PRETRIAL CHALLENGES TO PUBLIC POLICY: MENTALLY ILL OFFENDERS

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Abstract

Mentally Ill Offenders (MIOs) in the pretrial stage present formidable challenges to public policy and criminal justice sanctuaries. Their processing and treatment, in view of the generally overcrowded inmate population, raises questions about the rights and the safety of MIOs as well as the community at large. This article focuses on the issue of pretrial release of MIOs in the Cook County (Chicago) Department of Corrections (CCDOC) because of chronic overcrowding.

Pretrial release practice raise fundamental questions about how community service organizations, mental health agencies, and criminal justice institutions could benefit from better program coordination. Efforts to develop pretrial programs in context with the unique circumstances of MIOs and community safety would facilitate decreasing of MIO detention populations and advance their successful social reintegration.

Increasingly new demands and stresses are being placed upon the criminal justice system as the result of adjustments and "downsizing" of the social welfare safety net. Criminal justice personnel are expected to take on new and challenging roles for which they have not been properly prepared. For over a decade, gradual widespread cutbacks in public spending for care of the chronically mentally ill have produced a population of "street people." This population would have been provided for in the high spending era of the “Great Society,” but now they are relegated mainly to “homeless shelters” and, increasingly, problematic encounters with the criminal justice system. Public policy is frequently presented with problems that are perhaps as difficult to formulate as they are to solve. The substantial increase in the number of mentally disordered persons residing in the community represents a classic social dilemma (Teplin, 1985). A long-standing and widespread problem throughout the United States and Canada, no population poses a greater challenge to policy-makers than MIOs (Laberge & Morin, 1995; Solomon & Draine, 1995).

Because of chronic overcrowding, urban jails, such as those maintained by the CCDOC, have been forced to release many detainees who would otherwise be retained in custody. The overwhelming preponderance of this population, of course, has not been found guilty of a crime but they are being held pending trial. Manikas (1989) says, “Since only 15% of those found guilty are actually sentenced to prison, while the remaining 85% are sentenced to probation (a form of “out-patient” treatment) it is unclear why the defendant should suffer greater deprivation of liberty while awaiting trial than if actually convicted. The challenge before correctional institutions is not how to confine all those who have been arrested and charged, but to seek the most appropriate population for the institution.

Cook County Department of Corrections, Chicago

Chronic overcrowding at the CCDOC has resulted in the need for hundreds of inmates to sleep on floors--up to as many as 2,000 on a given day (Myrent, 1989). This situation has resulted in a Federal Court Order (Duran v. Elrod, 1982) mandating administrative intervention to reduce and eliminate corrections overcrowding (John Howard Association, 1991). A Pretrial Services Department has been established to enable pretrial release of inmates on individual recognizance bonds to reduce overcrowding. Additionally, the Sheriff of Cook County, as the chief administrator of the city jail, was given wide latitude over whom to accept into the jail under terms of the Duran consent decree (Manikas, 1989).

Mentally Ill Offenders In Cook County Corrections

Studies of the inmate population at CCDOC have revealed the incidence of severe mental disorders "two to three times higher than those in the general population and that "over six percent of all incoming corrections detainees were suffering from a current psychotic illness" (Teplin, 1990, pp. 1, 4). To meet the needs of this population, Cermak Hospital, Division 8 of CCDOC, a 700-bed hospital primarily devoted to psychiatric illness and drug and alcohol addiction, was established. Cermak Hospital's psychiatric program was expanded following another court suit (Harrington v. Divito, 1982) which determined that MIOs have a right to treatment. In addition, that court suit mandated that Cermak Hospital should provide a stipulated level of psychiatric care. A sampling of the range of MIOs is provided in Tables A1 and A2: the Cermak Department of Psychiatry Diagnostic Breakdown for March 14, 1991.

[Insert Table A1 and Table A2]

Deinstitutionalization has contributed significantly to the homeless population and has become a national scandal. A considerable etiology has emerged in the field analysis of this phenomenon (Isaac & Armat, 1990). Belcher (1988), states that "deinstitutionalization of state mental hospitals and narrowly defined civil commitment statutes have contributed to an increase in the number of chronically mentally ill persons being incarcerated." And, further, "Involvement with the criminal justice system can become more commonplace . . . in part because of community intolerance of mentally ill people's behavior." Those persons "wandering aimlessly in the community, in a psychotic state much of the time and unable to manage their internal control systems . . . found that the criminal justice system was an asylum of last resort" (pp. 185, 187, 193). Anxiety over public safety is concurrently manifested with concern for potential liability. According to Appelbaum (1988), ". . . concern about potential liability is leading some clinicians to participate in the creation of a system of preventive detention for persons thought likely to commit violent acts" (p. 779). Innovative models involving community mental health agencies and municipal jails are emerging in response to the dilemma of MIOs. The Milwaukee County Forensic Unit and the Milwaukee County Jail-Judiciary System are participating in a cooperative screening process at the booking stage with linkage to the psychiatric services of the Milwaukee County Mental Health Complex (Palermo, Smith & Liska, 1991; Palermo, Gurnz, Smith & Liska, 1992).

The level of involvement of homeless mentally ill persons with the criminal justice system in Chicago is high. Rossi (1991, pp. 146, 164), has shown that 16.5% of Chicago's homeless have served a sentence in a state or federal prison. Some 40.6% served time in a city or county corrections institution, and 28.3% were granted probation. Correlated with this is the finding that about one in four (25%) of Chicago's homeless has had at least 1 episode of hospitalization in a psychiatric institution. Of those hospitalized, 60% have been hospitalized more than once and 30% have had 4 or more hospitalizations.

Further studies (Lewis, et al, 1990, p. 114) of 313 patients released from 4 state mental hospitals near Chicago showed that 19% of this group (60/313) were arrested for 128 charges and 106 separate arrests. Twenty-six of those arrests were for felony charges, and of these, 12 were for violent crimes.

When assessing the criminal histories of this group, Lewis (1990) found that a total of 129 of the 313 possessed a criminal history, that 36% of them had previously been arrested for felonies and that 26% of their arrests had involved violent offenses, e.g., murder, rape, armed robbery, aggravated battery and aggravated assault.

Substantial portions (72%) of the MIOs held in the CCDOC suffer from co-occurring disorders, e.g., they are substance-abusers in addition to being mentally ill. Teplin (1990, p. 1036) suggests that "persons with multiple problems are persona non grata at many treatment facilities and may be arrested as a way to manage their disorders."

Lewis (1990, pp. 25, 29, 30) found that "the overwhelming majority are without work and are on welfare, with only 21% of those surveyed having incomes exceeding $1,000 a month. Many, (45%) are considered transient--having moved at least once during the preceding 6 months. Pallone & Chaneles (1990), point to the even more severe problems encountered by the female subset of this population (p. 65).

Given the above statistics, it is reasonable to assume that many of the homeless, chronically mentally ill who commit offenses do so, in part, because of their impaired condition and because, for whatever reason, they are not receiving sufficient medical and social attention. New York City, the first municipality to develop mental health minimum standards in 1984, has promulgated for standards for priority development of a range of available housing options for mentally ill persons who are incarcerated and homeless (Rock & Landsberg, 1994, p. 10).

Officials working with this population complain of the difficulty of finding suitable out-placements for MIOs. They state that existing facilities for the chronically mentally ill, especially the homeless, are hopelessly overburdened. Furthermore, many of these facilities are unwilling to receive clients who are dually diagnosed, or who are involved with the criminal justice system.

It is necessary, from a policy standpoint, to answer these questions:

1. Is the present system, which incarcerates chronically MIOs awaiting trial, in the best interest of the criminal justice system? How does this policy impact the urgent necessity to incarcerate only the most appropriate and end overcrowding?

2. How can the constitutional right of bail or pretrial release be afforded to mentally ill offenders?

3. What should constitute the program outline for mentally ill offenders who reasonably could be released pending trial? What form should this program take?

Continued incarceration of MIOs who could be appropriately treated on an out-patient basis puts an unnecessary burden on the already strained facilities of Cermak Hospital and CCDOC. Yet, there is reason to believe that criminal justice costs could substantially be reduced if these offenders were counseled in a community setting. Moreover, incarceration may be an inappropriate restriction of inmates who could adequately function in alternative settings. A manual prepared by the Administrative Office of the Illinois Courts warns “in addition to the disruption it poses for any ongoing treatment/habilitation program, for some such individuals, placement in Corrections can be harmful or dangerous...such placements can cause de-compensation and exacerbate psychiatric tendencies” (Hafemeister, et al., 1989, p. 31).

If it is desirable to obtain pretrial release for MIOs, how can the criminal justice system assure adequate measures of supervision for those offenders? Currently, personnel supervising release programs have reported varied problems associated with MIOs. Officers have reported difficulties in these areas:

1. Level of supervision. It is believed that MIOs require a high level of supervision and need frequent contact with supervising officers. Often, it is perceived that requiring MIOs to make frequent visits to regular supervising offices is disruptive to treatment and is unnecessarily burdensome or unsettling to the offender. Frequent home visits are more appropriate; however, these place a greater burden on staff resources. Officers who supervise MIOs require special training in order to interact properly with these offenders to address their needs and conditions.

2. Adequate medical placement. Many community mental health centers are overburdened and understaffed. Additionally, there appear to be rather wide variations in approach to chronically mentally ill offenders. Not all community-based mental health centers are receptive to MIOs as clients. MIOs, according to Sayner (1989, p. 4), are considered to be "unmotivated, resistive, sometimes openly hostile and excessively acting out . . . who do poorly in treatment because they fail to stay in treatment or follow treatment directives" (Carney,1977).

[As observed above, MIO problems are further exaggerated by drug and alcohol abuse. These "dual-diagnosis" clients have an especially hard time finding appropriate treatment. The mental health community often declines to treat drug and alcohol abusers, while the drug and alcohol treatment community is unprepared to address the complex issues of mental illness. Frequently, these clients are on a merry-go-round and their needs as dual-diagnosis patients seldom are comprehensively addressed (Teplin and Abrams, 1991).]

3. Housing. Many MIOs lack an appropriate residence; either their families cannot or will not take them in, or do they have money even to rent a room in a Single-Room-Occupancy hotel (Lewis, 1990). Landlords are often reluctant to house MIOs. Sheltered residential programs serving the mentally ill in Chicago report overcrowded conditions. Finding appropriate housing can be an overwhelming problem for MIOs. Their help-seeking skills are overly challenged, and therefore they represent a full-time job for Pretrial Officers responsible for these clients.

4. Life-skills support. MIOs frequently are unable to cope with basic life skills or are unable to manage money obtained through entitlement programs. Their lack of life skills negatively influences their ability to regularly attend scheduled court appearances or other events that the court may dictate.

Fully meeting the conditions that would allow the release of MIOs into pretrial supervision would require additional programmatic initiatives, especially if such released supervision were to encompass the entire CCDOC population. Since these initiatives would inevitably require additional resources, what improved cost-benefit ratios might accrue from such a program?

The actual cost of housing and treating an MIO in CCDOC is substantial and far exceeds the already high cost of housing an offender in the general population: Alaimo (1991) suggests a sum in excess of

$18,000 per year. The average length of stay in CCDOC for a pretrial detainee is 137 days. It is possible that the financial benefit resulting from pretrial release and placement in an appropriate outpatient setting would be significant.

Bowen J. Sayner, Assistant Executive Director of the Wisconsin Correctional Service, places this question in a moral as well as an economic context:

> In communities where, not just the arrest and conviction rate of mentally ill offenders is higher, but where the detention rate is high and the length of detention tends to be long--costs for such things as Corrections per diem, in Corrections treatment, forensic services and other prosecutorial activities will be extremely high indeed. I will not dwell on the simple moral issue of jailing of the untreated mentally ill for basically being sick--nor will I question the efficacy of treating the mentally ill in a Corrections setting. I merely make the case that doing so costs a lot in terms of money and human suffering and, in my opinion, it is unnecessary. (1989, p.4)

Programs For MIOs In Other States

Sayner (1989, p. 6) estimates that the cost is $3,000 per year for one MIO in his Community Support Program (CSP) in Milwaukee, Wisconsin. The Wisconsin Corrections Service-Community Support Program follows a medical model that provides a stand-alone clinic with the following services:

> 1. There is program provision for the basic needs of the client: food, shelter, clothing, and medical care from the first day of release.
>
> 2. There is program provision for administering medication and other services daily (5 days a week) following an intensive casework model.
>
> 3. The program staff initially assist clients with their financial needs by initially-securing a source of income, acting as payee, and assuring that basic needs are paid for, thus, the CSP alleviates one of the most common problems facing mentally ill persons, the inability to manage their finances (Worzella & Sayner, 1990).

Other models, such as one developed in Florida, concentrates on organizing and coordinating local community resources moving from a situation in which "in 1986, it was almost impossible to place a mentally ill offender . . . into a community residential program in Florida." But, following "years of encouragement, opportunity and persistence" the situation has improved (Griffin, 1990, p. 102).

In Texas, the Department of Corrections (TDC) has developed a high level of interagency cooperation to provide intensive case management and coordinated social services to offenders (TDC, 1989).

In New York, a variety of institutions address the needs of the MIOs, utilizing such programs as Treatment Alternatives to Street Crime (TASC) which pursues a referral model, and Mental Health Alternatives to Incarceration (MHATI), which pursues an intensive case-management model. Another New York agency, the Mental Health Clinic for Socio-Legal Services, in Rochester, provides a free-standing mental health clinic and has a goal of establishing a "forensic halfway house" that would provide a 24-hour structured routine (Taft, 1989, pp. 20, 13).

A program in Los Angeles County, California, according to Lamb, Weinberger & Gross (1988a, pp. 452, 453, 456), followed 79 individuals who had been found not guilty by reason of insanity and who had been referred to the Conditional Release Program of the Los Angeles County Department of Health. Of this group, 99% were charged with felonies and 67% were charged with crimes of violence against persons. The group is described as "a seriously mentally ill, violent group: 72% had a history of psychiatric hospitalization". The Los Angeles study found that of the 79 subjects studied over a 33-month period, 13 (16%) were re-arrested . . . and that 27 (34%) were re-hospitalized. These figures worsened over a 5-year period: 32% were rearrested and 47% were re-hospitalized.

In Contra Costa County, California, a psychiatric resident from the local Community Mental Health Center rotates through both the Corrections and the center during the course of a week, providing a certain continuity of care (Steadman, et al, 1989, p. 140).

A similar group supervised by Oregon's Psychiatric Security Review Board found that, of 165 subjects released into its community programs, 10% were charged with new crimes, and "40% had

conditional releases revoked, primarily as a result of deterioration of their mental health status" (Lamb, Weinberger & Gross 1988, p. 450).

A similar effort operates in Cook County, Illinois where, since April 1989, the Department of Adult Probation maintains a separate Mental Health Unit to supervise MIOs through a system of case management. Spica (1991) cites the "compartmentalized nature of the mental health system" as a retarding factor in implementing his program. The shortage of coordinated services perpetuates a "revolving door syndrome" and results in the shunting of mentally ill offenders from one system to another and back again in the community with little or no improvement in their disorders or lives. These conditions are not limited to the United States, but occur as well in other developed nations such as Britain, where the community resources have been sorely overtaxed after years of cutbacks in social spending (Scanell, 1989).

The lack of effective linkage between CCDOC and community mental health agencies is described by Carl Alaimo, clinical director of Psychiatry at Cermak Health Services as "a tragedy for this population with a near total lack of linkage to community-based psychiatric services subsequent to their discharge from CCDOC."

These results underscore the value of carefully supervised programs in order to assure public safety while providing for the needs of the offender. While they provide no panacea, their benefits seem to outweigh their detriments. Some communities have risen to the challenge of caring for seriously mentally ill individuals. Exemplary programs include diversion programs to keep the seriously mentally ill out of jail (Torney, et al, 1992).

Conclusions

The current policy of incarceration of MIOs in CCDOC while awaiting trial is costly, contributes to jail overcrowding, and may not be in the best medical interests of the offender.

Pretrial release of MIOs is undermined due to lack of sufficient resources in the community and inadequate staffing and staff training. This problem carries over to MIOs who subsequently are found guilty and sentenced to probation, or found not guilty by reason of insanity and released to community-based programs.

Various models for community-based treatment of MIOs exist around the country that show promise in addressing this difficult situation. These models range from case-management models (California, Oregon, Illinois) to more structured stand-alone centers such as Milwaukee's Community Support Program.

The case-management models are challenged by:

1. The declining resources available to outside referral agencies and programs in this age of fiscal and economic austerity;

2. the reluctance of community agencies to serve mentally ill offenders; and,

3. the necessity to maintain intensive social control of the criminal-justice system regimen.

The Community Support Model is specifically designed to serve the needs of this population and can provide a "seamless" program that satisfies the specific mental health and social needs of this population--while providing the close interface of social control required in meeting the safety needs of the community. This model is subject to the same budgetary constraints that impact all of the community agencies serving a destitute and unattractive group of people who are seldom the beneficiaries of public sympathy.

Which defendants can best be served by such a program? What sort of guidelines can assist in selecting appropriate clients and in recommending levels of care? The typology developed by Lewis (1991, pp. 116, 119) classifies mentally ill criminals into three categories:

1. Individuals whose criminal behavior is "incidental to their mental disorder. Indeed, being symptomatic in public appears to be their only crime.

2. Patients who resort to criminal behavior as an act of survival or of desperation, who commit crimes to supplement meager income and/or welfare support.

3. Patients who have patterns of arrests for serious crimes over a period of several years and whose mental disorders "seem incidental or secondary to their criminality."

The type of offense and prior convictions for inmates participating in the Mental Health Technical Assistance Project are profiled in Charts B and C.

[Insert Chart B and Chart C]

Lamb, Weinberger, & Gross (1988b, p. 1084) outline a series of conditions for a successful program serving the needs of MIOs:

A clearly articulated treatment philosophy; close liaison with the court; access for both the criminal justice and the mental health systems to a comprehensive data base; an emphasis on structure and supervision; recognition of the importance of neuroleptic medication; a reality-based approach; a focus on the problems of everyday living; incorporation of the principles of case management; and the employment of treatment staff who are comfortable with the treatment philosophy and are not ambivalent about setting and enforcing limits.

The question of how to proceed or which type of program would be most successful is not necessarily an "either-or" question. The development of effective programs in Cook County or other large urban jurisdictions may, because of specific history and objective political conditions, involve a variety of approaches and stages of development.

A stage-based program would:

> 1) Seek to make maximum use of existing facilities and programs by providing coordination through a system of case management; and, 2) Seek to develop a stand-alone program that would most efficiently serve the specific needs of this very special population. 3) Develop a program of staff training to enable staff to effectively screen MIOs and divert them as early as possible in the process. Training in case-management of the mentally ill is an important component of a successful system.

The case-management structure followed by the Cook County Department of Adult Probation has established a Mental Health Unit that fields specially-trained staff who provide services that could eventually dovetail with existing programs.

A longer-range strategy would envision the development of a stand-alone component modeled after the Milwaukee Community Support Program. Such an approach would demand careful consideration of the radically-different demographic, geographic, social, economic, and political characteristics of the City of Chicago. This effort would require active involvement by a variety of interested agencies and parties to secure the necessary support of the city, county, state, and federal political and service institutions. A program development component of a Pretrial Services Mental Health Unit would seek to address this concern. Answers can be found in the very foment of seeking alternatives and collaboration in the custodial processing and treatment of mentally ill offenders.

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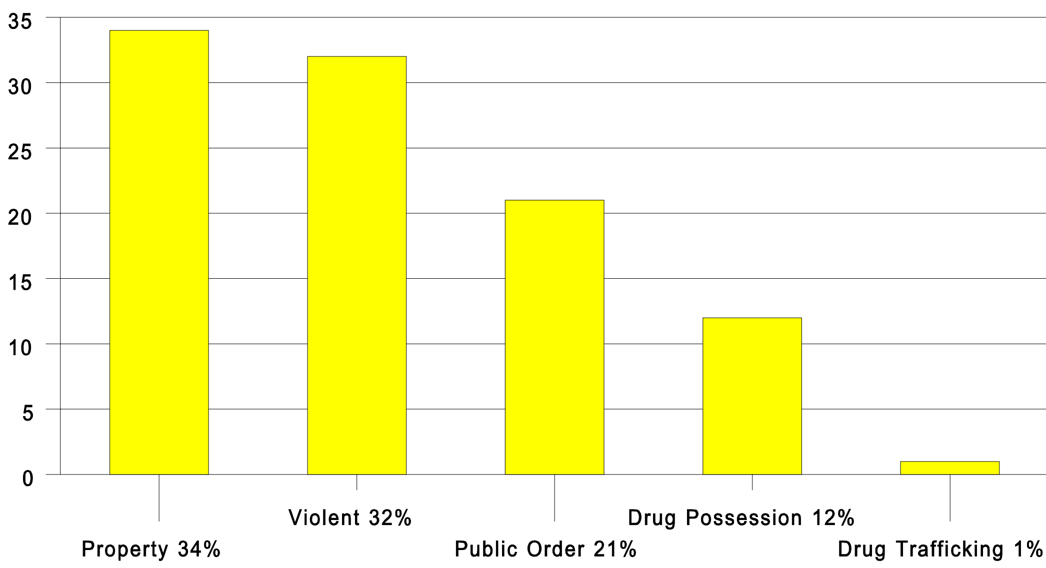
Table A1: Cermak Department of Psychiatry Diagnostic Breakdown (3/14/91)

Diagnosis	N	%
Schizophrenia Paranoid	32	6.8
Schizophrenia Undifferentiated	37	7.49
Schizophrenia Disorganized	2	0.40
Schizoaffective Disorder	23	4.66
Atypical Psychosis	31	6.28
Delusional (Paranoid) Disorder	1	0.20
Induced Psychotic Disorder	1	0.20
Brief Reactive Psychosis	1	0.20
~~	~~~~~	~~~~~~~
Psychosis & Schizophrenias	128	25.91%
Bipolar Disorder (mixed)	5	1.01
Bipolar Disorder (depressed)	1	0.20
Bipolar Disorder (manic)	12	2.43
Bipolar Disorder (NOS)	12	2.43
~~	~~~~~	~~~~~~~
Bipolar Disorders	30	6.07%
Adjust Disorder (anxious)	22	4.45
Adjust Disorder (depressed)	72	14.57
Adjust Disorder (mix-cond/emot)	8	1.62
Adjust Disorder (mix emot ftrs)	17	3.44
Adjust Disorder (conduct)	1	0.20
Adjustment Disorder (NOS)	12	2.43
Phase of Life Problem	5	1.01
Uncomplicated Bereavement	1	0.20
~~	~~~~~	~~~~~~~
Adjustment Problems	138	27.94%
Major Depression (Recurrent)	11	2.23
Major Depression (single epsd)	5	1.01
Dysthymia	25	5.06
Depressive Disorder NOS	16	3.24
~~	~~~~~	~~~~~~~
Depressive Syndromes	57	11.54%
Generalized Anxiety Disorder	3	0.61
Anxiety Disorder NOS	2	0.40
~~	~~~~~	~~~~~~~
Anxiety Syndromes	5	1.01%

Table A2: Cermak Department of psychiatry Diagnostic Breakdown (3/14/91)

Conduct Disorder Undifferentia	1	0.20
Intermittent Explosive Disorder	5	1.01
Impulse Disorder NOS	1	0.20
~~	~~~~~	~~~~~~~
Impulse Disorders	7	1.42%
Borderline Personality Disorder	9	1.82
Personality Disorder NOS	3	0.61
Antisocial Personality Disorder	1	0.20
Obsessive-Compulsive Disorder	1	0.20
Pedophilia	1	0.20
~~	~~~~~	~~~~~~~
Personality/Character Disorder	15	3.04%
Developmental Disorder (NOS)	1	0.20
Undifferentiated ADD	1	0.20
Mild Mental Retardation	2	0.40
Moderate Mental Retardation	2	0.40
Organic Mood Disorder	8	1.62
Organic Delusional Disorder	1	0.20
Organic Anxiety Disorder	5	1.01
Senile Dementia NOS	1	0.20
~~	~~~~~	~~~~~~~
Organic/Developmental Disorders	21	4.25%
Poly Substance Dependence	13	2.63
Opioid Dependance	3	0.61
Opioid Abuse	4	0.81
Cocaine Dependance	3	0.61
Cocaine Abuse	10	2.02
Other PsycActiv Subs. Organ NOS	6	1.21
Other PsycActiv Subs. Withdrawl.	2	0.40
Other PsycActv Subs. Intoxicat.	32	6.48
Alcohol Dependance	5	1.01
Alcohol Abuse	12	2.43
Alcohol Intoxication	1	0.20
Alcohol Hallucinosis	1	0.20
Uncomplicated Alcohol Withdraw	1	0.20
~~	~~~~~	~~~~~~~
Substance Abuse Problems	93	18.83%
	~~	~~~~~~~
Total Diagnosed ->	494	100%
Malingering	4	
Missing/Deferred/No Diagnosis	126	

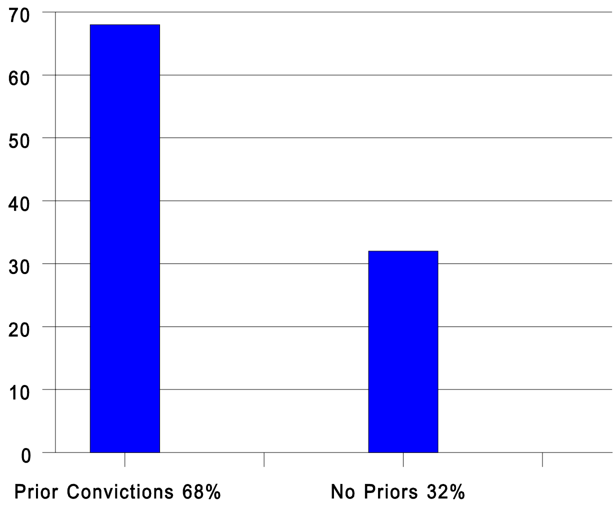
Figure 1: Mental Health Technical Assistance Project



Type of Offense For
Inmate Sample (N:414)

Source: Cook County
Department of
Corrections

Figure 2: Mental Health Technical Assistance Project
Prior Convictions For Inmate Sample (N:414)



Source: Cook County Department of Corrections

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