MICA) can be accommodated.

The Medication Grant Program

The Medication Grant Program was established through Mental Hygiene Law 9.60 (a/k/a "Kendra's Law") and provides for the provision of an identification card for use at local pharmacies to provide psychotropic medications for individuals with Serious and Persistent Mental Illness as they are released from local jails and the State prison system. Enrollment in the program is designed to assist these individuals until such time as their applications for Medicaid are accepted and approved by the Department of Social Services. Under the Medication Grant Program these individuals are provided with the psychiatric medications they need to maintain stability in the community.

The M.O.R.R.E. Program:

The M.O.R.R.E. Program (Mobile Outreach Resources Referrals and Education) is a new initiative between the Division, three consumer-related agencies in the community and the Suffolk County Police Department. This initiative is an attempt to make precinct-level interventions with persons with Serious and Persistent Mental Illness who come into contact with law enforcement personnel as a function of their non-violent, but deficient, quality-of-life behaviors. This program is currently underway at the First, Third and Fifth Precincts and will provide linkage between the Police Officers in the community and the services of the mental health system. It is anticipated that many of the persons who will be identified will be undomiciled individuals in need of sustained outreach services.

The CAMERA Unit

In addition, the Division may arrange for the provision of mental health case management services following the involvement of the specialized Probation personnel assigned to the Mental Health Court, through the CAMERA Unit. This Program component of the Division serves as the single point of access to case management (including Intensive Case Management, Supported Case Management and assertive Community Treatment Teams) throughout Suffolk County.

Chapter 6 Training

" If the only tool you have is a hammer,
You tend to see every problem as a nail."
--- Abraham Maslow

**WORKING WITH INDIVIDUALS
WHO HAVE MENTAL ILLNESS:
A TRAINING PROGRAM
FOR CRIMINAL JUSTICE PROFESSIONALS
2000/2001**

A one day training program prepared for the Suffolk County Criminal Justice Coordinating Council

MICA/MI Subcommittee of the CJCC

Robert J. Gaffney Suffolk County Executive

Joseph C. Michaels Assistant Deputy County Executive Chairman - CJCC

Agency Contributors:

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SUNY at Stony Brook, School of Social Welfare
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Training Overview

One of the recommendations in our first report called for the development of specialized training to help criminal justice and treatment personnel work with persons with mental illness. The recommendation read as follows:

“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 seriously mentally ill.”

In response to this recommendation, a training program entitled, “Working with Individuals Who Have Mental Illness” was developed. This one-day training program was developed and delivered by a multidisciplinary team from Suffolk County Probation, Suffolk County Department of Health-Community Mental Hygiene, Stony Brook University, The Mental Health Association of Suffolk County, and the National Alliance for the Mentally Ill.

The training began in November of 2000 and has been delivered to over 300 criminal justice and treatment personnel to date. A brief overview of the training description and a one year follow-up evaluation of the training program follow.

Morning Session

Topic Areas	Presenters
<p>Stigma – enlightening discussion of the history of mental illness and the stigma associated with it through the eyes of a parent/advocate. Provides compelling argument for how stigma has impeded the progress of treatment for persons with mental illness and their families.</p>	<p>Dr. Davis Pollack – National Alliance for the Individuals with mental illness (NAMI), Founder and Board Member of Clubhouse of Suffolk.</p>
<p>Consumer View – powerful first hand account of what it is like to live with a mental illness and how treatment providers can best help.</p>	<p>Marilyn O’Neill R.N., Clubhouse of Suffolk.</p>
<p>Physiology – brief overview of how brain chemistry helps define mental illnesses.</p>	<p>James Golbin, PhD, Chief Planner, Suffolk County Department of Probation</p>
<p>Culture and Mental Health – provides a framework for how service providers can best serve persons with mental illness by understanding the impact of culture on diagnosis and treatment of mental illness</p>	<p>Carlos Vidal, PhD; Robert Marmo, PhD, School of Social Welfare Stony Brook University</p>
<p>Overview of Mental Health Disorders – provides a brief yet comprehensive view of the most common types of disorders including substance abuse. Major diagnosis, symptoms, treatments, and strategies for working with individuals with mental illnesses are presented.</p>	<p>Patricia Parry, MSW, FECS Transitional Case Management Program</p>

Afternoon Session

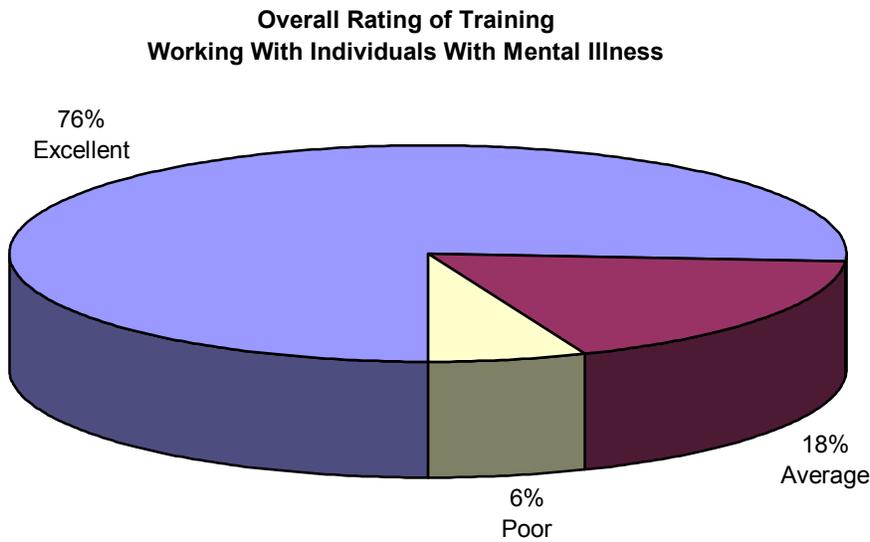
<p>Comprehensive Psychiatric Emergency Program – an in-depth overview of Stony Brook University Hospital psychiatric emergency room program. Includes an interactive discussion of how the criminal justice programs can best work with the mental health system to best serve persons with mental illnesses.</p>	<p>Linda Winter MSW , Coordinator CPEP, Stony Brook University Hospital</p>
<p>Suffolk County Community Mental Health Services – an informative and stirring presentation of Suffolk County’s response to mental illness over the past 40 years. How persons deal with treatment and how treatment has changed over the years is discussed.</p>	<p>Lou Gallagher, PhD, Suffolk County Department of Health Division of Community Mental Hygiene</p>
<p>Substance Abuse Services for Persons with Mental Illness – a brief overview of Suffolk County substance abuse services for persons with mental illness. Includes directories of all treatment agencies and admission criteria.</p>	<p>Art Flescher, MSW Jackie Best, Suffolk County Department of Health Division of Community Mental Hygiene</p>
<p>Where to Find Help and Advocacy – a comprehensive review of how the Suffolk County Mental Health Association can find help for all services for persons with mental illness.</p>	<p>Lou Cherry, MSW, Mental Health Association of Suffolk County</p>
<p>Criminal Justice Response to Persons With Mental Illness in the Criminal Justice System – an overview of current research, programs, and initiatives by the criminal justices agencies in Suffolk to respond to the growing number of persons with mental illness within the criminal justice system.</p>	<p>James Golbin, PhD, Chief Planner, Suffolk County Department of Probation; John Desmond, Principal Probation Officer, Suffolk County Department of Probation; Robert Marmo, PhD, School of Social Welfare Stony Brook University</p>

Evaluation

Working with Individuals with Mental Illness Training Evaluation Results

Six training sessions were held between November 2000 and November 2001. Cumulatively, 298 people attended the trainings and of that, 83% (n=247) returned evaluation forms.

The following is a summary of all evaluation results:

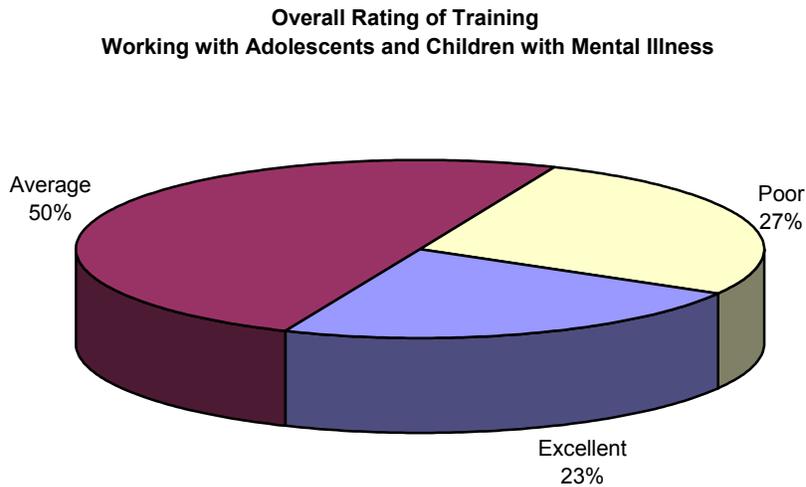


%	Number	Response
95%	N=234	Felt that the training activity met their needs
98%	N=243	Felt the training was well presented
76%	N=187	Gave the training an overall rating in the Excellent Range
6%	N=14	Gave the training an overall rating in the poor range
18%	N=44	Gave the training on overall rating in the average range
23%	N=57	Felt the presenters were the best aspect of the training
22%	N=53	Felt the handouts were the best aspect of the training
46%	N=114	Felt that the handouts and the presenters were the best aspect of training
6%	N=14	Felt that the presenters, handouts & the panel were the best aspects of training

New Training Initiatives: Working with Adolescents and Children with Mental Illness Training Evaluation Results

To date we have held one training session. Thirty-eight probation department employees attended the training and of that, 79% (n=30) returned evaluation forms. The following is a summary of the evaluation results:

(Training Date: 5/31/02):



%	Number	Response
73%	N=22	Felt that the training activity met their needs
87%	N=26	Felt the training was well presented
23%	N=7	Gave the training an overall rating in the Excellent Range
27%	N=8	Gave the training an overall rating in the poor range
50%	N=15	Gave the training on overall rating in the average range
20%	N=6	Felt the presenters were the best aspect of the training
17%	N=5	Felt the handouts were the best aspect of the training
40%	N=12	Felt that the handouts and the presenters were the best aspect of training
7%	N=2	Felt that the presenters, handouts & the panel were the best aspects of training

Chapter 6

Systemic Analysis

The great aim of education is not knowledge but action.
-Herbert Spencer

Gaps in the system

To help identify the gaps in services, a small survey was conducted with members of Suffolk Probation Intensive Mental Health Unit. The unit was developed in response to a recommendation in the first report. The survey asked probation officers to identify areas of program improvement based upon their experiences with probationers with mental illnesses. From that survey these gaps/problems were identified:

- ❑ Lack of complete psychiatric history in case records
- ❑ Medication compliance is a problem. Treatment agencies need to supervise the medication of clients.
- ❑ Psychiatric conditions of probation are sometimes too general and need to be more specific and include psychiatric evaluation, therapy as required, and compliance with taking medication as prescribed
- ❑ Lack of communication between treatment providers (substance abuse and mental health) and probation. Some agencies don't send progress reports for clients unless constant requests are made. Mental health providers do not provide information regularly on changes in treatment including medication or problems with compliance. More contact with case managers is needed.
- ❑ Waiting lists for substance abuse treatment can be too long
- ❑ Reductions/limitations in coverage for both mental health and substance abuse treatment have created problems for clients seeking treatment
- ❑ Lack of services is a problem. Not enough treatment providers-especially long-term in-patient. Locating outpatient treatment for MICA, also very few substance abuse agencies address mental health and substance abuse
- ❑ Turnover rates and need for more experienced staff in the treatment programs specifically MICA programs with staff who understand mental illness
- ❑ Poor discharge planning

- ❑ Infrequent drug testing
- ❑ Transportation
- ❑ Access to controlled, decent, and affordable housing

Although strides have been made to improve the system, gaps still remain.

A major problem identified by several agencies is the lack of suitable and safe housing for the individuals with mental illness. Currently, much of the housing that exists is unsuitable. It has been suggested that one of the reasons for reasons for recidivism among this population stems from the lack of safe housing. We know that transitional housing is an integral part of most successful programs nationally and clearly in Suffolk this still remains an area which improvements need to be made.

Regarding Medicaid there still are considerable problems, more specifically if a client misses one visit during the application process they have to start all over again. Officials assert that Medicaid Presumptive eligibility is needed. In addition, while the Medication Grant certainly improved the likelihood that those in jail would be able to attain medication when they were unable to afford it, this problem needs to be expanded to include both probationers and adolescents.

From these identified gaps and problems with the system come recommendations to help bridge these gaps.

Recommendations

Planning/Research:

- Full involvement of the key actors across the full spectrum of the justice system in the planning process

- Continue to conduct empirical research and statistical analysis of the nature and prevalence of individuals with mental illness in Suffolk County Criminal Justice System
- Conduct Evaluation of the specialized programs (Transition Jail Linkage/Probation ISP)
- Conduct a systemic analysis of the individuals with mental illness in the criminal justice system in order to determine suitable levels of diversion and where that diversion should take place. The study should include a review of existing protocols of all criminal justice agencies.
- Best Practices and exemplary programs should be identified and evaluated

Systems Improvement:

- Create Enhanced Pre Sentence Investigations
- Explore development and potential funding for a Mental Health Court
- Expand Pretrial Services
- Expand Expeditor and Supervised Release Services in order to reduce the number of individuals with mental illness detainees in jail
- Diversion at pre booking
- Establish Precinct House intervention
- Initiate a Stigma Reduction Campaign (research funding sources)
- Expand the development of specialized intensive supervision caseloads for seriously individuals with mental illness probationers and parolees.
- Provide more specific psychological treatment conditions of probation
- Provide drug testing to monitor individuals for medication compliance
- Create a standardized or universal progress reports that could be used across agency's- (mental health & criminal justice)
- Enhance the correctional treatment model- by enhancing communication and cross training between mental health professionals and criminal justice professionals

- Expand the Day Reporting Center to include a psychiatrist and treatment consultants to work with individuals with mental illness on probation

Client Services:

- Support the timely development of Building 55 in Pilgrim State
- Create appropriate and adequate safe housing for the individuals with mental illness.
- Expand MICA services for adults and adolescents
- Develop vocational counseling and job placement services for the individuals with mental illness.
- Expand case management services

Training:

- Continue implementation of the specialized training programs for all relevant members of the criminal justice and social services treatment systems regarding the appropriate response to and intervention with individuals with mental illness in criminal justice
- Provide clinical supervision in addition to caseload review, for the people in the specialized units who work with individuals with mental illness.

Legislative/Policy:

- Expand the Medication Grant to include other populations including probationers and adolescents
- Support the State Medicaid Presumptive Eligibility bill
- Support Insurance Parity for individuals with mental illness
- Current policy should be amended so that benefits and support services for individuals with mental illness are put in abeyance while they are incarcerated and then reclaimed upon release
- Identify alternative funding sources and secure additional funding for systems improvement with this population.

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Sources of Psychological Literature & Research

Research and Experiments in Psychology

Leads to current and online research in psychology via the American Psychological Society <http://psych.hanover.edu/APS> Provides an excellent listing of psychological experiments currently underway at different Universities, by topic areas.

<http://psych.hanover.edu/APS/exponnet.html>

Psychological Abstracts

Provides abstracts of journal articles in psychology. Available online at UCSB and otherwise (password required; fees charged to non-APA members) through the A.P.A.

<http://www.apa.org/psycinfo/psycinfo.html>

Experimental vs. Correlational Research

Investigation of causal and quasi-causal relationships in psychological research.

<http://www.indiana.edu/~gasser/experiments.html>

More Experimental Psych

Describes principles, procedures and misconceptions of psychology as a science.

<http://www.york.ac.uk/depts/psych/web/etc/whatispsych.html>

National Institute of Mental Health

<http://www.nim.nih.gov>

Psychiatric Research

<http://www.iop.bpmf.ac.uk/home/depts/library/ment.htm>

Mental Health Research Institute

Overview on current developments in mental health research in Australia.

<http://www.mhri.edu.au>

Prevalence of Mental Illness

Two sites; the first from the Centers of Disease Control; the second from all U.S. Government agencies. <http://www.cdc.gov> www.fedstats.gov

American Association for the Advancement of Science

<http://www.aaas.org/>

Annual Reviews in Psychology

<http://www.annurev.org>

Library of Congress

<http://http://lcweb.loc.gov>

Psychological Journals

On Line Journals

The American Psychological Society provides an extensive and current listing of on line articles. <http://psych.hanover.edu/Krantz/journal.html>

APA Journals

The American Psychological Association lists its Journals with Tables of Content: no articles but helpful for library searches. <http://www.apa.org/journals>

Educational Resources Information Center: <http://www.aspensys.com/eric/>

Other Journals

These online journals often contain articles of relevance to psychology.

New England Journal of Medicine <http://www.nejm.org>

Scientific American <http://www.sciam.com>

Mental Health Web Sites

Behavior On-Line

A forum and gathering place for mental health and applied behavioral science professionals to discuss theory and developments in mental health. Affiliated with some well-respected mental health organizations. www.behavior.net

Internet Mental Health

Extensive mental health information to promote the understanding, diagnosis and treatment of mental illness. www.mentalhealth.com/p.html

Self-Help Mental Health

Resources and support groups. www.cmhc.com/

DSM

An APA site that provides the terms, definitions and criteria of mental illness from the Diagnostic & Statistical Manual of Mental Disorders. www.apa.org/science/lib.html

Psychiatry

Psychiatric information for the public. www.med.nyu.edu/Psych/public.html

Society of Behavioral Medicine

Extensive links to sources related to health and psychology.

<http://psychweb.syr.edu/sbm/sisterorg.html>

PTSD

A web page devoted to the research and treatment of post traumatic stress disorder.

www.long-beach.va.gov/ptsd/stress.html www.teleport.com/-dvb/trauma.htm

National Clearinghouse for Alcohol and Drug Information

Data bases focused on the use, abuse and treatment of psychoactive substances.

www.health.org

Clinical Psychology Resources

www.gasou.edu/psychweb/resources/bytopic.htm#therapy

Eating Disorders

A web site that provides extensive links on bulimia, anorexia and obesity.

www.stud.unit.no/studorg/ikstrh.ed

Mood & Anxiety Disorders

Several sites that provide information and guidance on managing depression, anxiety, phobias, mania or seasonal affective disorders. URLs:

- www.psych.helsinki.fi/~janne/asdfaq/
- www.psycom.net/depression.central
- www.sonic.net/~fredd/phobial.html

Schizophrenia

Two sites; the first for on the disorder, the second for family & friends.

www.mentalhealth.com/dis/p20-ps01.html

www.mentalhealth.com/book/p40-sc02.html

Dissociative Disorders

A site focused on multiple personality, amnesia and other interesting but very rare psychological phenomena. www.tezcat.com/~tina/dissoc.shtml

Borderline Personality Disorder

<http://members.aol.com/BPDCenral/index.html>

GLOBAL ASSESSMENT OF FUNCTIONING SCALE (GAF SCALE)

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Note: Use intermediate codes when appropriate; e.g., 45, 68, 72.

Code

- 90 – 81 Absent or minimal symptoms (e.g., mild anxiety before exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
- 80 – 71 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).
- 70 – 61 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
- 60 – 51 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with co-workers).
- 50 – 41 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
- 40 – 31 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
- 30 – 21 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
- 20 – 11 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
- 10 – 1 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.