

Reversing the Criminalization of Mental Illness

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In 1972, a federal court reinforced the deinstitutionalization of state psychiatric hospitals when they held that people with mental illness have a constitutional right to treatment (Wyatt v. Stickney, 1972). Although many states released patients and closed hospitals in response to this decision, they neglected to provide adequate community-based treatment resulting in the unintended reinstitutionalization of this population into our state and local jails. Recently, many state and local stakeholders have come together to address this situation. This article will discuss how the criminal justice system has become a primary mental health provider and strategies being utilized to reform the current system.

Keywords: jail diversion; diversion programs; criminal justice; mental health

THE LAW: RIGHT TO TREATMENT

In 1972, in the case of *Wyatt v. Stickney* (1972), a district court for the Middle District of Alabama took the unprecedented step of recognizing a constitutional right to treatment for people with mental illnesses.¹ Prior to the 1960s, people with mental illnesses were “stored” in large state hospitals, often under deplorable conditions without regard for their health, safety, or habilitation.² The court in *Wyatt* recognized that many individuals warehoused in these facilities did not require long-term institutionalization but rather needed effective treatment. The court found that mere custodial care

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did not guarantee “the constitutional right to receive such individual treatment as will give each [individual with mental illness] a realistic opportunity to be cured or to improve his or her mental condition” (*Wyatt v. Stickney*, 1972). Accordingly, the court ordered the appropriate state actors to cease committing individuals to state mental institutions if services and programs in the community could provide adequate habilitation.³ The order placed the burden on the state to create community-based outpatient treatment facilities in which people with mental illnesses who were deinstitutionalized by the court could get treatment.⁴ The court’s goal was to reintegrate these individuals into the community so they could live productive and dignified lives.

The arrival of psychotropic drugs into the field of psychiatry, pressure from advocates for people with mental illnesses and other mental disabilities, and court decisions such as *Wyatt* placed a greater duty of care on the states in their treatment of individuals with mental illness. This eventually resulted in a movement toward deinstitutionalization of people with mental illnesses from state hospitals. Unfortunately, many states saw deinstitutionalization as an opportunity to save money rather than an opportunity to improve their mental health services. States closed down hospitals condemned for failure to meet the minimum constitutional standards of care for people with mental illnesses, but they did not use the money saved to develop community-based outpatient treatment centers or much-needed social services. The result has been nothing short of disaster. The states left an entire category of individuals with mental illnesses without adequate resources or treatment. In return, over the past 40 years, most states have experienced a proliferation in homelessness and the frequent incarceration of people with mental illnesses. Ironically, instead of deinstitutionalization, we have witnessed the reinstitutionalization of individuals with mental illnesses from deplorable state psychiatric hospitals to correctional institutions, where conditions are often worse. In 1955, there were approximately 560,000 people in state psychiatric hospitals around the United States. Today, there are fewer than 60,000, yet there are more than 300,000 people with mental illnesses in jail (National Association of State Mental Health Program Directors Research Institute, 2000).

THE PROBLEM: CRIMINALIZING MENTAL ILLNESS

The unintended consequence of deinstitutionalization is that many states responded by criminalizing mental illness. Abramson (1972) was the first to coin the term *criminalization of mental illness*, which means that individuals with mental illness who tend to engage in minor criminal offenses are

often subject to arrest and prosecution in a county jail system (Lamb & Weinberger, 2001). It has been noted that many individuals with mental illness, when left without adequate treatment, eventually enter the criminal justice system (Lamb, 1998; Lamb & Weinberger, 2001; Lee-Griffin, 2001; Sigurdson, 2000). Instead of being directed to the appropriate public mental health resources, individuals with mental illness are branded criminals and either kept in jail or sent back into the streets only to return again. According to Lamb and Weinberger (2001), the criminalization of mental illness may happen for reasons such as the unavailability of long-term hospitalization in state hospitals, more rigid criteria for civil commitment, lack of adequate support systems in the community, difficulty gaining access to mental health treatment in the community, and law enforcement's belief that deviant behavior can be dealt with quicker and more efficiently within the criminal justice system than the mental health system. Once set in motion, the revolving door into the criminal justice system is difficult to stop. There are more people with mental illnesses in jails and prisons in the United States today than in all state hospitals combined (Sigurdson, 2000). In fact, approximately 15% of all individuals in jails have a major mental disorder (Walsh & Holt, 1999) such as schizophrenia, bipolar disorder, or major depressive disorder, and 75% of these also have a co-occurring substance-abuse disorder (Steadman et al., 1999). The numbers appear to be rising. For instance, the number of people with mental illnesses in jails more than tripled between 1955 and 1984 and increased by 119% in the national jail census (Walsh & Holt, 1999).

On a state level, Florida jails have become the largest public psychiatric hospitals, housing more than 10,000 inmates with mental illnesses, many of whom are low-level offenders.⁵ This is 5 times the number of people in Florida's psychiatric hospitals. According to the president of the Florida Council for Behavior Healthcare, up to 23% of Florida inmates suffer from serious mental illnesses, and 50% of all youth in Florida's juvenile justice commitment programs have been diagnosed with mental illness (Bob Constantine, personal communication, May 21, 2002). These numbers are higher than the national average, demonstrating the severity of this problem in Florida. Even more so, Miami-Dade County has the highest percentage of people with mental illness of any urban area in the United States. Approximately 9% of the total population in Miami-Dade (200,000) suffers from a mental illness.⁶ Yet, less than 13% receive treatment. In fact, there are twice as many people with mental illness in the Miami-Dade County Jail than at the South Florida Evaluation and Treatment Center, the local state hospital responsible for forensic psychiatric care. At any given time, the Miami-Dade County Jail houses between 800 and 1,200 inmates with serious mental illness. An estimated 500 inmates receive psychotropic medication daily. This

represents a significant percentage of the Miami-Dade County Jail population (approximately 20%). Almost \$4 million is spent annually by the Miami-Dade Department of Corrections on overtime to manage inmates with mental illness. Miami-Dade's problem is exacerbated by the fact that a large percentage of those with mental illness are not U.S. citizens and, therefore, ineligible for many benefits and services.

The surgeon general (U.S. Department of Health and Human Services, 1999) recently called untreated mental illness the silent epidemic of our times. Unfortunately, much of the problem has fallen on law enforcement and, ultimately, the courts. However, neither are qualified nor equipped to handle this difficult and growing problem. It has been shown that less than 50% of the inmates with mental illness in county jails receive mental health treatment while incarcerated (Teplen, Abram, & McClelland, 1997; Veysey, Steadman, Morrissey, & Johnsen, 1997, as cited in Walsh & Holt, 1999).

*ELEVENTH JUDICIAL CIRCUIT'S RESPONSE:
GAINS CENTER SUMMIT CONFERENCE*

The first step taken by the court to break this cycle of despair was securing a small grant from the GAINS Center to help facilitate a meeting of traditional and nontraditional stakeholders. In the summer of 2000, the Eleventh Judicial Circuit undertook the monumental task of reviewing and reforming how the Miami-Dade community deals with individuals entangled in the criminal justice system due to mental illness and substance abuse. With the help of the grant from the GAINS Center in New York, the Eleventh Judicial Circuit organized and personally invited key stakeholders to a 2-day summit that brought together many different community agencies and individual actors to untangle a failing process.⁷ The GAINS Center provides practical assistance to communities interested in developing new strategies to deal with mental health and substance abuse issues in the criminal justice system. In particular, the GAINS Center helps communities identify gaps in services and develop integrated approaches; provides target technical assistance through the use of national experts; convenes coalitions; provides a comprehensive database for access to research, innovative programs, and other resources; and fosters new policies on key issues affecting the treatment and management of people with co-occurring disorders in the justice system.

The purpose of the GAINS Center Summit Conference was to implement a countywide system that provides a comprehensive continuum of care program that treats people with mental illnesses in a more appropriate and humane manner. At the conference, we assessed the range and scope of men-

tal health and substance-abuse services available in our community, tailored the suggestions provided by the GAINS Center to the specific needs of our locality, and came up with a cost-effective Criminal Mental Health Project. The project was memorialized in a cooperative agreement signed by all of the representatives who participated in the GAINS Center Summit Conference.

*THE SOLUTION: ELEVENTH JUDICIAL
CIRCUIT CRIMINAL MENTAL HEALTH PROJECT*

In response to the growing population of inmates with mental illness, the Eleventh Judicial Circuit began working with the many diverse organizations and stakeholders in the mental health system. This included the state attorney; public defender; Miami-Dade Department of Corrections; Florida Department of Children and Families; the public community mental health providers; Jackson Memorial Hospital–Public Health Trust; Mount Sinai Hospital; South Shore Hospital; City of Miami Police Department; City of Miami Beach Police Department; the Miami-Dade Police Department; consumers; and mental health advocates.

The court is in the unique position to help the community reform and improve its mental health delivery system, particularly as it affects the criminal justice system. As the neutral arbitrator, a judge's role and concerns are significantly different than the other involved parties. The court not only has the ability to see the larger issues affecting the mental health system, it is also in the position to bring the necessary parties together to address the problems. Since the establishment of the project, the court continues to play a leadership role in the implementation of the cooperative agreement. The court uses its resources to organize monthly meetings, prepare documents and handouts, and chair the regular monthly meetings attended by the appropriate stakeholders. The Florida Legislature also recognized the court's unique role when they passed H.B. 2003,⁸ which mandated the court to work with stakeholders to develop diversion programs and cooperative agreements.

The goal is to implement a program that will alleviate the burden placed on our criminal courts and jails while helping those with mental illnesses get the treatment they need and deserve. The project is also designed to reduce crime and police injuries, expedite the return of police officers to patrol, save critical tax dollars, and streamline the judicial process. The Eleventh Judicial Circuit Criminal Mental Health Project integrates all of the services available in Miami-Dade for this distressed population. The goal is to divert individuals with mental illnesses from the criminal justice system to the mental health system and provide a linkage to comprehensive care, thereby making jail the

last resort. The Criminal Mental Health Project is divided between a prearrest and postarrest diversion program and includes a comprehensive care program that addresses transition and housing issues as well as substance abuse. Research suggests that jail diversion programs reduce recidivism rates for rehospitalization and rearrest (Lamb, Weinberger, & Reston-Parham, 1996; Project Link, 1999; Steadman et al., 1999), and there appears to be a vast consensus that diversion programs are needed in our communities (Draine & Solomon, 1999; McCarthy & Sharp, 2002; Sigurdson, 2000; Walsh & Holt, 1999).

Pre-Arrest Diversion: Crisis Intervention Team Policing

Based on the Memphis Crisis Intervention Team (CIT) Model,⁹ the prebooking diversion program aims to prevent persons with mental illness from ever entering the criminal justice system. The CIT is made up of uniformed police officers who receive special training from Jackson Memorial Hospital–Mental Health Hospital Center on how to deal with individuals who are in crisis due to mental illness. Through the summit and follow-up planning meetings, we learned that police officers were not properly trained to handle crisis calls involving these individuals. This is not unusual. The need for formal training on mental illness for police officers has been acknowledged by a variety of researchers (Husted & Nehemkis, 1995; Lamb, 1998; Lamb & Weinberger, 2001; McCarthy & Sharp, 2002; Murphy, 1989). Instead of taking individuals in crisis to county mental health facilities, police officers often arrest them, thus leading them into the revolving door of the criminal justice system, or worse, they escalate the situation into a violent encounter. The prearrest diversion program requires that CIT officers be sent out on crisis calls. CIT officers evaluate the situation and, if needed, de-escalate and transport individuals suffering from a mental illness to appropriate receiving facilities for evaluation, treatment, and referrals, instead of subjecting them to immediate arrest.

CIT originated in Memphis, Tennessee, after a person with mental illness was fatally injured in a potentially avoidable situation (Jamieson, 2000). In Memphis, this program substantially reduced police injuries (sixfold decrease), the time it takes officers to return to patrol, the arrest rate of individuals with mental illness, and recidivism among these individuals. Thus far, the CIT program appears to have functioned successfully in the cities of Miami and Miami Beach. Preliminary data have suggested that there has been a significant reduction in the amount of inappropriate arrests of people with mental illnesses and a reduction in incidences of police violence and injuries resulting from police mishandling of people with mental illnesses.

The Miami-Dade, Key Biscayne, and Coral Gables Police Departments and Department of Corrections will soon establish a similar program. Our long-term goal is to implement a prearrest diversion program with CIT officers throughout the county.

Postarrest Diversion Program

The postarrest diversion program aims to reduce the expenses and inefficiencies that exist in the current system. Within 24 to 48 hours after arrest, misdemeanor defendants suffering from a mental illness are now diverted to community mental health facilities for appropriate treatment. The two county court jail division judges play an integral role in the implementation of this program. Within 24 hours of an arrest, the jail psychiatrist determines whether a defendant meets criteria for an evaluation for involuntary hospitalization. If the psychiatrist issues a professional certificate for an evaluation, the case is expeditiously placed before one of the two jail division judges to determine if the defendant should be transported to a mental health crisis receiving facility. Based on the severity of the charges and the defendants' criminal and mental health history, a determination is made in consultation with the State Attorney's Office and the defense counsel whether to dismiss charges on the client's stabilization and completion of a discharge plan. If it is determined at discharge that the defendant requires greater supervision, the defendant is transported back to court by the Department of Corrections, where the court decides the appropriate outcome and conditions for release. As part of the project, probation officers were specially trained to handle defendants with mental illnesses. When appropriate, defendants are placed on probation with these particular probation officers, who work to keep the defendant compliant with treatment. Competent defendants who potentially pose a danger to themselves or others receive a greater level of court intervention, which includes regular monitoring and status hearings before the court. Monitoring a defendant on a misdemeanor charge ranges from 6 months to a year. Failure of a defendant to comply with treatment may result in the initiation of Baker Act proceedings or, on rare occasions, incarceration. In cases in which it has been determined that the defendant does not need to return to court, the charges are dismissed after the court receives a discharge summary from the receiving facility. The defendant is then referred to a case manager at a community mental health center, a treatment program, or the Florida Assertive Community Treatment (FACT) team for ongoing treatment. The majority of misdemeanor cases are adjudicated in this manner.

Until this program was instituted, individuals with a mental illness who were arrested for a misdemeanor were often held at the Miami-Dade County

Jail for an average of 10 days awaiting unnecessary and expensive evaluations, only to be released without ever receiving treatment. Each full evaluation costs \$150 (an expedited evaluation cost \$125), and every person with mental illness received an average of three such evaluations. In addition, it costs approximately \$100 a day to keep an individual with mental illness in jail. If a defendant is in jail for 10 days, the county spends an average of \$1,450 (\$1,000 for housing and \$450 in evaluations). Since implementing the postarrest diversion program, we have saved approximately 2,000 jail bed nights and \$100,000 in unnecessary psychiatric evaluations. Moreover, these numbers do not include the money continually spent on the same individuals recycled through the system.

Comprehensive Care Program

Perhaps the most important element in the Eleventh Judicial Circuit's Mental Health Project is its integrated comprehensive care program. The deinstitutionalization experience has proved that a comprehensive and integrated system is needed to care for the chronic, mentally ill population (Lamb, 1998). Without follow-up services for individuals diverted up by CIT officers or defendants diverted from county jail to community mental health facilities, all efforts at assisting this vulnerable population will only have a limited effect. A comprehensive care program is essential in instituting long-lasting reforms. Its purpose is to create linkages between the criminal justice and mental health systems to address categorical barriers. Several aspects need to be addressed for a comprehensive system to be effective, such as comprehensive and accessible psychiatric and rehabilitative services (Lamb, 1998), intensive case management services (Dvoskin & Steadman, 1994), access to appropriate community housing, and community support systems. Attention to co-occurring substance-abuse disorders must also be included in such a system.

Steadman et al. (1999) examined and described research conducted by the Substance Abuse and Mental Health Services Association (SAMHSA), which focused on the components of a successful diversion program. SAMHSA found that most successful diversion programs were those that (a) included relevant mental health, criminal justice, and substance abuse agencies in the development of the program; (b) held regular meetings between all key figures from the various agencies; (c) employed a liaison to facilitate the integration of services between all parties; (d) had strong leadership; and (e) utilized nontraditional case management approaches. Assertive community treatment has been shown to work effectively with this particular population (Detrick & Stiepock, 1992; Lamb, 1998). Assertive community treatment is

composed of multidisciplinary teams that go to the clients in the community on a regular basis to provide services such as medication monitoring, psychiatric and psychological follow-up, case management, crisis intervention, substance-abuse treatment, and vocational and social rehabilitation. The Miami-Dade County Criminal Mental Health Project involves (a) a case management system; (b) transition and housing assistance; (c) a system for improving standards of care at adult living facilities (ALFs); (d) monitoring the quality of care and access to services at ALFs working with the court; and (e) regular monthly meetings between all key stakeholders in the community.

The Department of Children and Family Services has assigned a court case management specialist¹⁰ to the county court jail division to solely concentrate on connecting appropriate misdemeanor defendants in the post-arrest diversion program with the local mental health facilities and substance-abuse treatment services. The chief clinical social worker at the Department of Corrections and Health Services refers clients to the court case management specialist once the jail psychiatrist has issued a professional certificate. At this point, the court case management specialist works with the CSU case managers to ensure that the client receives adequate aftercare planning. This individual also assists clients in obtaining and managing their medication on discharge from the CSU and tracks the clients progress after discharge. The court developed an assessment tool for misdemeanor defendants in the diversion program as part of the comprehensive care program. This tool provides the court with the necessary client information needed to ensure a continuity of care is met. The Department of Children and Families has also agreed to fund a FACT team¹¹ for this diverted population. This year, the court case management specialist will refer eligible defendants to a FACT team.¹² In addition, the court is working to improve the quality of care and access to mental health services at the ALFs. The court formulated new standards of care for individuals housed in these facilities and developed a referral program that encourages ALFs to adopt these heightened standards. Participating ALFs agree to comply with the court's standards and avail themselves to a monitoring system, which consists of unannounced site visits by court-appointed professionals. In return, the court will refer eligible clients to appropriate participating ALFs when referring individuals involved in probate, civil, or criminal procedures. Finally, the Eleventh Judicial Circuit has applied for research grants in an effort to better analyze the criminalization of mental illness and is working to establish a one-way computer link between the Miami-Dade County Jail and the public community mental health facilities. The program would allow the jail to exchange daily arrest information with the Department of Children & Families (DCF). DCF would take the information and cross-check it with their database of clients who

have been or are currently being served by one of their funded mental health facilities. DCF would then be able to relay information to the mental health facilities so that continuity of care is maintained for incarcerated clients with previous histories of psychiatric treatment. Of course, confidentiality is maintained. Information on daily arrests are public record, and the information obtained by the system will only be used by DCF to track clients and ensure continuity of care is realized.

OUR NEW PROCEDURE AT WORK

A call comes into 911. The caller informs the operator that a man is in the middle of the street with a shopping cart and that the man is acting “crazy.” The 911 operator passes the call on to CIT officers, who are sent out to the location. The specially trained CIT officers de-escalate the situation and come up with an initial, basic evaluation of the individual’s behavior. Instead of arresting the man and taking him to the county jail, or worse, escalating the situation into a violent confrontation, the CIT officer takes the man to the appropriate public community mental health facility (Crisis Stabilization Unit—CSU) if the officer suspects the man’s behaviors are due to a mental illness. At this point, the receiving facility conducts a full psychiatric evaluation and determines whether the man is in need of crisis stabilization as determined by Baker Act criteria. To meet criteria, the man must be a danger to himself or others or must be neglecting himself to the point at which he poses a substantial threat of harm to his well-being (The Baker Act, 1972).

A different procedure would have occurred if the man in our example would have been arrested and taken to jail. In the event an individual with mental illness is arrested for a misdemeanor (other than domestic violence), a qualified mental health professional (i.e., a physician, clinical psychologist, psychiatric nurse, or clinical social worker) from Corrections Mental Health Services will examine the individual to assess his/her mental health needs. Based on this examination, the mental health professional may execute a professional certificate to initiate an involuntary examination pursuant to Florida Statute §394.463(2)(a) 3. The goal is to issue the professional certificate within 24 hours of the arrest so as to limit the time these individuals spend in jail. Once a professional certificate is issued, the individual is scheduled for a hearing before the county court jail division judge on the next day of court and transported to the crisis stabilization unit. To ensure that the individual remains at the receiving facility, the court sends the individual out with an alternate bond.¹³ The bond only has effect if the individual leaves the facility

without first being released by the court. Only the court can order an individual's release, not the receiving facility.

Once at the receiving facility, if the defendant does not voluntarily accept treatment he or she will undergo an evaluation to determine whether he or she meets the criteria for involuntary placement pursuant to Chapter 394 of the Florida Statutes (The Baker Act, 1972).¹⁴ If it is determined that the individual does not meet the criteria for involuntary placement pursuant to The Baker Act (1972), then a comprehensive discharge plan is developed at the CSU before the client is discharged back out into the community. This includes finding appropriate housing and linkages of services for the maximum continuity of care. A variety of agencies participate in ensuring that continuity of care is facilitated. For instance, the Florida Department of Children and Families (DCF) provides information regarding available resources for payment of medications. DCF also extends a continuum of mental health services, including intensive case management services for certain individuals, such as those admitted under the Baker Act (involuntarily committed), those diagnosed as chronically and persistently mentally ill, those with an Axis I diagnosis of a major mental illness pursuant to the *Diagnostical and Statistical Manual of Mental Disorders (DSM-IV)* (American Psychiatric Association, 1994) and who meet all necessary Medicaid eligibility requirements.¹⁵

GAPS IN THE SYSTEM

The advent of our criminal court diversion program demonstrates that concerns over mental health issues have reached political and judicial levels in Miami-Dade County. Our mental health, judicial, and governmental communities have together engaged in discussions on how to make the system more efficient while maintaining patient care as the priority. The deinstitutionalization of people with mental illnesses from inpatient hospital settings and the reinstitutionalization of this population into the criminal justice system has caused enough concern regarding the wasting of taxpayer money and the resulting inappropriate treatment of people with mental illnesses.

Such concerns have spawned the criminal court's mental health projects to grow in several areas. Even though the program is in its infancy, we are working diligently to assess and address the gaps in our current system. For instance, preliminary research on Miami-Dade County's homeless population has indicated that a significant proportion suffers from mental illnesses. In fact, information obtained from the Miami-Dade County Homeless Trust (2002) indicated that approximately 45% of the homeless individuals in

Miami-Dade County suffer from some sort of chronic mental illness or dual diagnosis (mental health and substance abuse). Research has indicated that one third to one half of all chronically homeless individuals in the United States suffer from a major mental illness (Lamb, 1998). Much of these individuals' mental illnesses remain untreated, and they often find themselves in the criminal justice system. In fact, in 2001 alone, 30% of the total number of clients diverted to the mental health system by the diversion program were homeless when arrested. Of these clients, 20% remained homeless on discharge from a crisis stabilization unit due to reasons such as the lack of transitional bed availability in the community, lack of appropriate assisted living facility placements, ineligibility for Supplemental Security Income (SSI) or Medicaid benefits, or client refusal of placement. The Criminal Division Mental Health Project has begun to actively address these issues by creating a working alliance with professionals and organizations, such as the Miami-Dade Homeless Trust and the U.S. Department of Housing and Urban Development (HUD), whose main focus is on addressing the homelessness issue. Efforts of such community organizations and the county courts are now being directed at assessing the current need to influence the appropriation of the necessary housing services to ensure a continuum of care is followed on discharge from the treating facility.

One of the most challenging obstacles for the program has been maintaining continuity of care for undocumented alien clients. Difficulties are encountered during the discharge-planning phase due to this population's ineligibility for public benefits. Collaborating agencies in the community, such as Social Security, Department of Children and Families, Miami-Dade County Court, and Florida Immigrant Advocacy Center, have come together to discuss this and consider possible remedies. Without benefits such as health insurance, SSI, or Medicaid, most undocumented clients will find it difficult or almost impossible to obtain the necessary mental health treatment subsequent to their CSU discharge. As a result, all CSU efforts are wasted, and they more than likely continue to recycle through the system time and time again. Research conducted by our program to locate existing resources for immigrants has revealed that a limited amount of services are offered to certain immigrant populations by the federal government.¹⁶ However, this is not enough. As a result, one of the program's goals is to call attention to this current gap in services and influence any immigration initiatives in the legislature. Currently, there are efforts to influence the federal legislation to allow for federal reimbursement of monies spent by treating facilities on mental health treatment of undocumented individuals.

CONCLUSION

The goal of the Eleventh Judicial Circuit Criminal Mental Health Project is to develop diversion and linkage to comprehensive care, thereby making jail the last resort. Unlike mental health courts, the emphasis of this program is to utilize and maximize the mental health system as the primary provider of mental health treatment rather than the criminal justice system. Making the criminal justice system the primary provider rather than requiring the mental health system to appropriately perform its function only serves to institutionalize the criminalization of mental illness. The criminal justice system is ill prepared to provide adequate and appropriate care for this distressed population. The program is focused on continuing to collect data about the makeup of our jail population, specifically those individuals with mental illness. Future evaluation needs to focus on the trends that emerge from our research on this population and how such trends may be influencing recidivism rates in both the jail and the CSUs. Particular focus will be paid to gaps in our system and the specific needs of this population.

A report by the surgeon general, U.S. Department of Health and Human Services (as cited in Sigurdson, 2000) on mental illness called all Americans to become part of the solution to our nation's mental health crisis. Miami-Dade County has responded by instituting the County Court's Criminal Mental Health Projects, which encompasses a comprehensive misdemeanor diversion program and work on targeted legislative initiatives, ALF court monitoring system, research and computer linkages committee, and CIT program. We have also joined forces with Florida Partners In Crisis,¹⁷ a statewide advocacy organization consisting of law enforcement officers, judges, state attorney's public defenders, mental health providers, advocates, and consumers committed to improving Florida's mental health delivery system. We continue to grow as the gaps and needs in the community are explored. Like the surgeon general, we too call on all Americans and urge counties across the nation to also develop programs to address the proliferation of people with mental illness in our jail systems. Together, we can stop the revolving door.

NOTES

1. 324 F. Supp. 781 (M.D. Ala. 1972) held that individuals involuntarily committed for mental illness have a "constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition." The court further found that if the state deprived an individual of his or her liberty "upon the altruistic theory that the confinement is for humane therapeutic reasons," then failure to provide adequate treatment violated the very fundamentals of due process; but see *Burnham v. Department of Pub-*

lic Health, 349 F. Supp. 1335 (N.D. Ga. 1972) (denying right to treatment); also see *New York Association for Retarded Children v. Rockefeller*, 41 USLW 2581 (E.D.N.Y., April 10, 1973) (no right to treatment).

2. This issue was addressed in *Wyatt v. Stickney* (1972). See case for more detailed information.

3. See *Wyatt v. Stickney* (1972) for the actual court ruling.

4. The *Wyatt* court later outlined three fundamental conditions that must exist before a program in a public mental health institution is considered adequate and effective treatment meeting constitutional standards. These are (a) a humane psychological and physical environment, (b) qualified staff in numbers sufficient to administer adequate treatment, and (c) individualized treatment plans. The court also adopted minimum constitutional standards of care for the mentally ill.

5. Partners In Crisis.

6. This information was provided by the Florida Department of Children and Families.

7. These interested bodies include: the Eleventh Circuit County Courts, the State Attorney's Office; the Public Defender's Office; various police departments; local community hospitals; public community mental health facilities (receiving facilities); the state and local Department of Children and Family Services; Homeless Trust; and the National Alliance for the Mentally Ill. GAINS is an acronym that stands for Gathering information, Assessing what works, Interpreting the facts, Networking with key stakeholders, and Stimulating change. This acronym is used as the basis for the name of the organization.

8. H.B. 2003, 18 FL Stat. § 99-396.

9. For more detailed information on the Memphis CIT model, contact Major Sam Cochran (901) 576-5735; samcit@memphispolice.org; 201 Poplar, Memphis, TN 38103.

10. Qualifications of the court case management specialist include a master's degree with specialization in mental health and should include previous experience in case management, considerable knowledge of community resources, and experience with forensic clients.

11. Florida Assertive Community Treatment (FACT) is a self-contained clinical team that is responsible for directly providing the majority of treatment, rehabilitation, and support services to identified individuals with psychiatric disabilities. At minimum, the team refers clients to outside service providers. However, they also provide services on a long-term care basis with a continuity of caregivers. The FACT team delivers the majority of the services outside its program offices. The team consists of a variety of mental health professionals, which include psychiatrists, licensed and unlicensed master's and doctoral level mental health professionals, peer specialists, registered nurses, and case managers. The goal of the FACT team is to reduce the number of psychiatric hospitalizations, increase community tenure, and improve the quality of life for individuals with psychiatric disabilities. The target population to be serviced by the FACT team includes individuals at high risk of repeated psychiatric hospital and crisis stabilization unit admissions due to their severe psychiatric symptoms, interactional impairments, and lack of community-based services. Many of these individuals may be homeless and/or involved with the judicial system.

12. The following criteria must be met to be eligible for the FACT team: (a) *DSM-IV* diagnosis of schizophrenia or other psychotic disorders, mood disorders, anxiety disorders, or personality disorders, and (b) high risk for hospital admission or readmission, or (c) prolonged inpatient days, or (d) more than three crisis stabilization contacts. In addition, clients must also meet three of the following criteria to be eligible: (a) an inability or repeated failure at performing daily living activities, (b) an inability to maintain consistent employment at a self-sustaining level, (c) an inability to maintain a safe living situation, (d) a substance abuse disorder for a duration

greater than 6 months, (e) destructive behavior to self or others, (f) high risk of criminal justice involvement.

13. The "alternate" bond is for \$9,999. It serves as an outstanding warrant in case the defendant absconds from a receiving facility. In the event the defendant absconds, law enforcement will seek to pick up the defendant on the warrant. The defendant would then have to pay either a cash or surety bond to be released. The amount was designated to serve as a clue for corrections, law enforcement, and the court that the defendant is a mental health defendant and needs to be returned to the mental health floor of the county jail.

14. The criteria for involuntary civil commitment under The Baker Act include the following: (a) he/she has refused voluntary placement or is unable to determine whether placement is necessary; and (b) he/she is incapable of surviving alone or with the help of others and without treatment is likely to suffer from neglect that poses a real and present threat of substantial harm to his or her well-being; or (c) there is a substantial likelihood that in the near future she/he will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting, or threatening such harm; and (d) all other less restrictive treatment alternatives have been judged to be inappropriate.

15. The provision of mental health services by the Department of Children and Families is subject to the limitations as referenced in Attachment I of the County Court Jail Division Agreement–Mental Health Agreement dated November 27, 2000. The provision is further limited and contingent on availability of funds by the legislature and allocation of necessary resources by the State Alcohol, Drug Abuse, and Mental Health (ADM) program office.

16. There are seven qualifying immigrant statuses for benefits eligibility. They are (a) lawful permanent residents, (b) refugees, (c) asylees, (d) granted withholding of removal/deportation, (e) Cuban Haitian entrants, (f) parolees into the United States for at least 1 year, or (g) certain battered spouses and children. More information can be obtained from the U.S. Department of Justice Immigration and Naturalization Services by calling (800) 375-5283 or on the Web at www.ins.gov.

17. Florida Partners In Crisis is a statewide coalition of stakeholders who have come together to advocate for improvements in Florida's mental health and substance-abuse service delivery system. The focus of Florida Partners In Crisis is to advocate with the governor and the Florida Legislature on behalf of children and adults who have mental health and substance abuse disorders. They meet monthly to discuss and plan advocacy strategies. They have been very successful in raising awareness and increasing state funding for mental health and substance-abuse programs. In fact, during this past legislative session, they successfully advocated against funding cuts and successfully advocated for increased funding. Advocacy included a press conference in Tallahassee, which received statewide exposure, lobbying the legislature in Tallahassee as well as in the legislators' home districts, billboard and television commercials, and an active letter-writing campaign.

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