

**GUILTY OF BEING ILL: DOES THE PUNISHMENT FIT
THE CRIME?
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The title of this paper is intentionally provocative to underscore the failure of society and mental health policy to provide adequate access and treatment for individuals with mental illness. As a result, a large number of adults and children are incarcerated simply because of the untreated symptoms of their illness.

My son has a serious and persistent mental illness. I have watched him struggle for eleven years to do the simple things in life that I take for granted. I have developed an enduring interest in the criminalization of those with a mental illness. At least to date, there but for the Grace of God goes my son.

I. CRIMINALIZATION OF THE MENTALLY ILL

The United States has the largest incarcerated population in the world. One in every thirty-two adults was behind bars or on probation or parole at the beginning of this decade. According to the Bureau of Justice statistics, a record 6.6 million people are in our correctional system, with more than two million behind bars. Being the leading incarcerator is primarily the result of policy decisions and not rising crime rates.

There is a disproportionate representation of those with a serious mental illness relative to the general population. According to the Bureau of Justice, sixteen percent of all inmates report a mental illness or an overnight stay in a mental hospital. In addition, another fourteen percent reported having received mental health services at some point in the past.

It has been estimated that the occurrence of mental illness in prison could be at least five times greater than in the general population, and the gap is growing. The fastest-growing segment of the prison system is the female population and more than one in four incarcerated women have been identified as having a mental illness.

As large as these numbers are, they are believed to understate the problem because of under-reporting by those who do not want to reveal that they are ill, or because roughly fifty percent of the ill population lacks awareness of their illness. This overrepresentation in our prisons and jails is often referred to as the criminalization of those with a mental illness.

Those of us with an ill family member want criminals in jail, whether or not they have a mental illness. But for those whose crime is non-violent

and is a result of the untreated symptoms of their illness, there is a much more humane and cost-effective treatment.

This issue constitutes one of the gravest social matters facing the country. Well-intentioned but ill-informed decisions and policies have led, for example, to the Los Angeles County Jail being the largest mental institution in the country; followed closely by the Cook County Jail in Chicago, Riker's Island in New York, and the Harris County Jail in Houston.

The French novelist, playwright, existentialist philosopher, and literary critic Jean Paul Sartre gives us a perspective from which to understand history. He suggests that comprehending past events is similar to looking out the rear window of a speeding vehicle. Objects passing close to you are a blur and difficult to clearly image. As they become more distant, they reach focus. Society's handling of those with a mental illness during the past half-century is now coming clearly into focus. These illnesses are common, yet treatable, but the general public's view of someone with a mental illness is fraught with myth and misunderstanding. Thanks to the knowledge and improved science flowing from research during the last decade, the nature of these illnesses is now much better understood.

One in five of us will experience diagnosable symptoms of a mental disorder in our lifetime. One in twenty will suffer symptoms so severe as to be disabled. As much as ten percent of all children experience serious mental health disorders.

These are real, diagnosable disorders, not character flaws or the result of personal weakness. They are more properly called neurobiological brain disorders (NBBB). Success rates for treating the symptoms of NBBB are as high or higher than other serious illnesses, with sixty- to eighty-percent efficacy rates or better. Much like diabetes, these disorders cannot yet be cured, but the symptoms can be controlled through treatment and therapy, and most individuals can lead a fairly normal life. Neurobiological brain disorders are the second most disabling group of illnesses in the world according to the World Health Organization. There is a high level of co-occurrence of mental and addiction disorders. The Mental Health Association estimates that two of three jail detainees have a NBBB and/or a substance abuse disorder.

These are killer illnesses. More people die in America from suicide than from homicide. Suicide is the third leading cause of death for young people aged 15 to 24. White men 85 and older have a suicide rate that is six times that of the overall national rate. According to the National Alliance for the Mentally Ill (NAMI), as much as ninety percent of suicides are related to a severe but treatable mental illness. Because of a variety of factors, not just suicide, the life expectancy of someone with a serious mental illness is substantially shortened relative to the general population.

Contrary to the way in which they are portrayed in the mass media, individuals with a NBBB are no more violent than the public in general when they receive proper treatment. However, when untreated and particularly when mixed with illegal substances, the rate of violence increases.

Stigma is the most formidable obstacle to future progress. Throughout history we have referred to those who were institutionalized with a mental illness as inmates. That image and stigma has carried over into modern-day life resulting in a variety of forms of discrimination. Due at least in part to the stigma, half of those who are ill do not seek treatment.

Health insurance providers discriminate by either not insuring or through higher co-pays, fewer allowed visits, and lower lifetime caps. Ninety-eight percent of private health insurance plans discriminate with benefits unequal to those of other illnesses. Interestingly, several studies have now documented that instituting parity of insurance coverage costs only about one percent more than not equitably covering someone's mental health. The benefits of doing so undoubtedly outweigh the cost.

In general medicine there is no lack of coverage for illnesses that have only mild or temporary disability and no real treatment that works, as in the case of viral upper respiratory tract infection, or for illnesses in which there is at best only a very slight chance of success, as in the case of pancreatic cancer. In most cases, highly-disabling and yet highly-treatable mental disorders receive far fewer resources due in large part to the stigma surrounding them.

Research is under-funded. In spite of having committed to take care of those who cannot care for themselves, our public system of mental health care has historically been substantially under-resourced and does not serve a large percentage of those people needing treatment.

II. DE-INSTITUTIONALIZATION

State mental hospitals have undergone roughly a ten-fold downsizing, from a peak population of about 560,000 in the mid 1950s, as a result of de-institutionalization. During that same period, our jail and prison population increased nearly ten-fold to more than two million. Interestingly, the court has remanded about one-third of the current population of state hospitals there.

De-institutionalization occurred concurrently with major legal, political, and societal changes. These changes include: Increasing stigma about mental illness that made it more difficult to ask for or receive help; the 1960s and 1970s drug culture that made illegal drugs easily accessible to those with a mental illness making drug offenses a primary cause of incarceration for a large number of people with and without mental illness; legal changes prompted by the consumer rights movements made commitment for treatment much more difficult than incarceration; the anti-psychiatry movement of the 1960s that fed the stigma; and the philosophy

of incarceration changed from rehabilitation to punishment (“get tough on crime”) creating a very hostile environment for treatment and recovery.

Even though the 1990s economy was very robust, relatively little of the “extra” economic boom money found its way into the mental health treatment system.

III. TRANS-INSTITUTIONALIZATION

As a consequence of these and other factors, de-institutionalization became trans-institutionalization when large numbers of untreated or under-treated people found their way into the criminal justice system. Consciously or unconsciously, society established high barriers to entry into the mental health treatment system and low barriers to entry into our jails and prisons.

Unfortunately, most state governments saw de-institutionalization as an opportunity for cost savings by closing expensive state-funded institutions for federally-subsidized community services. Consequently, forty percent or more of individuals with a serious mental illness who need care are not receiving it at any given moment.

Rationing treatment to those who have no alternative feeds the homeless population, which is a breeding ground for low-level drug crimes and misdemeanors. NAMI reports that forty to fifty percent of public mental health consumers have had at least one experience with criminal detention, and the percentage is growing. Ironically, a person may appear dangerous enough to himself or herself or someone else to be arrested, but not hospitalized.

Lacking appropriate care, many individuals are arrested simply because of their symptoms. Families are often forced to call the police when all other options have been exhausted.

Police often resort to arrest when the local mental health system is unresponsive. In most communities there is a lack of coordination and sensitivity between law enforcement agencies and the community mental health center. The result, arrest and incarceration, is often the path of least resistance.

After cycling through local jails and courts, minor offenders with a mental illness frequently end up in prison on a misdemeanor offense or for a parole or probation violation. In one survey, twenty-nine percent of jails reported holding individuals with a NBBB for significant periods of time without formal charges, simply because there was no alternative. The criminal justice system has become the asylum of last resort for many mentally-ill persons who need treatment.

Nationally, at least six times more individuals are now institutionalized in the criminal justice system than in state mental hospitals. Because of their impairments, these individuals are some of the most vulnerable members of the prison or jail population. They are disruptive or are abused, and they disproportionately end up serving administrative

detentions and solitary confinement. This is not conducive to treatment and recovery and it makes them some of the most expensive members of the prison population because of individual facility requirements and the larger numbers of necessary human resources. Not surprisingly, suicide accounts for more than half of prison deaths, and almost all who attempt suicide in jail or prison have a psychiatric disorder. There is a more cost-effective approach.

We know there is a more humane way to treat those who are less fortunate than us, but does it make economic sense? The short answer is yes.

Our state and federal governments have constructed an almost impenetrable and dysfunctional system to administer public mental health benefits. I have a Ph.D. and serve as a trustee on the board of the Mental Health and Mental Retardation Authority of Harris County Texas, and I have trouble deciphering this overly-complex system. How then can we expect someone with a thinking disorder to figure out how to get treatment?

I recently served on a state task force to improve services in Texas which determined that at least a dozen different state agencies administer mental health benefits in an uncoordinated way. We have a fragmented, overly complex, non-communicative system of care for those whose fragile existence depends on simplicity.

IV. THE HIGH COST OF INCARCERATION

These are “pay me now, or pay me later” illnesses. We cannot save money by withholding treatment. Those “savings” evaporate as clients deteriorate and end up in the emergency room of the county hospital or in one of the few remaining beds of the state mental hospital if they are lucky enough to avoid jail. In either case, the cost escalates from dollars a day for care in the community to hundreds or up to thousands of dollars per day for care in the local emergency room. This clearly makes no economic sense.

As noted earlier, these are some of the more expensive members of the jail and prison community. While we would very much like to have detailed cost information to make economic comparisons, that information is difficult to impossible to access.

Three years ago, I did an analysis of the cost of Texas prisoners with a mental illness. The results, reviewed with state corrections officials, indicated that in general, offenders with mental impairments are nearly twice as expensive to incarcerate as the “average” prisoner, in this case, about \$30,000 per year compared to \$15,000 to \$20,000 per year.

The Department of Justice indicates that annual costs can be as high as \$50,000 per person to house individuals with a NBBB in jails and prisons.¹

¹ 1996 Source Book: Criminal Justice Statistics.

These estimates do not attempt to capture the related cost of dealing with someone with a NBBB through the entire criminal justice system. To determine these additional costs we would have to add court costs, police costs, social service costs, and ambulance and emergency room costs, to name a few.

In addition to the costs we can estimate, there are intangible costs to be considered, including the deterioration of public facilities, loss of use of certain public areas, and loss due to suicide, among others. The largest intangible cost, of course, is the devastating impact on the individual and his family.

While the Texas Department of Criminal Justice did not confirm my cost analysis, they did not argue with it. I therefore concluded that it does not overstate the cost. Based on available data, it is probably reasonable to assume that the average operating cost of incarcerating someone with a NBBB is in the range of \$30,000 to \$50,000 per year.

In attempting to understand the relative cost of treatment versus incarceration, we have often made the mistake of using average prisoner cost to make the argument that it is less costly to incarcerate than to treat. That is not only an inhumane argument, but it appears to be a fallacious economic argument as well.

IV. THERE ARE EFFECTIVE ALTERNATIVES

We know that there are effective alternatives to incarceration that have been established by community centers in Texas working with Texas Council on Offenders with a Mental Impairments (TCOMI). These programs pick up parolees at release and keep all but a small percentage of them from returning to jail or prison. I am confident that a large number of individuals could be diverted and treated with equal success on the front end of the process, avoiding the debilitating affects of imprisonment while at the same time saving tax payers millions of dollars.

Based on information developed from Assertive Community Treatment teams (ACT teams), it appears that the fully-loaded cost of intensively treating those with mental illness outside of the jail system can be as low as \$10,000 to \$20,000 per individual per year. The higher costs relate to programs dealing with the most difficult cases including those with up to sixty individual arrests and charges as serious as murder, where the majority involved substance abuse as well as a severe NBBB.

Based on more than three years of data from such a program in Wisconsin, it appears that only about twenty percent of the individuals in these programs had been arrested again, indicating an eighty percent success rate, and that fifty to sixty percent of that population was working, versus five to fifteen percent in the comparable general population with a NBBB.

The program I am most familiar with is the partnership noted above between TCOMI and the Harris County Texas Mental Health and Mental

Retardation Authority called the New Start Project. This program serves a few hundred adult felony offenders annually and includes room, board, treatment of their illness, and rehabilitation at a cost of less than \$10,000 per year per individual. The re-arrest rate has been only about five percent, split roughly between new charges and parole or probation violation.

If we were able to develop community services (this would be a monumental challenge for the system) to handle the 8,000 to 12,000 non-violent inmates that TCOMI estimates are in Texas prisons solely as a result of their untreated symptoms, the state could potentially save hundreds of millions of dollars annually while doing the right and humane thing.

V. CHANGES ARE NEEDED

The needed changes include the following:

- adequate funding of community programs;
- blended funding and integrated care for the dually diagnosed (do not make ill individuals deal with two separate agencies for the services they need, particularly when research shows that best results are obtained through integrated services);
- open access to services including education, support, personal care, job training, and housing;
- Crisis Intervention Training (CIT) programs for local law enforcement officials;
- emergency community care with an early response commitment to law officers;
- mental health courts;
- diversion programs to get individuals who are not criminals into treatment instead of jail;
- a modern standard of care in prison (failure to properly treat individuals while incarcerated only makes them more treatment resistant and poor candidates for re-integration into society resulting in higher recidivism rates); and
- discharge planning, or connection with community services at release.

In the middle of the nineteenth century, Dortha Dix and other crusading reformers embarrassed state governments into building mental hospitals after it became obvious that jails and prisons were flooded with inmates having a NBBB.

In the last 150 years we have come full circle and once again are warehousing the mentally ill in our prisons and jails. We now know that in addition to being as inhumane as it was a century and a half ago, it also does not make economic sense.