

THE MENTAL HEALTH AND THE CRIMINAL JUSTICE CONUNDRUM: SOLUTIONS

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I have been asked to write about who I am. I also wonder what I am, sometimes where I am, and always why I am. To paraphrase one of the great philosophers of our time, Popeye, "I am what I am." Many years ago, I was diagnosed manic depressive psychotic and ever since then I have tried to live up to it. I was a rebel without a cause before spending three years in psychiatric institutions. During those three years I found a cause.

– Howard Geld (Howie the Harp)

The subject of mental illness and criminal justice is seemingly very complex. Solutions would appear to be costly at best and unaffordable at worst. Our expectations of the public mental health system would appear so great that those providers in mental health and criminal justice, no matter how concerned and caring, may be unable to meet the growing need.

As a person with a mental illness and as an advocate for others with a psychiatric diagnosis, however, my perspective may be somewhat different. I've been accused of seeing simple solutions to complex problems. Consider, however, that the public mental health system is a \$1.5 billion industry in Ohio. Criminal justice is even larger, and there are many who are quite interested in protecting a system that provides their employment and security. Many may jump to say that my approach is too simplistic. Maybe they will be right. I would argue, however, that what we are doing doesn't seem to be working and that maybe a fresh look at an old problem is in order.

I am a bit awed by being asked to write an article for a prestigious law journal, as well as by the experience, education, and expertise of the experts contributing to this work. Frankly, my introduction to mental health is from the opposite end of the spectrum. I had a career, a home, and a future that ended up trashed because of my failure to get treatment when needed. I spent years using long work hours to avoid looking at myself, and I used alcohol to self-medicate.

The title of this Article is *Solutions*. Those experts in mental health will, I am sure, tell you that the keys to the problem of increasing numbers of people with mental illnesses filling our jails are the following:

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- Treatment must be available;
- Medications must be available;
- People must have safe, affordable housing;
- People must have safe, affordable transportation; and
- People must have an opportunity to contribute to society.

Let me focus on several issues of importance to me—issues that I feel may be a key to many of the problems facing the system and people with psychiatric disabilities. They are quite interrelated.

I. STIGMA AND DISCRIMINATION

Those of us with mental illnesses are often viewed as psychotic stalkers, comic figures, neurotics who do everything to excess, or sometimes as sympathetic characters. Seldom are we depicted as competent.

How do we break that stereotype? We can complain to the media, to Hollywood producers, or to publishers. But the heart of the problem, I believe, is segregation. People with mental illness are placed in separate hospitals or in separate, locked wards in general hospitals. We have separate treatment facilities. We frequently live in segregated housing. And we get services in a system that mandates that you be impoverished to get long-term treatment, and remain impoverished to stay in treatment. To the general public, we remain separate, unknown, and feared.

One could argue that people with mental illnesses can't get jobs and housing in the community because of stigma. One could just as easily argue that until people with mental illness are part of the community working and living side-by-side with the "chronically normal," we can't hope to break those false beliefs any more than we could break the prejudice that women and minorities couldn't be lawyers, judges, or mental health professionals until they were given the chance to prove the prejudice wrong.

The first step in breaking that cycle is to emphasize services that move people from dependence to independence, from tax users to tax payers. We need to promote services that permit people to achieve economic independence. Without hope for a normal life, a stable income, a family, and our own home in the community of our choosing, what incentive is there to want to recover? Without hope for the future, alcohol, drugs, and crime may seem a logical solution in an illogical world.

II. INCREASING CASELOADS AND DEMAND FOR SERVICES

A second problem I see is that the public mental health system continues to grow. Since Ohio passed the Mental Health Act of 1988, state hospital populations have dropped from 4,000 average daily populations to about 1,100 people. The public mental health system, however, has grown

from 225,000 people to more than 300,000 clients. The number labeled as severely disabled has doubled from 38,000 to 76,000.

A major reason for this growth is that laws enable insurance companies to have a lower annual and lifetime benefit for mental illness than for other illnesses or impairments. People enter the system in poverty, referred from an inpatient stay or from a corrections program. And once in the system, people seem to stay forever. Caseloads grow, demand for services grows, and people entering the system are on waiting lists for community support and housing. A dozen years ago at Ohio Advocates for Mental Health, we received many calls from people in the state hospitals trying to get out. Now we get calls from people who feel they need inpatient care and can't get in.

The public mental health system, because of the huge unemployment problem and poverty among its customers, has an "open" front door, but the back door is closed and locked. One becomes so dependent on the system for housing, support, treatment, medication, and even social life, that mental health becomes all-consuming. I have begun referring to public mental health as the giant "roach motel." You can get in, but you never get out.

The solution, I believe, is opening that back door and encouraging people with mental illnesses to get training, education, and employment. I seem to have circled back to the same solution I proposed for the discrimination/stigma issue.

I believe that work is therapeutic for everyone. It gives us an identity, a reason to get up every day and hope for the future. People who work use fewer services, are hospitalized less often, and use fewer medications. And by reducing the demands and costs for maintaining the mentally ill in the public system, dollars are freed to serve those more in need, or those newly entering this system. Work is also a social outlet where we meet friends, confidants, and partners. Most important, when people work, their disability benefit checks are reduced or eliminated, and they pay taxes to support public services,

As advocates we must promote opportunities to reduce disincentives for people to work. The Medicaid system in Ohio, for example, requires that one have no more than \$1,500 in assets to keep services (the same level since 1978), and that if one has income higher than \$482 per month, she must "spend down" that income each month before getting a Medicaid card. Programs like Medicaid Buy-In, implemented in 35 states (but not Ohio) open the doors for people to move toward independence and self-sufficiency. National Medicaid reform should be considered:

Work for Ohioans with disabilities . . . and serious mental illnesses is much more than just a job. Jobs bring dignity, increased opportunities for self-determination. Jobs are people's identity. Jobs are where people meet

their friends, and frequently their life partners. And a job is an opportunity to break the cycle of dependence and isolation that so often accompanies a severe mental illness, or any disability.

A dozen years ago I was sitting at home, smoking cigarettes, drinking coffee and pacing the floor day after day. A job working evenings as a janitor broke that cycle. I got out of the house. I was able to have some income again. Most important, that job gave me back hope that there was a future. We encourage this committee to recommend that an injection of hope for all people with disabilities can occur if we choose to participate in the Medicaid buy in option.¹

We also need to advocate for federal and state legislation that prohibits the insurance discrimination that treats this illness so differently than others and that essentially allows insurance companies to shift costs from the private sector to the public. Many legislators object because they view those changes as a “mandate” for employers and insurers. I view the changes as an end to discrimination.

III. PEOPLE WITH MENTAL ILLNESSES AND CRIMINAL RECORDS

Third, these issues are confounded for people with mental illnesses who have a criminal record, especially for those with a felony conviction. Fifteen years ago most employment applications asked, “Have you been convicted of a felony within the last five years?” Some asked for seven years. Now applications consistently ask, “Have you ever been convicted of a crime?” The record thus follows the employee forever. Expungement may eventually be available to some, but not all, offenders. Even then, if one works in a field or industry where people know each other, and gossip, expungement may not help.

As we consider the more punitive nature of our society in terms of getting ex-offenders into the work force, we see legislators passing more and more bills that restrict the ability of judges to “judge” by increasing minimum sentences and decreasing the ability of the judge to consider mitigating circumstances in sentencing.

The development of drug courts and mental health courts where diversion to treatment in lieu of a criminal record is an important step in the right direction. Expanding this concept beyond misdemeanor convictions to first-time felony convictions may be a logical next step. However, at any level we must proceed with caution. Many people with

¹ Doug DeVoe, Executive Director, Ohio Advocates for Mental Health, Testimony before the Ticket to Work Program Evaluation Committee (March 8, 2001).

mental illnesses see these specialized courts as a way to coerce people into treatment that has been ineffective or inappropriate.

Why would treatment be ineffective or unwanted? As the “system” gets more and more taxed, medications are equated more and more as synonymous with treatment. However, as psychiatrists have less time to spend with each patient, the opportunity to discuss medications, side effects, and alternatives and to really manage a relationship between symptom control with drugs and symptom management without drugs becomes problematic.

For many, when reporting an adverse side effect for a prescribed drug, the solution is another medication to counteract the side effect. And when that produces another side effect, a third, fourth, or fifth drug is added to the mix. Older generation psychotropics may cause permanent neurological disorders. Some newer medications have been linked to huge weight gain, diabetes, and sexual dysfunction. Yet we blame the patient when he or she fails to comply with medication regimens.

Outpatient commitment and jail diversion programs are viewed by many as only an excuse to force pharmaceuticals on people regardless of the consequences to the individual. For some, their programs mean that society values elimination of symptoms of mental illness far more than the quality of life of the patient.

We also need to be cautious to make a distinction between criminals who may have a mental illness and people with mental illnesses who may commit a crime. A person who commits a crime should not be automatically exempt from consequences because of a psychiatric diagnosis, assuming that she is able to understand the nature of the crime; is capable of controlling her behavior and not committing the crime; and is competent to participate in her own defense.

The responsibility of the judge is to weigh mitigating circumstances, including the diagnosed mental illness, to assure that the punishment is just and appropriate. Diversion programs must honor the desire of a person to go to jail rather than to go back to treatment that to them may represent a more restrictive environment.

Diversion to treatment programs is getting more common, as it should. Diversion to hope for the future is uncommon. We, as the *diagnosed*, need a reason to be well and hope for normal lives, relationships, safe places to live, and jobs. Again, I seem to have returned to employment as a key to the success of treatment. We must develop and use employment programs that give offenders hope for the future and a reason to recover. Leaving jail and returning to the same treatment, the same benefit check, and the same lack of hope for the future can only encourage recidivism, not recovery.

IV. CONSISTENT MESSAGES

Fourth, as advocates we must send to policy makers and the general public consistent messages. When we tell those that provide funding that unless we get more money for treatment, the jails will be filled with the mentally ill, we send a message to them, and the public, that without treatment those who have psychiatric diagnoses are dangerous. Unfortunately, public safety sells better than effective treatment.

Yes, those without treatment are more likely to be irrational and do inappropriate things. Yes, without treatment people are more likely to use alcohol and drugs to self-medicate and to end up in the criminal justice system. And without treatment or effective treatment, far more people will end up in hospitals or in danger.

However, the link between alcohol and substance abuse and homelessness or involvement in criminal justice is far more pervasive than the link between mental illness and the criminal justice system. One-third of those committed to Ohio prisons in 2000 had drug-related offenses. Many more who did not have drug charges had substance abuse histories.

Once again this morning I picked up a mental health advocacy flier that said, "One in five Americans lives with a mental disorder each year."² For years advocates have been using this data to argue for more funding for mental health treatment or to combat stigma/discrimination.

Recently, however, I have heard testimony from advocates that there is a serious problem with our public mental health system because twenty percent of people in prisons and jails have a mental illness. Sometimes you hear both figures cited in the same testimony.

Both propositions may be true. It is not surprising, though, that an equal proportion of inmates have a mental illness as compared to the percentage of mentally ill in the general population. By screaming that rising prison populations are directly attributable to untreated mental illness, we reinforce the perception that without drugs we are all dangerous.

If twenty percent of those in Ohio prisons have a diagnosed mental illness, that still represents less than three percent of the number not in jail receiving public mental health treatment. People with mental illnesses are not criminals. A small percentage of people with mental illnesses break the law, sometimes because of lack of treatment, but sometimes because they just break the law. If there is a clear link between the offense and the illness, diversion, and not jail time, is appropriate. If, however, the person appears to be a habitual offender who happens to have a mental illness, no special exemption from consequences should be considered.

² Resource Center to Address Discrimination and Stigma, Informational Update (Spring, 2003).

I have been asked frequently in recent years about the famous *Berry* case, which involved a man who volunteered to be executed in Ohio, and whether executing a person with a mental illness is cruel and unusual punishment. I object to that characterization. There are many adequate controls in the justice system to evaluate: the ability of the individual to understand the crime they committed and the consequences; and the competence to participate in one's own defense.

There are also opportunities for pre-sentence investigation to determine to what extent a mental illness may have been a mitigating factor that might affect sentencing. If the court addresses those issues appropriately and adequately, those of us with a mental illness should be held to the same level of accountability as everyone else. I cannot go into the community and argue that people with mental illnesses need to have opportunities for employment, housing, and community access, and then argue that should we violate that trust, there is a different standard of accountability.

Advocates for more medications, outpatient commitment, and court-enforced treatment have, in my opinion, played a bit loose with data. I recently read an article, for example, citing the percentage of people with mental illnesses in jail at twenty percent. However, instead of comparing that data to the incidence of mental illness in the population (remember that advocates have been citing 1 in 5 for years), the author compared that percentage to the incidence of those with serious mental illnesses, such as schizophrenia, in the general population. Obviously comparing the twenty percent in prison to a serious mental illness figure of 2.8 percent in the general population raises red flags, except that the article never mentioned what percentage of those in prison had serious mental illnesses.

People with mental illnesses share several things with other members of prison populations, such as being poor, disenfranchised, discriminated against, and without hope for the future. Is the link between criminal behavior and poverty and loss of hope, or is it related to mental illness? I think the literature has failed in this analysis.

It is also true that among any population with high unemployment, poverty, and lack of hope, crime is higher and substance abuse and addictions are more prevalent. The link to poverty and hopelessness has significance. The solution is employment programs that give people meaning in their lives and hope for their future. I seemed to have circled once again back to the issue of employment for people with mental illnesses.

Many will argue that people with mental illnesses just are not ready for work or cannot work. A few years ago I had the opportunity to visit The Village, a program for the most severely mentally ill in Long Beach, California. There, the focus is on employment. The staff indicated that they have used a variety of techniques to test readiness for work. Evaluations, interviews, staffing discussions, and testing were used. The

only predictor of success in work that was reliable was the client's stated interest in working.

V. CONCLUSION

At the beginning of this Article, I said that I sometimes see simple solutions for complex problems, maybe unrealistically. However, from personal experience and the experiences of my brothers and sisters who have also been diagnosed with a mental illness, the one thing we take away from people with these diagnoses that we cannot restore is hope. We have come a long way with newer generation psychotropic medications in controlling symptoms. We better understand what works and what does not. But of those 300,000 people in Ohio's public mental health system, nearly seventy percent are unemployed. Of those diagnosed as severely mentally ill, approximately ninety percent are unemployed.

Most have never committed a crime and are unlikely to do so. Few are a danger to themselves or others. Mostly, we are people with an illness, locked into poverty and a treatment system that we would like to escape. We are people with a desire for a decent job, someone to love, and a safe place to live.

Mental illness robs us of that, not because of the illness, but because of insurance discrimination that forces people into poverty to get long-term care, because of a public system that is over-burdened and about to collapse under its own weight, and a public that will not accept us because it believes only the sensationalized image of people with mental illnesses portrayed in the headlines and the marquees. They will not know any difference until their brother, sister, mother, father, or child is affected.

Do we need more funding for mental health treatment? Absolutely. We need a mental health system that can provide treatment, not just drugs, and that can provide individual services to meet individual needs in recovery, including hope for the future and a job.

Do we need more money to treat prisoners with mental illnesses? Of course. If people leave prison without treatment, without links to community treatment, and without hope, they will more likely return.

There is not a simple solution. But if we could cut the unemployment rate for the 300,000 people in Ohio's public mental health system to only fifty percent, compared to six percent in the general population, and half of those people were able to leave public-supported housing and give up their disability benefits, the savings to the public mental health system, the diversion from and the injection of hope to the other fifty percent could make a phenomenal difference. If 100,000 people who are now unemployed and without hope got jobs, paid taxes, and found their own homes, and could contribute to the cost of their own treatment, the injection of funding to assist the other 200,000 in achieving the same recovery could be remarkable.

Maybe there are simple solutions to complex problems. This one starts with seeing a job, a date on a Saturday night, and a safe place to live as integral to treatment and recovery.