Chapter 27
Mental Illness and the Law

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Abbreviations

PMI	Persons with mental illness
OPC	Outpatient commitment
RCT	Randomized Controlled Trial
SSI	Supplemental Security Income
SSDI	Social Security Disability Insurance
MHC	Mental Health Court

In its distribution of benefits and burdens, the law employs the term "mental illness" and its synonyms in a variety of contexts to provide differential treatment of persons deemed to be so afflicted. In each legal context, the definition and scope of the class so labeled varies with the purposes of the legal rule at issue. Thus, even though the term remains the same, "mental illness" carries a variety of meanings for purposes of competency to make a will or contract, guardianship, eligibility for and management of government disability benefits or housing, employment discrimination, competency to stand trial, criminal responsibility, and involuntary treatment inpatient or outpatient (Wales, 2009, pp. 390–392).

The legal contexts attracting the principal academic attention of sociologists are those pertaining to the law's role as society's agent for controlling the deviant (nonnormative) behavior of persons with mental illness (PMI). In these contexts, the law strikes attitudes toward PMI that are at once protective/benevolent and fearful/distancing. The former is captured in the notion of *parens patriae*—that the state has a paternalistic duty and authority to assist those unable (by reason of illness, irrationality, immaturity, etc.) to care for themselves. The latter is captured in the police power of the state to take measures to protect citizens from harms inflicted by others. The two intersect in the popular belief that the behavior of those impaired in their capacity for rationality is unpredictable and that they therefore are dangerous (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Phelan & Link, 2004).

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The notions of incompetency (impaired capacity for rationality) and danger (to the person or property of others) are thus central to the law's differential treatment of PMI. Unfortunately, the law struggles to operationalize these concepts in measures that are capable of reliable application (Slobogin, 2007). Consequently, legal decision-makers—in what are often low-level, hurried proceedings in criminal and civil commitment contexts—are accorded substantial unguided discretion. Their tendency is to conflate "mental illness"—and the definitions thereof employed by those psychiatrists and psychologists serving as expert witnesses—with both concepts; this occurs despite the findings that PMI are substantially more competent, in the legal sense, and less dangerous, in particular less inclined to violence, than is popularly supposed (Grisso & Appelbaum, 1995; Hiday, 1995, 2006).

The central nonlegal fact determining the limited efficacy of the law's response to PMI is the paucity of money and resources devoted to the mental health system; thus, the system is one of triage. Triage means substantial and often exclusive reliance on medication for management of deviance associated with PMI. Hence, legal mechanisms are largely devoted to leveraging, by conditioning the receipt of government benefits, or coercing, by threat of hospitalization or jail, PMI to take medications to minimize their deviance (Bonnie & Monahan, 2005; Monahan et al., 2005; Wales & Hiday, 2006).

The Civil Law

Involuntary Hospitalization

Between the Civil War and the last quarter of the twentieth century, society controlled most deviance of PMI by civil commitment to large, isolated state mental hospitals. It essentially turned over nonconforming mentally ill persons—and many other deviants—to mental hospitals for care and treatment, but there was little or no effective treatment available and few resources to develop any treatment. The legal system and psychiatry operated in a paternalistic mode, assuming hospitals and doctors were doing what was best for patients while ignoring the increasingly deplorable conditions that came to exist in these vastly overcrowded and often unsanitary public mental institutions (e.g., Hiday, 2011).

At midcentury, journalistic exposés of these conditions, sociological studies of the harm of institutionalization and stigma, new pharmacological treatments, and the community mental health movement prepared the way for the spread of the civil rights reform for mental patients (e.g., Hiday, 1983). A mental health bar arose that sought to check abuses of prior paternalistic neglect by minimizing civil commitment, arguing that involuntary hospitalization was basically punitive with harmful outcomes. Beginning in the late 1960s, court cases and statutory reforms brought substantive and procedural changes in the law that granted mentally ill persons basic rights and placed limits on how they could be treated against their wills and for what reasons (Appelbaum, 1994; Hiday, 1983). These changes led to large reductions in hospital rolls from both fewer involuntary admissions and shorter stays, although some studies reported increased involuntary admissions after initial declines (e.g., Hiday, 1977). Over the longer term, civil commitment reforms combined with the concurrent passage of Medicaid and its use by states to shift costs to the federal government led to dramatic declines in the numbers of both voluntary and involuntary patients in state mental hospitals from almost 600,000 in 1955 to just under 50,000 in 2001 (Grofein, 1985; Grob, 2008; Rochefort, 1997).

Most nonadmitted and discharged mental patients stayed with or returned to their families or to voluntary care in local nonskilled nursing facilities and did not come into civil commitment proceedings again. However, large numbers of nonadmitted/discharged patients received little or no treatment or services to help them survive in the community. Some, unwilling or unable to comply voluntarily with treatment, fell into a revolving door syndrome in which they were involuntarily hospitalized, stabilized on medication, released, and then deteriorated without adequate treatment, and were involuntary

hospitalized again, accounting for the increased admissions. Although involuntary admissions remain low today, they are still used for persons with severe mental illness in the revolving door syndrome and others in crisis whose behaviors are seen as dangerous to self or others.

Outpatient Commitment

One of the principles of civil commitment reform established in court cases and state statutes is the *least restrictive alternative* whereby persons meeting civil commitment criteria were not to be involuntary hospitalized when their dangerous behavior could be controlled in less restrictive ways. Outpatient commitment (OPC), a legal mandate ordering an individual to obtain treatment in the community while allowing that individual to go about daily activities freely, developed as one such less restrictive alternative (Hiday & Goodman, 1982). Although conditional release had been used by hospitals to coerce patients to obtain community treatment under the threat of rehospitalization, reform legislation allowed commitment to community treatment *instead of* involuntary hospitalization (Wales & Hiday, 2006). Some states later extended OPC to address the revolving door syndrome with "preventive" OPC whereby community treatment could be ordered for mentally ill persons who did not yet meet the involuntary hospitalization criteria but who were unwilling or unable to accept treatment voluntarily and who had a history indicative of the need for treatment to prevent deterioration leading to multiple hospitalizations or dangerousness to self or others (Hiday & Scheid-Cook, 1987; Link, Epperson, Perron, Castille, & Yang, 2011; Wales & Hiday, 2006).

OPC has been controversial because of its extension of the state's coercive power from the hospital to the community (Wales & Hiday, 2006); the relatively few extant empirical reports indicate that no net widening has occurred (Geller, Fisher, Grudzinskas, Clayfield, & Lawlor, 2006; but see Wales & Hiday, 2006, pp. 460–462). In fact, OPC has been used infrequently in most jurisdictions since its beginning because of liability concerns, funding conflicts, inadequate resources, logistical and infrastructure problems, ignorance of the law, skepticism, and inertia (e.g., Christy, Petrila, McCranie, & Lotts, 2009; Wales & Hiday, 2006). Reports from various jurisdictions range from no use to OPC constituting a quarter of outpatients and a quarter of involuntary hospital admissions (e.g., Burgess, Bindman, Leese, Henderson, & Szmukler, 2006; Dawson, 2005; Geller et al., 2006; Hiday & Goodman, 1982; Hiday & Scheid-Cook, 1987; Monahan et al., 2005). In some instances of OPC orders, mental health centers or individual clinicians do not assume responsibility for ensuring treatment such that no intended monitoring, treatment, or service provision transpires; thus, OPC fundamentally does not occur in actuality (Wales & Hiday).

Observational studies of OPC in its first 12–15 years reported positive effects on treatment compliance and safety in the community, but these studies were subject to selection bias. Skepticism that persons meeting involuntary commitment criteria for dangerousness could be treated safely in the community likely led to selection into OPC on the basis of traits predictive of low risk such as family support, employment, and no history of violent acts (Hiday & Goodman, 1982). Later studies conducted after mental hospitalization was reduced to a minimum ran into the opposite bias: Selection into OPC occurred because of a higher risk of noncompliance and dangerousness (McKenna, Simpson, & Coverdale, 2006; Vaughan, McConaghy, Wolf, Myhr, & Black, 2000). Randomized Controlled Trials (RCT) can overcome these selection problems of naturalistic studies, but only two RCTs, with both experimental (court treatment order) and control (no treatment order) groups receiving comparable community treatment, have been published.

The first RCT reported numerous positive outcomes (lower victimization, increased treatment compliance, and better quality of life) as days under OPC orders increased (Elbogen, Swanson, & Swartz, 2003; Hiday, Swartz, Swanson, Borum, & Wagner, 2002; Swanson, Swartz, Elbogen, Wagner, & Burns, 2003). Other positive outcomes (fewer hospital admissions and days, fewer acts of broadly

defined violence, and better treatment adherence) occurred only when the orders were extended beyond their initial 3 months and when combined with more frequent mental health services (Swanson et al., 2000; Swartz et al., 1999). There is a question of whether these last three outcomes may have been due to delayed selection bias as extension of OPC orders was not random. The second RCT (Steadman et al., 2001), which followed the same design, ran into technical difficulties that crippled its ability to evaluate OPC (enforcement mechanisms not in place, many control subjects thinking they were on OPC with orders to comply with treatment, subgroup sizes too small to obtain significance on clearly apparent trends, and most damaging, significantly more substance abusers among the experimental [OPC] group). The study reported no statistical difference on multiple outcomes between the experimental and control groups (Steadman et al.). Some have interpreted this lack of significance as indicative of OPC's inability to improve conditions for persons with severe mental illness (e.g., Pollack, McFarland, Mahler, & Kovas, 2005), but the finding of no difference in outcomes despite OPC's disproportionately high substance abusers arguably suggests that OPC did indeed work better than treatment without a court order.

Costs have precluded more RCTs of OPC, but recent quasi-experimental studies using comparison groups, pre-post designs, and controls for confounders have consistently reported positive effects of OPC on medication adherence and use of outpatient mental health services (Pollack et al., 2005; Segal & Burgess, 2006; Swartz et al., 2010; Van Dorn et al., 2010) and reduced emergency commitments (Christy et al., 2009), but mixed results on mental hospitalization and arrests (Frank, Perry, Kean, Sigman, & Geagea, 2005; Gilbert et al., 2010; Link et al., 2011; Pollack et al., 2005; Segal & Burgess, 2006; Van Dorn et al., 2010). Two New York studies have reported improvements in other outcomes less frequently measured: functioning (Link, Castille, & Stuber, 2008; Phelan, Sinkewicz, Castile, Huz, & Link, 2010), quality of life (Link et al., 2008; but Phelan and colleagues, 2010, found no change in quality of life), violence, and suicide risk (Phelan et al., 2010).

Studies of patient opinions of OPC indicate ambivalence: dislike of its coercive elements but appreciation of the help, structure, safety, and security obtained while on OPC orders (Gibbs, Dawson, Ansley, & Mullen, 2005; Link et al., 2008; O'Reilly, Keegan, Corring, Shrikhande, & Natarajan, 2006). Except for a few persons who remain resentful of the treatment order, OPC's coercive aspects do not appear to interfere appreciably with building therapeutic relationships and benefiting from treatment (Gibbs et al., 2005; Link et al., 2008; Phelan et al., 2010). Taken together, results from all studies representing numerous jurisdictions with variation in legal provisions, enforcement mechanisms, and mental health systems provide substantial empirical evidence that OPC can work to maintain a significant proportion of severely mentally ill persons safely in the community who would otherwise be in a revolving-door scenario.

Other Forms of Leveraged Treatment

There are two other applications of the civil law besides OPC that are used to leverage (pressure or coerce) patients with mental illness to accept psychiatric treatment in the community: (1) representative payees for persons who are deemed unable to manage their Social Security or Veterans Administration payments and (2) requirements attached to obtaining and maintaining supported housing (Monahan et al., 2005). Social Security Administration (2010) data indicate that 37.5% of the 1.7 million adults under 65 years with a mental disorder who receive payments for mental disability have representative payees. In a survey of severely mentally ill patients awaiting discharge from involuntary hospitalization to outpatient commitment, 29% had a representative payee and an additional 14% had their finances managed informally by others (Elbogen, Swanson, & Swartz, 2003). Most of these patients said they had sufficient money for necessities and desired activities, but a minority complained of insufficient money, which varied by spending category from 7% reporting insufficient

funds for housing to 44% for enjoyable activities (Elbogen, Swanson, Swartz, & Wagner, 2003). According to a multicity survey of outpatients with severe mental illness in public mental health systems, 7–25% have their Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) checks sent to representative payees, most frequently immediate family members or mental health providers (Monahan et al.). Fifteen to thirty-three percent of patients reported that their representative payees use the payments to leverage their compliance with medication and treatment appointments, and abstinence from alcohol and illegal drugs (Appelbaum & Redlich, 2006; Elbogen, Swanson, Swartz, et al., 2003; Luchins, Roberts, & Hanrahan, 2003; Monahan et al., 2005). Those who were subject to formal or informal money leverage felt more coercion and less autonomy; nonetheless, they thought that it was effective as a tool to obtain treatment compliance (Appelbaum & Redlich, 2006).

Among the legal mechanisms used to mandate community treatment, housing is most often used as leverage. The above-mentioned multicity study of severely mentally ill outpatients reported that 23–40% had lived "somewhere where they were required to stay in mental health or substance abuse treatment or required to continue taking [their] medication" (Monahan et al., 2005). Federal, state, county, and city subsidized housing programs for severely mentally ill persons who otherwise would be homeless characteristically require both sobriety and participation in mental health and substance abuse treatment to keep program housing and move through a step-by-step progression of services from initial outreach to transitional housing (e.g., safe haven, shelter), to congregate living facilities (e.g., group homes), and finally to independent housing (Culhane, Metraux, & Hadley, 2002; Gonzales & Rosenheck, 2002; Skeem, Markos, Tiemann, & Manchak, 2006; Tsemberis & Eisenberg, 2000). The few studies of supportive housing report positive effects over time in reducing homelessness and shelter use while increasing residential stability (Skeem et al., 2006; Tsemberis, Gulcur, & Nakae, 2004); reducing days in state mental hospitals, public city hospitals, jails, and prisons (Culhane et al., 2002); and improving mental health and abstinence (Gonzales & Rosenheck, 2002; Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Skeem et al., 2006). However, these programs have high dropout rates because of the abstinence and treatment compliance requirements. To include dropouts and refusers, some localities have tried a new model, *Housing First*, that provides supported independent housing immediately on outreach with no demand of abstinence or treatment. This model does require participation in a money-management plan and meeting with staff at least twice monthly, and it offers modified assertive community treatment (ACT) to reduce harm (Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004). One study has shown that *Housing First* produces larger increases in residential stability than the more coercive step model (Tsemberis et al.), but when an independent housing program has no legally mandated treatment, some landlords informally insist on medication compliance and participation in treatment programs as conditions of continued residence (Monahan et al., 2001).

The Criminal Law

Arrests

Police are frontline law enforcers. They employ multiple methods to keep order, arrest being only one. Observational studies in the USA find that most police interactions with mentally ill persons, as with persons who are not mentally ill, do not lead to arrest (Engel & Silver, 2001; Teplin & Pruett, 1992; Watson & Angell, 2007). Police calm confrontations, mediate disputes, offer solutions, placate complainants, provide transportation to mental health facilities, and give assistance to those victimized, and for PMI, they also act as "street corner psychiatrists" (Teplin & Pruett). When there is evidence of law violation, police prefer informal management, limiting arrest to situations that are likely to reignite and

require reintervention, or situations in which a person shows disrespect (Engel & Silver, 2001; McNiel, Hatcher, Zeiner, Wolfe, & Myers, 1991; Novak & Engel, 2005; Steadman, Deane, Borum, & Morrissey, 2000; Teplin, 1994; Watson, Corrigan, & Ottati, 2004). Even then police tend to choose mental health treatment over arrest when the individual is a known mental patient, manifests obvious mental disorder symptoms, or appears to lack criminal intent (Engel & Silver, 2001; McNiel et al., 1991).

The treatment option is more likely to be chosen when the community has adequate mental health resources and when there is a cooperative program between police and mental health agencies such as an intervention team, a crisis unit, and especially a no-refusal mental health facility that is open 24/7 (Grudzinskas, Clayfield, Roy-Bujnowski, Fisher, & Richardson, 2005; McNiel et al., 1991; Skeem & Bibeau, 2008; Steadman et al., 2000). But most communities lack adequate mental health resources and social services. However, service inadequacy in the face of the large numbers of poor persons with severe mental illness who have been living in the community since deinstitutionalization has increased the likelihood of homelessness and substance abuse that, in turn, increase the likelihood of illegal behavior and subsequent arrest (Draine, Salzer, Culhane, & Hadley, 2002; Fisher, Silver, & Wolff, 2006; Hiday & Wales, 2011; Swartz & Lurigio, 2007). To make matters worse, mental health practitioners have often resisted treating criminal offenders and substance abusers (Steadman et al., 2000; Watson & Angell, 2007).

Studies reporting rates of arrest (number of arrests per 100 sample members) or percentages of persons arrested in samples show persons with severe mental illness to have higher arrest rates and percentages arrested than those of the general population (e.g., Crocker, Hartford, & Heslop, 2009; Fisher et al., 2011; Hiday, 1991). One study estimated their likelihood of arrest to be larger for all categories of crime, ranging from 1.84 times as likely for drug-related offenses to 4.72 times as likely for offenses against public decency, with the exception of one category, assault and battery on a police officer that was almost six times as likely (Fisher et al.). The last offense is often charged in cases of resisting arrest, an action more common among mentally ill suspects, especially those intoxicated (Novak & Engel, 2005).

In any 1 year arrests tend to be concentrated among less than a fourth of any sample of persons with severe mental illness (Borum, Swanson, Swartz, & Hiday, 1997; Hiday, 1992; Swanson et al., 2001); over longer periods, slightly more are arrested with reports of 24–28% over a decade (Cuellar, Snowden, & Ewing, 2007; Fisher, Roy-Bujnowski, et al., 2006) and 38–51% over lifetimes (Monahan et al., 2005; Theriot & Segal, 2005).

Samples of PMI in all these arrest studies are drawn from the public mental health system that excludes two groups: (1) the larger number of PMI who are treated privately and (2) the even larger number of those who are not in any treatment. These samples are, thus, not representative of the population of persons with mental illness. In particular, these samples overrepresent persons of lower socioeconomic status affected by multiple socio-environmental factors that exist in poor, crime-ridden, drug-infested, deteriorating neighborhoods with high rates of broken families, unemployment, and homelessness that put them at higher risk of arrest than the general population (Draine et al., 2002; Hiday & Wales, 2011; Kushel, Hahn, Evans, Bangsberg, & Moss, 2005; Sheldon et al., 2006).

Although public mental health clients have a greater chance of arrest than members of the general population, the pattern of types of offenses for which they are charged is similar: The majority of their offenses tend to be misdemeanors rather than felonies; despite media feature stories of mentally ill persons assaulting, raping, and murdering (e.g., Angermeyer & Schulze, 2001), only a few persons with severe mental illness are charged with such violent crimes (Borum et al., 1997; Engel & Silver, 2001; Fisher, Roy-Bujnowski, et al., 2006; Hiday, 1992; Shafer, Arthur, & Franczak, 2004; Swanson et al., 2001). In fact, empirical studies indicate that persons with severe mental illness whom police arrest tend to be charged with nonviolent offenses, most commonly nuisance and survival crimes such as trespassing, loitering, vagrancy, disturbing the peace (loud/obnoxious behavior), disorderly conduct, indecent exposure (for urinating in public), shoplifting, failure to pay for meals ("dine and dash"), passing bad checks, and vandalism. Substance-related crimes (drunkenness, drunk driving, and use

and distribution of illegal drugs) are the second most common (Borum et al., 1997; Engel & Silver, 2001; Fisher et al., 2011; Hiday, 1992; Swanson et al., 2001), but they are often responsible for some of the misdemeanors and assaults (Junginger, Claypoole, Laygo, & Crisanti, 2006; Peterson, Skeem, Hart, Vidal, & Keith, 2010; Swartz & Lurigio, 2007).

Three recent studies of arrests over longer time periods (a decade and lifetime) reported a similar pattern of offenses among pubic mental health clients as that found for shorter periods of time (1 year or less). For instance, the largest category of charges to those with severe and persistent mental illness in the Massachusetts public mental health system over a decade was subsistence and nuisance crimes, which accounted for 28.3% of offenses, followed by property crimes (20.1%) which were almost all theft, some of which were likely to have been for subsistence (Fisher, Roy-Bujnowski, et al., 2006). But these longer term studies differ from short-term studies in having larger proportions charged with more serious offenses (Cuellar et al., 2007; Fisher, Roy-Bujnowski, et al., 2006; Theriot & Segal, 2005). In two of the studies, most of those arrested had at least one felony charge (Fisher, Roy-Bujnowski, et al., 2006; Theriot & Segal, 2005; the third study did not report felonies), and two of the studies reported higher levels of violent crimes (38% and 50%), although the seriousness of the violence was unclear (Cuellar et al., 2007; Theriot & Segal, 2005). Some studies that examined the context of violent charges indicate that PMI who physically resist arrest are commonly charged with assault on a police officer, and their other assault charges are frequently due to fighting with associates (Moore & Hiday, 2006; Junginger et al., 2006; Shafer et al., 2004). The one study reporting serious violent crimes (murder, nonnegligent manslaughter, forcible rape, robbery, aggravated assault, and assault and battery) found PMI to account for only slightly more arrests than studies with shorter follow-up periods (13.6% vs. 10%; Fisher, Roy-Bujnowski, et al.).

It must be noted that most persons with severe mental illness are not likely to become violent; that when they are, it is more likely to take the form of threats and more likely to be directed to themselves rather than to others; that when it is directed to others, the others tend to be family members and associates with whom they have ongoing altercations in which the others are frequently violent toward them; that the actual violent behavior tends to be hitting, kicking, pushing, pulling hair, and throwing objects; that the harm they inflict, if any, tends to be minor; and that they tend to be victims of others' violence more often than perpetrators of violence (Choe, Teplin, & Abram, 2008; Hiday, 2006; Hiday, Swartz, Swanson, Borum, & Wagner, 1998; Teplin, McClelland, Abram, & Weiner, 2005).

Incarceration

Among the large number of persons in the US criminal justice system, persons with mental illness are overrepresented not only among arrestees but also among those detained and incarcerated (e.g., Baillargeon et al., 2008; Ditton, 1999; Teplin, 1990a; Teplin, Abram, & McClelland, 1996). Estimates of the rate of mental disorder among persons in jails and prisons show wide variation depending on measures, methodologies and demographic group (Corrado, Cohen, Hart, & Roesch, 2000; Ditton, 1999; McNiel, Binder, & Robinson, 2005; Steadman, Osher, Robbins, Case, & Samuels, 2009; Teplin, 1994; Teplin et al., 1996). The most frequently quoted rate, 16% (Ditton, 1999), reflects a broad measure of mental illness. A more restrictive definition (severe mental illness) and use of standardized, forced-choice interviews (i.e., the Diagnostic Interview Schedule) yield substantially lower lifetime prevalence rates, about 9% (Teplin, 1990a, 1994): but even these rates are two to three times greater than those in the general population (Teplin, 1990a). The latest study of five jails in two states using the Structured Clinical Interview for DSM Disorders reported current prevalence of serious mental illness to be 16.9%, more than double that in Teplin's classic study, 6.4% (Steadman et al.). Extrapolating this rate to jail admissions across the country, the authors calculated that there were over two million persons with serious mental illness admitted to local jails in 2007. So many are

detained and incarcerated that on any 1 day more persons with severe mental illness are held in jails than are admitted to state mental hospitals (Morrissey, Meyer, & Cuddeback, 2007).

As with others in the criminal justice system, persons with mental illness tend to be single, male, young, poor, Black or from other minority groups, unemployed, homeless, and with low levels of education (Ditton, 1999; Fisher et al., 2011; Hiday, 1992; Sheldon et al., 2006; Steadman et al., 2009; Teplin et al., 1996). Although males are the majority of inmates, the number of women in all parts of the criminal justice system has been growing (Chesney-Lind & Pasko, 2004), and incarcerated women have two times the rate of serious mental illness as their male counterparts (31.0% vs. 14.5%, Steadman et al., 2009; 12.2% vs. 6.4%, Teplin, 1990a; Teplin et al., 1996). Female offenders with mental illness are more likely than comparable males to be young with less education, to be substance abusers and substance dependent, to have suffered trauma and victimization, and to have post-traumatic stress disorder, but they are less likely to have a personality disorder (Abram, Teplin, & McClelland, 2003; Blitz, Wolff, Pan, & Pogorzelski, 2005; Teplin et al., 1996). In prison, they are more than twice as likely as males to receive psychotropic medication and mental health therapy/counseling (Beck & Maruschak, 2001).

The disproportionate number of persons with severe mental illness who are arrested, detained, and incarcerated coupled with the historic, negative stereotype of persons with severe mental illness being violent (Link et al., 1999; Monahan, 1992) supports the belief that mental illness drives individuals to commit crimes, especially violent crimes. This belief underlies the legal verdict NGRI (not guilty by reason of insanity) that is based on the premise that mental illness can cause an individual to become insane, impairing the individual's capacity for rationality so as to distort the decision to engage in specific behaviors. Although there are cases of violent crimes propelled by psychotic hallucinations and delusions that threaten and take control away from the individual, such cases are rare (Fisher, Roy-Bujnowski, et al., 2006; Hiday, 2006; Junginger et al., 2006; Peterson et al., 2010). In fact, empirical evidence does not support the belief that severe mental illness is the main, direct cause of violent or other criminal offending (Fazel, Lichtenstein, Grann, Goodwin, & Långström, 2010; Fisher, Silver, et al., 2006; Hiday, 2006; Silver, 2006).

Although large community, birth cohort, and treatment studies report a statistically significant association between severe mental illness and all crime, violent crime, and violence without reference to arrest, the association is modest in magnitude (Baillargeon et al., 2008; Hiday, 2006; Link & Stueve, 1994). Many of these studies do not control for spuriousness resulting from sociodemographic factors that are associated with both mental illness and offending. Notably missing are controls for residence in disadvantaged neighborhoods, family correlates, and substance abuse/dependence, perhaps the strongest predictor of violence and offending. Studies that do control for such confounders report the relationship to be significantly reduced or even eliminated (Elbogen & Johnson, 2009; Fazel et al., 2010; Link, Andrews, & Cullen, 1992; Sheldon et al., 2006; Silver, 2000, 2006; Steadman et al., 1998; Swanson et al., 2002). In a meta-analysis of recidivism studies, Bonta, Law, and Hanson (1998) found no clinical symptom, pattern, or diagnosis to be associated with rearrest for violent or nonviolent offenses. Instead, they and subsequent researchers have found a common set of characteristics that offenders with mental illness share with other offenders: single, young, male, minority, low education, poor, unemployed, homeless, resident of a disadvantaged neighborhood, victimization, substance abuse, criminal history, family histories of multiple dysfunctions—especially physical/sexual abuse and criminal and/or substance abusing parents—and early evidence of antisocial and aggressive behavior (e.g., Bonta et al., 1998; Crocker et al., 2005; Fazel et al., 2010; Lang, af Klinteberg, & Alm, 2002; McNiel et al., 2005; Sheldon et al., 2006; Silver, 2000, 2006; Swanson et al., 2002).

Extremely high levels of both substance misuse and antisocial tendencies (as measured by psychopathy, criminal thinking, or antisocial personality disorder diagnosis) are found among offenders with and without severe mental illness. For instance, Abram and Teplin (1991) reported rates so high among male jail detainees with a major mental illness that only 6.4% had neither substance abuse/dependence nor antisocial personality disorder. Morgan, Fisher, Duan, Mandracchia, and Murray (2010) reported almost two-thirds of mentally ill prison inmates endorsed measures of overt criminal thinking

that are supportive of a criminal lifestyle; even larger proportions (85% males, 72% females) scored in the high range of antisocial attitudes, values, and beliefs related to criminal activity. Findings from large clinical and population studies of persons with mental illness suggest that the deviance of persons with severe mental illness that is controlled by the criminal justice system is more likely the result of substance abuse and/or antisocial tendencies and their sequelae than the result of mental illness itself (Mulvey et al., 2006; Pandiani, Rosenheck, & Banks, 2003; Poythress, Skeem, & Lelienfeld, 2006; Steadman et al., 1998; Swartz & Lurigio, 2007). Two recent interview studies of offenders (one of jail diversion participants and one of prison parolees) examining reasons for behavior leading to arrest found that only a small proportion was arrested for offenses caused either directly or indirectly by psychiatric symptoms (Junginger et al., 2006; Peterson et al., 2010). Researchers described most parolee offenses as reactive antisocial, driven by hostility and impulsivity (90% of those with mental illness, 68% for those without), and few offenses of those with mental illness as drug or gang related, but did not mention those caused by alcohol abuse (Peterson et al.). Researchers attributed direct or indirect causation to substance abuse in just under one-third of arrests of the diverted offenders (Junginger et al.).

Criminal Justice Treatment

Most jails neither provide treatment while persons with severe mental illness are detained or incarcerated, nor are linkages to treatment and community services provided on exit, despite the high likelihood that their mental status will deteriorate under conditions of crowded confinement (Hartwell, 2004; Teplin, 1990b). Although court decisions require that incarcerated persons be provided medical and behavioral health treatment, relatively few persons with severe mental illness in jails receive any treatment (Teplin, 1990b). In contrast, almost four-fifths of state prisons screen and give psychiatric assessment, provide therapy/counseling, and dispense psychoactive medication, which results in 13% of inmates receiving some mental health therapy/counseling and 10% receiving psychoactive medication (Beck & Maruschak, 2001). However, connection to community mental health services on release is lacking (Hartwell, 2004, 2005; Skeem, Louden, Polascek, & Camp, 2007). Neglect of the mental health problems of these released offenders coupled with their return to disadvantaged neighborhoods without social capital or supportive services (Carpiano, 2006; Kushel et al., 2005; Pogorzelski, Wolff, Pan, & Blitz, 2005) has produced a second revolving-door scenario of arrest, jail, and release back into the community, where the same conditions that led to earlier offending then lead to reoffending and rearrest (Blitz et al., 2005; Hartwell, 2004; Moore & Hiday, 2006).

There are two groups of defendants with mental illness who are exceptions to treatment neglect: (1) the minority sent for evaluation of incompetency to stand trial (IST) who receive treatment to restore their competence so that they are able to understand the nature and purpose of the criminal proceedings and to assist counsel in their defense (American Bar Association, 1989; Crocker et al., 2005; Hubbard, Zapf, & Ronan, 2003) and (2) the even smaller minority (less than 1%) found not guilty by reason of insanity (NGRI), most of whom are sent to mental hospitals and a smaller proportion ordered to treatment in the community (Crocker et al., 2005; Hubbard et al., 2003; Silver, 1995; Silver, Cirincione, & Steadman, 1994). Even so, those falling in these two categories are likely to have little or no community services linkage when released.

Diversion

Some local jurisdictions have attempted to address the relatively late-recognized problem of revolving in and out of the criminal justice system by diverting PMI to receive mental health treatment. These jurisdictions have established various programs to intervene at different points along the path from

police encounter to arrest, detention, prosecution, and incarceration. To avoid arrest, police departments have developed prebooking interventions that include training police for recognition of and dealing with persons with mental disorders, especially those in crisis, hiring mental health professionals to work with police in the field, and establishing specialized police units for mental health crises (Broner, Lattimore, Cowell, & Schlenger, 2004; Draine, Blank, Kottsieper, & Solomon, 2005; Skeem & Bibeau, 2008; Teller, Munetz, Gil, & Ritter, 2006). Prebooking programs most likely to lead to mental health diversion instead of arrest are those with a no-refusal mental health center where police can take and leave offenders with mental illness 24/7 (e.g., Steadman et al., 2000). Some postbooking interventions that attempt to provide treatment and an alternative to incarceration at the earliest point screen and assess all new jail detainees for pretrial release and referral to mental health services. On positive identification of mental illness, these interventions may provide in-jail treatment and case management, pretrial court services involving evaluation and treatment recommendations to the court that may order treatment in conjunction with pretrial release or probation, direct court supervision and support for treatment in multiple status hearings over time, or reentry treatment and case management with linkage to community mental health and social service agencies. Model programs have early identification, integrated substance abuse and mental health treatment, cooperative mechanisms of regular meetings of key agency personnel, strong leadership, and designated boundary spanners in mental health, social service, and criminal justice systems (e.g., Grudzinskas et al., 2005; Steadman et al., 2000).

Empirical research indicates that diversion programs can increase services, reduce jail days, and increase time in the community without increasing psychotic behavior, substance abuse, or arrests (Broner et al., 2004; Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005; Frisman et al., 2006; Moore & Hiday, 2006); however, increases in services for those diverted compared to non-diverted controls, while significant, have tended to be small, that is, the increase in number, frequency, and intensity of services was not large and was substantially less than recommended to meet the need of those diverted (Boothroyd, Poythress, McGaha, & Petrila, 2003; Broner et al., 2004). In such cases, even though arrests showed no increase, there was not the intended *reduction* in offending and arrests (Broner et al., 2004; Chirsty et al., 2005; Frisman et al., 2006; Morrissey et al., 2007). Too often the diversion of these programs was *out of* the legal system but *not into* the mental health system (despite cooperation agreements) (Broner et al., 2004; Boothroyd et al., 2003) or was to mental health treatment-as-usual rather than to specialized services designed to impact the criminal behavior of defendants (e.g., Fisher, Silver, et al., 2006; Morrissey et al., 2007). When prebooking programs avoid arrest and postbooking programs release offenders with mental illness before their trials or shortly thereafter, there will be a reduction in jail days. While saving taxpayer money, and avoiding and reducing jail time, without more services, this practice fails to address the root problems of PMI revolving through the criminal justice system. Many of those so diverted are left without needed treatment and services only to return to former neighborhoods, associates, and ways that almost inescapably lead to their reoffending and rearrest.

To reduce criminal behavior among offenders with mental illness, communities need well-resourced programs that provide integrated mental health and substance abuse treatment and that also address social-environmental factors such as homelessness, unemployment, and criminogenic factors such as criminal thinking and social networks. Forensic assertive community treatment (FACT)—essentially assertive community treatment with a supplemental component that attempts to deal with criminal thinking and behavior and incorporates probation/parole offices as team members—is one such program that has produced positive results in terms of reduced substance abuse, arrests, jail days, and hospitalization; however, many FACT programs lack fidelity to the model and show no positive criminal recidivism outcome (Cusack, Morrissey, Cuddeback, Prins, & Williams, 2010; Lamberti, Weisman, & Faden, 2004; Morrissey et al., 2007).

Mental Health Courts

The most complex organization diversion model, the mental health court (MHC), embodies the components predicted to be successful in reducing criminal recidivism but adds court monitoring to give structure, support, encouragement to, and supervision of both defendants and service providers for a sustained period (Almquist & Dodd, 2009; Moore & Hiday, 2006). In contrast to traditional criminal courts, an MHC has (1) a separate docket, (2) one or two dedicated judges who preside at all hearings, (3) dedicated prosecution and commonly dedicated defense attorneys, (4) a nonadversarial team approach involving consensus decisions by law and mental health professionals, (5) voluntary participation of defendants, and (6) dismissed charges or avoidance of incarceration after successful completion of mandated treatment, depending on whether the defendant enters pre- or postadjudication.

Defendants agree to comply with court mandates that include following an individualized treatment regimen and appearing at regularly scheduled court sessions. Defense and prosecuting attorneys do not dispute innocence or guilt. Rather, they work as a team with judges, criminal justice personnel, mental health practitioners, and other providers to find treatment and services that address the underlying causes of each defendant's behavior—the mental illness itself, any co-occurring substance abuse, and the disadvantages of mental illness such as lack of income, employment, and housing—while protecting the public. Team members recognize relapse is common, and they offer second chances to help defendants try again to change their behavior leading to offending, but they enforce compliance and maximize defendants' motivation to change by using encouragement and graduated sanctions from more frequent court appearances to overnights in jail (Almquist & Dodd, 2009; Griffin, Steadman, & Petrila, 2002; Moore & Hiday, 2006; Redlich, Steadman, Monahan, Robbins, & Petrila, 2006; Redlich et al., 2010). Clinicians and case managers take primary responsibility for designing individually tailored treatment plans that may include medication, individual therapy, anger management, substance abuse counseling, AA, job placement, and housing. All team members work to provide structure, supervision, and encouragement for each defendant in order to improve functioning and reduce offending (Almquist & Dodd, 2009; Hiday, Moore, Lamoureaux, & de Magistris, 2005). These processes, with slight variations, prevail whether MHCs limit eligibility to nonviolent offenders (fearing serious harm from defendants), to misdemeanants (fearing public outcry over more serious offenders being handled too softly), or to felons (believing their longer sentences and the stronger sanction of return to prison are necessary to effect treatment compliance and behavioral change), or require more frequent and/or longer duration of court appearances (Hiday & Ray, 2010; Wales, Hiday, & Ray, 2010).

Given their relatively recent beginnings (late 1990s), there are few evaluations of the effects of MHC, but the few existing studies consistently find that defendants obtain more treatment while participating in MHCs than they did before entry into the MHC and more treatment than similar defendants in traditional criminal court (Boothroyd et al., 2003; Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2003; Herinckx, Swart, Ama, Dolezal, & King, 2005; McNiel & Binder, 2007; Ridgely et al., 2007; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011). Additionally, regardless of the type of offense, MHC defendants have lower arrest rates and percentages offending afterward than they did before MHC entry, and they are no more likely to reoffend than defendants with mental illness in traditional criminal court, even though they are at greater risk of reoffending because they are in the community longer (Herinckx et al., 2005; Moore & Hiday, 2006; McNiel & Binder, 2007; Ridgely et al., 2007; Steadman et al., 2011). There were initially mixed results about whether MHC defendants have a *lower likelihood* of reoffending than comparable traditional criminal court defendants, but recent studies indicate that MHCs reduce recidivism beneath the level of traditional criminal courts (McNiel & Binder, 2007; Moore & Hiday, 2006; Ridgely et al., 2007; Steadman et al., 2011) and accordingly reduce time spent in jail (e.g., Christy et al., 2005; Steadman et al., 2011).

As with OPC, there is a dearth of RCTs to evaluate MHCs; thus, all outcome studies except one RCT suffer from selection bias despite quasi-experimental designs and use of propensity scores in the better studies. Selection bias can arise from both court officers who select defendants most likely to succeed and defendants who are most motivated to change and take the opportunity to get the help offered by the court. No study has tested the mechanisms by which MHCs produce reduced criminal recidivism. According to the logic behind their creation, it is treatment of the underlying mental illness that should alleviate the cause of offending (Almquest & Dodd, 2009; Moore & Hiday, 2006), but as we have seen, the main cause of offending by PMI lies elsewhere in most instances. Furthermore, successful MHCs do more than marshal resources to provide mental health/substance abuse treatment: They also monitor and sanction compliance with that treatment and with behavioral mandates, and they provide supportive services to reduce or remove at least some criminogenic socioeconomic and environmental influences (Fisler, 2005; Hiday & Ray, 2010; Moore & Hiday, 2006; Redlich et al., 2010). These interventions have not been assessed in terms of type, level, and adequacy relative to individual needs. Also needing to be measured and tested are the court processes that may make a difference in motivating behavioral changes. The manner in which MHCs, as opposed to traditional criminal courts, interact with defendants appears to make a difference in defendants' changing their offending behaviors. Two observational studies suggest that procedural justice (that is fair and gives defendants voice, validation, and respect; Wales et al., 2010) and reintegrative shaming (that condemns offenses but not offenders, and forgives and welcomes offenders back into community; Ray, Dollar, & Thames, 2011) are important practices by which MHCs operate to reduce criminal recidivism. Testing these two procedural mechanisms must wait until studies that are in progress have completed their follow-up periods.

Conclusions and Remaining Questions

Many of the same individuals with mental illness who are leveraged into treatment by the civil law are charged with offenses by the criminal justice system, which then tries and punishes them with incarceration or probation, releases them into the community without any supports and services, or diverts them back into the mental health system. The mental health system, whether sent PMI by civil or criminal courts, commonly has too few resources to provide treatment addressing their mental disorders, much less provide the multiple services addressing their criminogenic behavior patterns and social environments.

Coerced treatment by either the civil or criminal court systems is likely to have the intended impact on improved functioning and behavior, including reduced offending, only if and when society makes significant funding commitments to needed treatment and services for PMI. Thus, the success of treatment, along with the choices made by local bureaucrats between civil and criminal paths for leveraging it, is most often explained by following the money trail (Grob, 2008). Although many federal, state, and local governments have been willing to provide additional funds to the criminal justice system for diversion programs under the banner of community safety, with few exceptions they have made relatively meager provision to mental health and welfare agencies for treatment and service needs of PMI who are added to agency rolls by either civil or criminal court orders (e.g., New York's outpatient commitment statute, Link et al., 2011; Wales & Hiday, 2006).

Given limited resources, what happens to voluntary patients when courts send new patients and old intermittent patients into existing programs for sustained treatment? As we have seen, most of those sent receive inadequate treatment (Boothroyd et al., 2003; Broner et al., 2004), but do those the courts send displace those asking for treatment? In the initial period after the passage of New York state's OPC statute, which allocated additional funding for treatment and services, those on new OPC orders received priority in allocation of assertive community treatment and intensive case management,

effectively displacing voluntary patients to further back in the line, but after 3 years, intensive services increased for both groups (Swanson et al., 2010). What is the effect of OPC and MHC programs on community mental health services? When they leverage coordination and integration of service providers, do these improvements carry over throughout the mental health and social service systems?

Although studies have shown OPC and MHCs to have positive effects on PMI for up to 2 years after expiration of court orders, what happens to them in the longer term? Because of the persistence of their severe mental disorders, they will have a continuing need for treatment and services. Will the benefits obtained and alliances formed during participation in these programs lead to their voluntarily seeking and obtaining needed care? What proportion will deteriorate to the point of reoffending or becoming dangerous so as to need legal intervention to coerce treatment in the community, in hospitals, or in jails?

How do MHCs and OPC compare in controlling the deviant behavior of PMI who revolve through both the criminal justice and civil commitment systems? Is one better than the other in reducing criminal recidivism, violence, victimization, substance abuse, and treatment nonadherence, and in improving quality of life? Is one better than the other in reaching these goals for certain types of persons? How do MHCs and OPC compare with less formal coercive programs such as supportive housing and representative payees in reaching these goals?

The current tilt toward the criminal justice system raises further questions. What is the effect of MHCs on traditional criminal courts? Do they become more sensitive to mental disorder or to the need to change socio-environmental influences to reduce recidivism? Do they employ other alternatives to punishment-by-incarceration in settling cases of defendants without mental illness? What is the effect of MHCs and other diversion programs on PMI? Do they cause police to pick up more PMI rather than resolving problems on the street or leaving PMI alone?

Although there are multiple commonalities in socioeconomic characteristics and poor socio-environmental conditions for offenders with and without mental illness, those who do have a severe disorder differ in the dominant risk factors that lead to offending, arrest, detention, and incarceration. Drawing from theory and empirical research, we suggest that there are five patterns of risk factors that produce five different offender groups, each requiring different programs and management if their criminal recidivism is to be reduced and public safety protected (e.g., Hiday & Wales, 2011). The first group, the "Illness Only Group," is small in number, consisting of those with severe mental illness whose psychosis is directly causative in their offenses, which are often the more serious ones of aggravated assault, arson, rape, and homicide. Because hallucinations and delusions are primary in their offending behavior, their deviance is more likely to be controlled with mental health treatment than punishment; but punishment under the law is a criminal-responsibility question, the answer to which depends on their capacity for rational judgment, not on the causes of their behavior.

The second, much larger group, the "No-Place-To-Go Group," also consists of persons with severe mental illness whose psychosis is causative in their offending but only in combination with their "no-place-to-go and nothing-to-do" situation. Their offenses are minor and relatively harmless, mostly nuisance offenses such as loitering, disorderly conduct and disturbing the peace for making requests of shoppers, trying to talk with them in front of stores and fast-food restaurants, or talking to voices while loitering in malls. These behaviors would not be cause for arrest if they did not occur in public. The deviance of this group of offenders is, like that of the first group, more likely to be remediated effectively by treatment in the mental health system to reduce their symptoms. However, they also need services addressing their social and economic problems that leave them with no place to go and nothing to do.

The third and fourth groups consist of persons with severe mental illness whose offenses are caused only indirectly by their mental disorders that leave them with low levels of education and the inability to obtain employment providing enough income for basic necessities. They live marginally, often homeless, in disorganized, impoverished neighborhoods where they face crime and victimization. Their social situation leads the third group, the "Survival Group," to commit survival offenses

such as shoplifting to obtain food and trespassing to obtain shelter; this social situation, in combination with poor judgment, commonly a secondary effect of severe mental illness, leads them to be easily misled by criminal associates into committing other offenses such as stealing and delivering drugs. As with the second group, mental health diversion coupled with social services to improve their functioning and meet their survival needs would be more effective than punishment in the criminal justice system.

The fourth group, the "Substance Abuse Group," like the third group, lives under these marginal conditions and commits survival offenses, but they have the additional problem of substance abuse that leads them to illegal drug use and disruptive and assaultive behaviors arising from intoxication, theft and prostitution to support their addictions, and violence associated with procuring drugs and drug money. All of these behaviors are criminal offenses arising out of their limited opportunities and their neighborhoods' negative influences; the acts are not directly caused by mental illness with the exception of substance misuse as a form of self-medication. Some members of this fourth group are frequent users of mental health crisis units, homeless shelters, hospital emergency departments, detox facilities, welfare agencies, and local jails, but their use of these services is only sporadic for short periods. To reduce their criminal recidivism, these persons need to be diverted to programs offering sustained treatment and services to change their addictive and mental health problems and to change their social and economic conditions.

The last group, the "Criminal Thinking Group," consists of persons who are psychopathic or have "criminal thinking" or antisocial tendencies, as do most prisoners without mental illness, and who only coincidentally have severe mental illness. Members of this group tend to be intimidating, threatening, and aggressive with high rates of substance abuse, violence, arrests, convictions, and incarcerations. Because their violent and criminal behaviors are driven by their character disorder and not by mental illness, their deviance is not likely to be controlled by treatment in the mental health system and provision of social services. Members of this group are not good candidates for diversion, given currently available treatment modalities. Furthermore, the legal system does not consider psychopathy or personality disorders to be mental illness for any purpose (e.g., criminal responsibility, civil commitment, receipt of government benefits), except in the case of civil commitment of sexually violent predators.

This delineation of these five types of offenders points to the need for policymakers and practitioners in both the mental health and criminal justice arenas to recognize that (1) not all offenders with severe mental illness are the same; (2) severe mental illness is not a sufficient condition to explain offending behavior by most persons with severe mental illness (even in the small group whose psychoses drive the crime, there is still the likelihood that micro- and/or macro-social factors explain why only some with psychotic delusions and hallucinations act on them; Hiday, 1995); and (3) mental illness is only indirectly causative of crime in the overwhelming majority of offenses by persons with severe mental illness. Indeed, mental illness has been ascribed excessive importance as a possible cause of criminal offending, especially violent offending. In focusing on deviance by persons with mental illness that leads to criminal offending, one needs to remember that much larger than all of these five categories of mentally ill offenders combined are persons with severe mental illness who do not fit into any of these five groups because, like most persons without mental illness, they do not criminally offend.

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