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REVIEW ARTICLE

Deinstitutionalization and other factors in the criminalization of persons with serious mental illness and how it is being addressed

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One of the major concerns in present-day psychiatry is the criminalization of persons with serious mental illness (SMI). This trend began in the late 1960s when deinstitutionalization was implemented throughout the United States. The intent was to release patients in state hospitals and place them into the community where they and other persons with SMI would be treated. Although community treatment was effective for many, there was a large minority who did not adapt successfully and who presented challenges in treatment. Consequently, some of these individuals' mental condition and behavior brought them to the attention of law enforcement personnel, whereupon they would be subsequently arrested and incarcerated. The failure of the mental health system to provide a sufficient range of treatment interventions, including an adequate number of psychiatric inpatient beds, has contributed greatly to persons with SMI entering the criminal justice system. A discussion of the many issues and factors related to the criminalization of persons with SMI as well as how the mental health and criminal justice systems are developing strategies and programs to address them is presented.

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The United States prison population, including both federal and state prisons and county and city jails, was 2,162,400 inmates as of December 31, 2016.[1] The percentage of jail and prison inmates assumed to be seriously mentally ill (as defined in various studies as schizophrenia, schizophrenia spectrum disorder, schizoaffective disorder, bipolar disorder, brief psychotic disorder, delusional disorder, and psychotic disorder not otherwise specified) has generally been estimated at about 16%.[2] Using these numbers (2,162,400 × 16%) yields an estimate of 345,984 incarcerated persons with serious mental illness (SMI) in jails, and state and federal prisons. The actual number may be somewhat higher or lower, depending on the accuracy of the percentage.

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The figures noted above represent a substantial number of persons with SMI in correctional facilities. In a previous era, many more persons with SMI who came to the attention of law enforcement would have been hospitalized rather than arrested and incarcerated.[3] The extent to which persons with SMI have been arrested has significantly impacted both the mental health and criminal justice systems. This phenomenon has been referred to as the "criminalization of the mentally ill."

One of the major concerns in present-day psychiatry is that placement in the criminal justice system poses a number of important problems for and obstacles to the treatment and rehabilitation of persons with SMI.[4,5] Even when quality psychiatric care is provided in jails and prisons, the inmate/patient still has been doubly stigmatized as both a person with mental illness and a criminal. Furthermore, correctional facilities have been established to mete out punishment and to protect society; their primary mission and goals are not to provide treatment. The correctional institution's overriding need to maintain order and security, as well as its mandate to

implement society's priorities of punishment and social control, greatly restrict the facility's ability to establish a therapeutic milieu and provide all the necessary interventions to treat mental illness successfully.[6]

How can we explain these large numbers of people with SMI being arrested and falling under the jurisdiction of the criminal justice system? They come to the attention of law enforcement because they appear to have engaged in illegal behavior. It may well be that they have done so because their mental illness is not being treated adequately in the community. Some of the reasons for this are given in the following sections.

Psychiatric hospitalization and deinstitutionalization

Beginning in the late 1950s, the number of hospital beds declined precipitously. For example, in 1955, when the number of patients in state hospitals in the United States reached its highest point, 559,000 persons were institutionalized in state mental hospitals out of a total national population of 165 million (339 beds per 100,000 population). However, by 2016 (as a result of hospital closures and bed eliminations), the number of persons in state mental hospitals dropped to 37,679 for a total population of approximately 324,000,000, or 11.7 beds per 100,000 population. This rate is similar to that found in 1850 when persons with SMI received little care and concern.[7]

What were some of the reasons for the reduction of the number of involuntary psychiatric beds? It was the confluence of the following factors: the introduction of Thorazine and other powerful antipsychotic medications; the development of more efficacious community treatment interventions, such as assertive community treatment (ACT); the creation of federal programs (eg, SSI, SSDI, Medicaid, and Medicare), which funds community treatment and housing for persons with mental illness; the influence of the civil rights movement; and the high cost of institutionalizing persons with mental illness.[8]

Deinstitutionalization is one of the leading causes that has been viewed as increasing the number of persons with mental illness entering the criminal justice system. The community mental health system was developed in the 1960s and 1970s as a more appropriate setting than psychiatric hospitals to provide treatment for persons with mental illness who had moderate needs and could be maintained in the community. Consequently, the number of public psychiatric hospital beds was reduced with the belief that current and future psychiatric patients could be treated adequately in the community mental health system. Although deinstitutionalization held the promise of persons with SMI being able to live successfully in the community, that outcome did not occur for a sizeable number of people. Part of the reason for the failure was attributed to a lack of planning before or during deinstitutionalization as well as a lack of adequate funding for the community mental health systems. As a result, many of the important components of a community care system were not sufficiently provided (ie, housing, medical and psychiatric care, social services, and social and vocational rehabilitation) for the formerly hospitalized patients.

Despite this, the majority of deinstitutionalized patients were able to adapt successfully in the community; however, this was not the case for a substantial minority. Some of these individuals presented challenges in treatment—such as not seeing themselves as mentally ill, not taking their medications, abusing substances, and in many cases, becoming violent when stressed. Many of these persons needed highly structured care to replace that which had been provided to them, albeit imperfectly, in psychiatric hospitals. The flawed implementation of deinstitutionalization would thus appear to be a significant factor accounting for many persons with SMI migrating to jails and prisons as well as to homelessness (between one-fourth and one-third of homeless persons have a SMI).[9]

Initially, concerns about deinstitutionalization tended to focus on those persons with SMI who were discharged into the community after many years of living in state hospitals. However, treating the new generation that has appeared since the implementation of deinstitutionalization policies has proven to be even more difficult.[10] These individuals are different from those who were hospitalized for long periods and who tended to become institutionalized and not experienced in living outside a highly structured setting. When they are placed in a community living situation that has sufficient support and structure to meet their needs, most tend to remain there and to accept treatment. However, this has not been the case for the new generation of persons with SMI; they have not been institutionalized, they have not lived for long periods of time in hospitals and have developed considerable dependence on others, and for the most part they have spent only brief periods in acute care facilities. The lack of community resources capable of adequately treating this challenging new generation of persons with SMI, who often posed difficult clinical problems in treatment and rehabilitation, and may also suffer from homelessness, have contributed to their inappropriate incarceration.

Civil commitment criteria

In 1969, California enacted new legislation regarding civil commitment law, known as the Lanterman–Petris–Short Act (LPS). One of the intents of LPS was to "end the inappropriate indefinite and involuntary commitment of mentally disordered persons."[11] Under LPS, the commitment procedures and criteria were better defined than before; consequently, fewer people were involuntarily committed. Within a decade, every state made similar changes to their civil commitment codes. Such universal and significant changes are virtually unprecedented.

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The new civil commitment laws tended to incorporate three major changes. The first change referred to the criteria for involuntary psychiatric hospitalization. The criteria changed from being general in their focus on mental illness and the need for treatment to becoming more specific in addressing how the individual's mental illness contributed to the person's danger to self or others or the person's ability to care for oneself. The second change impacted the duration of commitment; that is, the length of involuntary psychiatric hospitalization went from an indeterminate period to one with specific time durations that were often brief. The third change addressed the patient's civil liberty and due process rights to have prompt access to independent hearings and trials as well as the assistance and representation of patient advocates and attorneys at the various hearings/trials.

These revised civil commitment laws resulted in fewer, as well as shorter, commitments. In fact, many patients who were discharged from the psychiatric hospitals because they no longer met the strict criteria for involuntary hospitalization were released into the community, often without the resources to help them adjust. They may have had difficulties maintaining psychiatric stability, controlling their impulses, living in unstructured community settings, and adapting to the demands of community living. Thus, some of these individuals might have decompensated to the point where they committed criminal acts and entered the criminal justice system.

Community support systems tend to be inadequate

Another factor that both leads to and perpetuates the criminalization of persons with SMI is the lack of adequate support systems in the community. This includes mental health treatment, case management, housing, and rehabilitation resources. The inadequacy of these support systems has three important aspects.

First, given the very large numbers of persons with SMI in the community, there may not be sufficient resources to serve them. For instance, case management has come to be viewed as one of the essential components of an adequate mental health program.[12] However, the mental health system is ill prepared to provide quality case management services to all persons with SMI who require it, including those leaving jails and prisons.

Second, the community treatment services that are available may be inappropriate for some of the population to be served. For example, there may be an expectation that persons with SMI go to the clinic when in fact a large proportion of them need outreach services.

Third, persons with SMI who have been released from correctional facilities may not be accepted into community treatment or housing, even when it is available. Clinicians may not want to treat this population because they are thought to be resistant to treatment, dangerous, and serious substance abusers. These individuals can be intimidating because of previous violent and fear-inspiring behavior. Working with this group is very different from helping passive, formerly institutionalized patients adapt quietly to life in the community. Thus, these are individuals who generally may not be considered desirable by most community agencies and staff. Moreover, some of these agencies may not have the capability to provide the structure and limit setting necessary to enhance safety for staff who work with these persons.

A difficult population

A large proportion of persons with SMI who commit criminal offenses are found to be highly resistant to psychiatric treatment. They may refuse referral, may not keep appointments, may not be adherent with psychiatric medications, may not abstain from substance abuse, and may refuse appropriate housing placements. There is evidence that many of these persons suffer from a disorder called anosognosia (a biologically based inability to recognize that one has a mental illness, and thus a biologically based lack of insight).[13] Consequently, such individuals are less likely to believe they need treatment and seek it when needed.

It should also be mentioned that some researchers suggest that criminogenic factors are a stronger predictor for criminal recidivism than mental illness.[14] On the other hand, active psychosis has been found to be a risk factor for violent behavior, independent of criminogenic factors such as antisocial personality characteristics or substance abuse.[15]

The plight of family members

Generally, family members can be an important source of support for persons with SMI. However, they will have to overcome a number of hurdles. These include coping with the symptoms of their relative's mental illness, dealing with their own emotions (eg, frustration, denial, anxiety, guilt, feeling inadequate), and ambivalence about involving the police when the relative is violent.[16] Given the many obstacles in dealing with their relatives with SMI as well as obtaining treatment for them, family members may feel overwhelmed and discouraged in their attempt to help their loved ones. As mentioned earlier, these challenges include not being able to obtain adequate involuntary treatment because of the insufficient number of inpatient psychiatric beds as well as the increasingly restrictive civil commitment criteria. In addition, community treatment services may not be sufficient in addressing the needs of the mentally impaired relative. Moreover, the nature of the individual's mental illness, which may also include substance abuse disorders, may pose additional problems for both the family and their relative with SMI. Finally,

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resistance to obtaining treatment is a common phenomenon among those with SMI and thus can contribute to the family's frustration which results from their inability to resolve their relative's problems.

Police and criminalization

Police play an important role in the criminalization of persons with SMI. Often, instead of directing the individual with mental illness to treatment, the person may be arrested and placed in jail.[17] There are several reasons for this.

When urgent situations arise in the community involving persons with mental illness, the police are typically the first responders.[18] Consequently, they play a major role as a mental health resource in determining what to do with the individuals they encounter. The police have dual roles. They are responsible for recognizing the need for the treatment of an individual with mental illness and connecting the person with the proper treatment resources as well as making the determination whether the individual has committed a type of illegal act for which the person should be arrested. These responsibilities thrust them into the position of primary gatekeepers who determine if the individual will enter the mental health or the criminal justice system.

For many years, police have had the legal authority to transport persons with SMI whom they believe are a danger to self, others, or gravely disabled to psychiatric institutions for involuntary treatment. This authority forces police to make decisions about the individual's mental condition and welfare. Police also have the discretion to use informal tactics, such as attempting to calm the individual by talking to them or taking them home instead of transporting them to a psychiatric hospital.

Generally, the police have a great deal of discretion in determining what to do when they encounter a person with acute mental illness in the community. In some cases, however, public policy limits the police officer's discretionary power. For instance, if the person with mental illness is alleged to have committed a major crime, the disposition is clear—that person is taken to jail because of the seriousness of the offense. However, in cases where persons with SMI are believed to have committed a minor offense the officer may use discretion; that is the officer may arrest the individual, transport the individual to an inpatient psychiatric facility for treatment or refer the individual to an outpatient clinic for mental health treatment. A major issue is that law enforcement officers do not have the training and experience that mental health professionals have in recognizing symptoms of mental illness in their determination of dispositions.[19] Mental illness may appear to the police as simply alcohol or drug intoxication, especially if the person with mental illness has been using these substances at the time of the interaction with the police. Moreover, in the heat and confusion of an encounter with the police and other citizens, which may include forcibly subduing the person with mental illness, signs of a psychiatric disorder may go unnoticed.

Another major issue contributing to the criminalization of persons with SMI is that even if the police recognize the individual's need for treatment, treatment services are not always available. For example, there are often very few accessible hospital beds for psychiatric inpatients; however, the police are well aware that if they arrest a person with mental illness, that person will be dealt with in a more systematic and predictable way under the criminal justice system.

Efforts to Address the Criminalization of Persons with SMI

Diversion from the criminal justice system

There have been extensive efforts to divert persons with SMI from the criminal justice system to the mental health system. Diversion before the person is actually booked into jail, or pre-booking diversion, has gained recent attention and is exemplified by large-scale efforts to create community mobile crisis teams of police officers and/or mental health professionals.

A number of jurisdictions use sworn police officers who have special and extensive mental health training to provide crisis intervention services as part of crisis intervention teams (CIT programs) and to act as liaisons to the mental health system.[20] This approach is often referred to as the "Memphis model" because it was developed in Memphis, Tennessee. These specially trained officers may deal with mental health emergency situations on-site or act as consultants to the officers at the scene. This model places a heavy reliance on psychiatric emergency services that have agreed to a "no refusal policy" for persons brought to them by the police. Although this strategy has a close liaison with mental health, it does not require the actual participation of mental health professionals in the field.

In addition, mental health training for all law enforcement officers, and not only those who are on mobile crisis teams, may help them gain a better understanding of mental illness and result in their seeking treatment for such individuals rather than arresting them. The interventions of mobile crisis teams and law enforcement education of mental illness can reduce the number of people who previously may have been arrested and entered the criminal justice system.[21]

However, not all people with mental illness are diverted by law enforcement officers prior to booking. For those who are arrested and taken to jail, post-booking diversion occurs through a variety of other forms. These

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include specialized mental health courts that handle exclusively offenders with mental illness. Mental health consultation to other courts may also assist the judge by offering recommendations for treatment in lieu of incarceration.

Mental health courts

Post-booking diversion strategies are being used increasingly by special courts called mental health courts.[22] The first widely known mental health court was established in Broward County, Florida, in 1997. Since then, the number of mental health courts in the United States has increased greatly. Initially, these courts were set up to hear cases of persons with mental illness who were typically charged with misdemeanors, but now also include those charged with felonies. In mental health courts, all the courtroom personnel (ie, judge, prosecutor, defense counsel, and other relevant professionals) have experience and training in mental health issues and available community resources. These mental health courts have a particular set of characteristics: they hear specialized cases involving defendants with mental illness; they use a non-adversarial team of professionals (eg, judge, attorneys, and mental health clinician); they are linked to the mental health system that will provide treatment; and they use some form of adherence monitoring that may involve sanctions by the court.

Underlying the concept of mental health courts is the principle of therapeutic jurisprudence, which emphasizes that the law should be used, whenever possible, to promote the mental and physical wellbeing of the people it affects. The concept of therapeutic jurisprudence operates on the belief that the application of the law can have therapeutic consequences.[23] It should be emphasized that therapeutic jurisprudence does not diminish the importance of public safety, which is fully taken into account by the court.

Under the tenets of therapeutic jurisprudence, people with SMI charged with crimes may be diverted into programs designed to address their treatment and service needs rather than simply being incarcerated with their treatment needs either being neglected or not fully addressed. Even individuals with SMI convicted of serious crimes can be provided with humane and appropriate treatment while incarcerated. Generally, mental health courts facilitate linking offenders with SMI to appropriate needed services and supports on discharge from jail in order to enable them to successfully re-enter their communities.

Mental health courts were developed as a strategy to divert persons with mental illness from the criminal justice system into the mental health system. When offenders with mental illness are arrested, their case may be handled by mental health courts in lieu of traditional courts. Mental health courts work in a collaborative effort among the personnel in the criminal justice and mental health systems to devise, coordinate, and implement a treatment plan that includes medications, therapy, housing, and social and vocational rehabilitation, all in an effort to address the individual's mental illness and reduce the risk of recidivism.

Mental health consultation to the court

In non-mental health courts, the use of mental health consultation for persons with SMI who are being tried for criminal offenses may be helpful in influencing the court's disposition. By providing mental health evaluation, it may become clear to the court what factors may have played a role in the defendant's criminal behavior. If these appear to be more likely the result of inadequate treatment regarding the individual's mental illness rather than the person's criminal tendencies, the court may be inclined to place the individual in a mental health treatment program instead of jail or prison.

Clearly, the quality of services plays an influential role in the success of mental health courts. However, as seen in the past, community psychiatric treatment, rehabilitation, and housing capabilities have been historically insufficient to accommodate all persons with SMI. Will the necessary resources be provided for those who are diverted? Can the mental health system expand adequately to what is needed to serve this particular population? Another question is whether those in the mental health system would be willing to work with those who are diverted from the criminal justice system given their denial of illness and tendency for many to be violent.

Outpatient Treatment to Reverse or Prevent Criminalization

In order to decriminalize persons with SMI, it is necessary to find ways to help them become stabilized outside of jails and prisons and, to the extent possible, not enter the criminal justice system at all. Thus, the community treatment of persons with SMI who are or may become offenders has developed into an increasingly important and urgent issue. Many criminalized persons with SMI can be treated at mainstream mental health clinics on their release from jails and prisons, especially those who were arrested for non-dangerous and minor crimes.

Moreover, it must be acknowledged that there are a number who are discharged from correctional institutions who have multiple problems that cannot be adequately treated in traditional community-based facilities. This would include persons with SMI who have a history of violence. Rather, these individuals need special, highly structured and adequately secured (metal detectors, alarm buttons, security personnel) clinics staffed by

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professionals who understand dangerous offenders with mental illness and are willing to provide treatment to them. Usually, these clinics are an actual part of the criminal justice system (eg, run by parole departments).

Finally, it should not be assumed that persons with SMI engage in criminal behavior solely as a result of their mental illness; there may be other influencing factors such as antisocial characteristics or situational circumstances (eg, poverty, homelessness). If so, the following treatment interventions may not be very effective in reducing their criminal recidivism, unless concerted efforts are made to modify those particular risk factors, if possible.

Treatment of co-occurring disorders

It is estimated by professionals and other personnel in the criminal justice system, who are knowledgeable about incarcerated persons with SMI, that many of them also meet criteria for substance use disorders.[24] Clearly, if treatment after release is to be successful, both the mental illness and the substance abuse must be addressed. These services should be integrated in the community for the released offender. Treatment of co-occurring disorders very frequently needs to be a long-term process.

Assisted outpatient treatment

An important treatment modality that is available in almost all of the states is assisted outpatient treatment (AOT). AOT is an outpatient court-ordered civil commitment initiated by the mental health system and not the criminal justice system. The purpose of AOT is to ensure that persons with mental illness and a history of hospitalizations or violence participate in services in the community that are appropriate to their needs.[25] AOT is for persons with mental illness who are capable of living in the community with the help of family, friends, and mental health professionals but have a history of and are presently resistant to psychiatric treatment, including medications. Without such treatment, they may continue to relapse and become violent and/or dangerous to themselves and require involuntary hospitalization. Because of these characteristics, this population is also prone to be arrested, incarcerated, and criminalized. To prevent recurrent decompensation, these persons with SMI can be ordered to participate in outpatient psychiatric treatment, with their progress closely monitored by the court.

For AOT to be successful, intensive and evidence-based practices of treatment should be used. These include assertive community treatment (ACT) and forensic assertive community treatment (FACT). ACT is a community-based program with mobile mental health treatment teams that provide an array of treatment, rehabilitation, and housing services that are available 24 hours a day. Although similar to ACT, FACT is for individuals who have been convicted of crimes and includes legal leverage from the criminal justice agencies (eg, adding probation officers to the treatment team, use of court sanctions to encourage participation) in an effort to reduce recidivism.[26] The goal of ACT and FACT is to help persons with SMI stay out of the hospital and avoid incarceration as well as develop skills for living in the community.

Working in collaborative efforts

Not all persons with SMI who have a history of incarceration are obtaining treatment in the community with ACT or FACT. There are many who are being released from jail or prison on probation or parole and are required to attend outpatient treatment in community mental health clinics. Given these requirements, agents of the criminal justice system, including probation and parole officers as well as judges, are vested in knowing the mental health status of the client. Consequently, the treating mental health clinicians may be asked to communicate directly with these justice personnel regarding the client's psychiatric condition and progress, as well as the client's potential threat of harm. Similarly, clinicians may want to obtain information about their clients' criminal history in order to better understand the extent of their clients' problems. Therefore, clinicians should feel comfortable maintaining a liaison with the criminal justice personnel.

The importance of structure

The need for structure is an essential concept for persons with SMI. Often, they lack internal controls and have difficulty coping with stressful life demands. Structure provides external controls and organization which is needed by these individuals. Generally, mental health professionals who treat this population believe that their patients' days should be structured through meaningful, therapeutic activities such as work, day treatment, and various forms of social therapy.

Another form of structure that is essential for most of this population is that treatment be mandatory, and compliance be reviewed by the court or other criminal justice agent. Knowing that their community status may be revoked can be an influential factor in motivating these clients to adhere to treatment.

Management of violence

Not all persons with SMI who are incarcerated have been convicted of violent offenses or have a history of violence. However, for those who do, the need for them to control their impulses and inappropriate expressions of anger should be a priority in treatment. Persons whose violence is rooted in a major mental illness often experience their violence as a frightening loss of control. A clinician who is not aware of their destructive potential may be perceived

as unable to protect them. They tend to establish that knowledge by testing the clinician for limits. Therefore, the clinician must not only be aware of their potential for violence, but must also be continuously alert and firm in order not to risk being perceived as uncaring and unable to protect their patient from their destructiveness.

Persons with SMI, especially those with histories of violent behavior, generally need continuous rather than episodic care as well as adherence to psychiatric medications. Thus, regular monitoring is needed, especially when symptoms are absent or at a low ebb, in order to deal with individual and situational factors that may arise and result in violence. In addition, behavioral, cognitive, and psychoeducational techniques emphasizing anger management have been widely used and have been successful in the treatment and management of violence.

Therapeutic living arrangements

An important factor in determining community survival for the majority of persons with SMI appears to depend on an appropriately supportive and structured living arrangement.[27] Often, this can be provided by family members. In many cases, however, the kind and degree of structure the client needs can be found only in a living arrangement outside of the family home with a high staff–patient ratio, dispensing of medication by staff, enforcement of curfews, and therapeutic activities that structure most of the client's day.

Working with the family

The role of family members or significant others can be critical in the treatment of offenders with mental illness. However, their involvement may not always be possible. The treatment team should determine whether these individuals were the victims of the client's aggression, whether they have maintained contact with the client, and whether they are able and interested in continuing such contact.

Clinicians should help family members in understanding the client's mental condition, teach them to recognize symptoms of decompensation, emphasize the importance of self-protection, and explain the client's current legal situation.

Twenty-four-hour structured inpatient care

Community treatment is not necessarily the most efficacious or benign intervention at all times for all people with SMI.[10] There is a substantial minority who need the structure and support of acute, intermediate, or long-term care in a hospital setting or a highly structured, locked 24-hour care community facility. Providing access to care in psychiatric facilities when needed and for as long as required is absolutely essential if deinstitutionalization and the reduction of criminalization are to be successful.

A final word

In this time of extreme overcrowding in our jails and prisons, decarceration has become a necessity. Inmates with SMI have been included in those released from correctional facilities. Acknowledging that sufficient treatment resources did not exist following deinstitutionalization and that this contributed to the criminalization of persons with SMI, we are now at a place where we can aim to prevent the recurrence of this event. Mental health professionals are poised to provide persons with SMI the mental health treatment and supportive social services that were lacking for so many, and thus leading to their decompensation and criminal behavior. If the goals of reducing the criminalization of persons with SMI are to be accomplished, the mental health and criminal justice systems must be provided with all the necessary resources and funding, as mentioned in this chapter, to identify and treat these individuals in the most appropriate setting. It cannot be emphasized enough that the criminal justice system should not be used as a substitute for the mental health system in the treatment of persons with SMI.

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REFERENCES:

1. Kaeble D, Cowhig M. Correctional populations in the United States, 2016. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Web site, https://www.bjs.gov/content/pub/pdf/cpus16.pdf. Published April 2018. Accessed February 26, 2019.
2. Torrey EF, Kennard AD, Eslinger D, Lamb R, Pavle J. More mentally ill persons are in jails and prisons than hospitals: a survey of the states. Treatment Advocacy Center Web site, https://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf. Published May 2010. Accessed February 26, 2019.
3. Lamb HR, Weinberger LE. Decarceration of our jails and prisons: where will persons with serious mental illness go? *J Am Acad Psychiatry Law*. 2014; **42**(4): 489–494.
4. Olley MC, Nichols TL, Brink, J. Mentally ill individuals in limbo: obstacles and opportunities for providing psychiatric services to corrections inmates with mental illness. *Behav Sci Law*. 2009; **27**(5): 811–831.
5. Blevens, KR, Soderstrom, IR. The mental health crisis grows on: a descriptive analysis of DOC systems in America. *J Offender Rehabil*. 2015; **54**(2): 142–160.
6. Adams, K. Ferrandino, J. Managing mentally ill inmates in prisons. *Crim Justice Behav*. 2008; **35**(8): 913–927.
7. Torrey EF, Fuller DA, Geller J, Jacobs C, Ragosta K. No Room at the inn: trends and consequences of closing public psychiatric hospitals 2005-2010. Treatment Advocacy Center Web site, https://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf. Published July 19, 2012. Accessed February 26, 2019.

https://doi.org/10.1017/S1092852919001524 Published online by Cambridge University Press

8. Harcourt BE. Mass incarceration: causes, consequences, and exit strategies: reducing mass incarceration: lessons from the deinstitutionalization of mental hospitals in the 1960s. *Ohio St J Crim L*. 2011; **9**: 53–88.
9. Folsom DP, Hawthorne W, Lindamer L, *et al.* Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. *Am J Psychiatry*. 2005; **162**(2): 370–376.
10. Lamb HR, Bachrach LL. Some perspectives on deinstitutionalization. *Psychiatr Serv*. 2001; **52**(8): 1039–1045.
11. Section 5001 Welfare and Institutions Code.
12. Anthony WA, Cohen M, Farkas M, Cohen B. Clinical care update: the chronically mentally ill—case management—more than a response to a dysfunctional system. *Community Ment Health J*. 2000; **36**(1): 97–106.
13. Lehrer DS, Lorenz J. Anosognosia in schizophrenia: hidden in plain sight. *Innov Clin Neurosci*. 2014; **11**(5-6): 10–17.
14. Andrews DA, Bonta J, Wormith SJ. The recent past and near future of risk and/or need assessment. *Crime Delinq*. 2006; **52**(1): 7–27.
15. Lamberti, JS. Understanding and predicting criminal recidivism among adults with psychotic disorders. *Psychiatr Serv*. 2007; **58**(6): 773–781.
16. Rowaert S, Vandevelde S, Lemmens G, *et al.* The role and experiences of family members during the rehabilitation of mentally ill offenders. *Int J of Rehabil Res*. 2016; **39**: 11–19.
17. Lamb HR, Weinberger LE, DeCuir WJ. The police and mental health. *Psychiatr Serv*. 2002; **53**(10): 1266–1271.
18. Patch PC, Arrigo BA. Police officer attitudes and use of discretion in situations involving the mentally ill: the need to narrow the focus. *Int J Law Psychiatry*. 1999; **22**(1): 23–35.
19. Lurigio AJ, Smith A, Harris A. The challenge of responding to people with mental illness: police officer training and special programmes. *Police J*. 2008; **81**(4): 295–322.
20. Compton MT, Bahora M, Watson AC, Oliva JR. A comprehensive review of extant research on crisis intervention team (CIT) programs. *J Am Acad Psychiatry Law*. 2008; **36**(1): 47–55.
21. Ritter C, Teller JLS, Marcussen K, Munetz MR, Teasdale B. Crisis intervention team officer dispatch, assessment, and disposition: interactions with individuals with severe mental illness. *Int J Law Psychiatry*. 2011; **34**(1): 30–38.
22. Redlich AD. The past, present, and future of mental health courts. In: Wiener RL, Brank EM, eds. Problem Solving Courts: Social Science and Legal Perspectives. New York: Springer; 2013: 147–163.
23. Wexler DB, Winnick BJ. Therapeutic jurisprudence as a new approach to mental health law policy analysis and research. *Univ Miami Law Rev*. 1991; **45**(5): 979–1004.
24. Peters HP, Wexler KW, Lurigio AJ. Co-occurring substance use and mental disorders in the criminal justice system: a new frontier of clinical practice and research. *Psychiatr Rehabil J*. 2015; **38**(1): 1–6.
25. Swartz MS, Wilder CM, Swanson JW, *et al.* Assessing outcomes for consumers in New York's assisted outpatient treatment program. *Psychiatr Serv*. 2010; **61**(10): 976–981.
26. Lamberti SJ, Deem A, Weisman RL, LaDuke C. The role of probation in forensic assertive community treatment. *Psychiatr Serv*. 2011; **62**(4): 418–421.
27. Slate RN, Buffington-Vollum JK, Johnson WW. *Criminalization of Mental Illness*. 2nd ed. Durham, NC: Carolina Academic Press; 2013.