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The Treatment of People with Mental Illness in the Criminal Justice System: The Example of Oneida County, New York

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EXECUTIVE SUMMARY

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Foreword

This executive summary provides a general overview of a larger report, attached to this document, of the criminalization of the mentally ill. It begins by summarizing three case studies from the report that concern the intersection of mental health issues and the criminal justice system in Oneida County in New York State. It then provides a brief historical overview of mental health issues and the criminal justice system before going on to discuss the current best practices in addressing the criminalization of the mentally ill, including law-enforcement mechanisms, mental health courts, and reintegration programs. Next, the paper identifies the shortcomings of these practices and the lack of organizational and financial capacity that hobbles concerned stakeholders from effectively tackling the issue. The paper concludes by proposing a general program for immediate action on local and national scales.

The first case study, “The Treatment of the Mentally Ill in the Criminal Justice System: Survey of the Corrections and Forensic Environments in Oneida County, New York,” by Samantha Walther, surveys the current care practices and interventions at Oneida County Correctional Facility, Marcy Correctional Facility, Auburn Correctional Facility, Mid-State Correctional Facility, Mohawk Correctional Facility, Central New York Psychiatric Center (CNYPC), Hutchings Psychiatric Center, and Forensic Units (FU) in inpatient facilities. The study revealed that Oneida County has taken significant steps toward improving the treatment of the mentally ill, however, if suicide prevention is to be a priority state-wide, the authors recommend the removal of solitary housing units to decrease the exacerbation of mental health issues, self-harm, and suicides. The study also found that the most significant factor in reducing recidivism is employment upon release; therefore local and state correctional facilities should aid individuals in the reentry process through skill-development and employment programs. The study suggests several very inexpensive rehabilitation methods that may be implemented at any type of mental
health facility, many of which do not require the addition of more staff, another looming issue in the mental health world.

The second case study, “Hope and a Plan: An Evaluation of the Utica Mental Health Court, One Possible Model for Effective Management and Care,” by Alexander Scheuer, explores the best practices of mental health courts across the country, as well as the effectiveness of the Utica Mental Health Hub Court, which has been operating for 11 years and has yet to be evaluated by any official means. The study notes that while there are no accepted standards of operation and practice among mental health courts nationally, they share goals: reducing recidivism for mentally ill offenders, targeting and treating the root causes of their criminal behavior, and helping them remain crime free as they reintegrate back into society. The study deploys a longitudinal analysis of the Utica Mental Health Hub Court, finding that of the 43 graduates of the program in the sample years, only 19% recidivated, compared to the national average rate of recidivism (54%) for mentally ill offenders who receive little or no treatment.

The third case study, “Policing & Mental Illness in Oneida County, New York: Best Practices, Shortcomings, and Proposed Reforms,” by Connor O’Shea, examines the interactions between law enforcement and individuals with mental health issues. The study revealed that Oneida County (and New York State more generally) is both a participant in and progenitor of the deinstitutionalization problem, which has hamstrung law enforcement by insisting on ‘square-peg-round-holing’ mental illness into the criminal justice system. The author recommends that Oneida County de- emphasize law enforcement’s role in mental health care while aggressively expanding alternatives in the community and re-expanding institutional care. The County should also exhaust every possible mechanism of improving law enforcement’s ability to safely and effectively interact with people with mental illness. Most notably, the study argues that all police departments in Oneida County become Crisis Intervention Team departments, and that the County should pioneer a hybrid model of policing in which a CIT department also utilizes a Jail Diversion Program (see pages 7-8, below) by which psychiatric professionals co-respond with police officers in the same squad car to psychiatric emergency service calls.
Each study takes pains to point out that the criminalization of the mentally ill has become a chronic issue in American society for which there are no easy answers. The cost of such criminalization handicaps our ability to progress as a nation and weighs heavy upon our moral conscience. We can no longer afford to turn a blind eye. We can no longer afford to turn away because it is easier. When America’s roads and bridges are crumbling, when our public school districts continue to decline, we can no longer afford to spend billions of taxpayer dollars on jail and prison maintenance. Years of research and study have pointed the way for local initiatives that have found some success: now is the time for national action. The following pages illustrate just how critical that action is.

A Modern Crisis

A grossly disproportionate number of individuals with serious or severe mental health issues who are unable to access adequate care often end up in the criminal justice system. These are people who are too often homeless, jobless, and hopeless; they have nowhere else to go. They languish across the nation’s jails, and those most in need of help – the 2.5% of the population who suffer from severe mental health issues such as schizophrenia – are the most likely to be locked away in local jails or state prisons that were never designed to accommodate individuals with mental health issues (MHI). Worsening of their initial condition, self-mutilation, and suicide are commonplace results for these individuals.

This problem has not gone unnoticed, nor have concerned stakeholders failed to make their voices heard. Judges, police officers, psychiatric professionals, general care practitioners, and community leaders have joined forces to address this problem with laudable and creative initiatives. Despite this, stakeholders simply do not have the capacity to adequately address mental health issues in either the healthcare system or the criminal justice system. The deinstitutionalization movement of the 1960s reduced the capacity of the healthcare system to accommodate individuals with MHI: U.S. psychiatric institutional capacity plummeted from 559,000 beds in 1955 to 35,000 beds in 2017. The major federal funds for the local outpatient treatment facilities that were supposed to take place of psychiatric
institutions were appropriated instead for use in the Vietnam War. In one stroke, deinstitutionalization outstripped the capacity of community-based organizations to help individuals with MHI resolve the problems that they faced. It demanded that these organizations help people that they were not designed or organized to care for. And it hamstrung the ability of psychiatric facilities to provide adequate inpatient care for individuals with severe MHI.

For those individuals with severe mental health issues, this was the start of the long road to carceral re-institutionalization over the following decades. The mass influx of individuals with MHI into the criminal justice system – from 1955 to 1994, the number of inmates with mental health issues rose by over 600%¹ – created a ‘revolving carceral door’ that does not accomplish the goals of the criminal justice system. Correctional facilities, prisons, and jails are now the primary mental health institutions in the U.S.² while the criminal justice system runs a “shadow mental health system” with the only cards it has left in its deck: detention, arrest, incarceration, and prosecution.³ Local jails and state and federal prisons were never designed to function as psych wards, yet individuals with MHI, despite representing only 1.24% of the total U.S. population (approx. 4 million people)⁴, are involved in one-tenth of all law enforcement service calls and occupy over one-fifth of all jail and prison inmate beds.⁵ A 2017 report by the Federal Bureau of Justice estimated that 14% of state and federal inmates and 26% of jail inmates suffer from some form of mental illness.⁶ Yet no strategic organizational model exists for resolving such a persistent and pervasive problem.

Civil society as a whole remains unresponsive to the cruel treatment of defendants with MHI, even as it suffers from a waste of taxpayer resources on inefficient responses that have negative impacts on criminal or mental health crisis recidivism, e.g. the safety and well-being in the individuals and their communities. For example, upon completion of their time, mentally ill inmates – many of whom were homeless to begin with – are usually sent back out on the streets, often with no job, no contacts, and little to no support from the community around them. Unable to access healthcare or adequate treatment, they turn to self-medication, often returning to or developing drug abuse and alcohol issues. This tendency exacerbates existing mental health issues through a well-documented rise in comorbidity. Comorbidity
and self-medication are different but important factors to overcome, but individuals with MHI are seldom capable of making that jump on their own. Yet prisons, psychiatric facilities, courts, jails, and police forces all lack the organizational and financial capacity to deal with drug and alcohol abuse themselves, let alone these same problems when compounded by MHI. Worse yet, the historical stigma around and a general misunderstanding of serious MHI tends to inhibit effective co-operation between stakeholders and the community that are necessary for individuals with MHI to receive the help they need.

**Best Practices and Commonalities**

The operational complexity and emotional intensity required to successfully address MHI in the criminal justice system cannot be overstated. The detrimental effects of incarceration on individuals with MHI have been well-documented by a number of books, documentaries, and articles: it is clear that living a sustainable, let alone a productive, life becomes much harder for individuals with MHI once they have been incarcerated. Increased investment in the community and in inpatient and correctional mental health facilities promotes a more accepting environment for individuals with MHI. Furthermore, preventing individuals with MHI from becoming involved with the criminal justice system in the first place, or diverting those who become so involved from incarceration, are two avenues that offer significant promise. Developing all of these responses will be at once the most humane and efficient way to respond.

Diversion and prevention are tricky issues, however, as the criminal justice system has to regard community needs, penal and procedural legal requirements, and communicating without underestimating the problems that mentally ill individuals’ face due to their surrounding environs. These add a range of criminogenic risk factors including neighbors or contacts with antisocial personalities, criminal thinking, social support for crime, and substance abuse. Pre-existing psychiatric issues such as psychosis, paranoia, cognitive impairment, and trauma (to name but a few) exacerbate and are exacerbated by criminogenic risk factors, making people with MHI “more vulnerable and less responsive to standard
correctional intervention.” Creative and heterodox approaches that account for these criminogenic risk factors are vital to achieving any sort of forward progress.

Out of the many programs deployed over the years, the most successful approaches occur on two levels, and both fall into the category of rehabilitative justice rather than punitive justice. The first level is during initial police contact, using local law enforcement to the benefit, rather than to the detriment, of mentally ill individuals. The second level occurs post-arrest but pre-trial through mental health courts that offer another chance to prevent individuals with MHI from entering the revolving carceral door.

On the first level, the two most promising approaches are Crisis Intervention Team models and Jail Diversion Programs (see O’Shea, 2018, for a more detailed analysis). The Crisis Intervention Team (CIT) model is “internationally recognized as one of the leading police-based models to help individuals with mental illness that come into police contact.” The model itself calls for 40 hours of extensive, specialized training to a select group of volunteer officers to qualify them as CIT officers. The CIT model does not merely focus on police officers, rather, it demands systemic intervention through both operational changes in police department procedures and collaboration with the community at large through mental health providers and relevant stakeholders. This results in improving officers’ attitudes and knowledge about mental illness, increasing officers’ confidence in dealing with individuals with MHI, and increasing the utilization of mental health services through police referrals.

Jail Diversion Programs (JDP), in comparison, rely on mental health professionals to co-respond (i.e. in the same squad car as the police officers) to psychiatric crises calls. The co-response model recognizes that police officers simply cannot receive sufficient training to identify and manage every unique psychiatric emergency situations, nor do police departments have sufficient resources (i.e. psychiatric professionals) to adequately address the complex problems of distressed individuals with MHI. Co-response provides the benefit of ‘dual diversion’ from both arrest and emergency departments; trained clinicians can “facilitate arrest diversions and reduce costly and unnecessary referrals to hospital emergency departments.” For individuals who are arrested, co-response has the added benefit of providing them with immediate “receive support, resources, and referrals while in police custody.”
On the second level (post-arrest but pre-trial), the emergence of mental health courts (MHCs) offers another chance to prevent these individuals from entering the revolving carceral door (see Scheuer, 2018, for a complete overview of MHCs). MHCs, as a rule, are voluntary criminal diversion programs that remove mentally ill individuals from the traditional sentencing system and place them in court-supervised outpatient treatment programs to address the issues at the root of their criminal behavior. These courts are similar to other specialty courts as an effective and efficient means of solving persistent criminal conduct and diverting those with treatable clinical conditions from the traditional punitive sentencing system.

MHCs go beyond the boundaries of jail or prison sentencing, forging multifaceted partnerships of administrative and treatment teams composed of lawyers, case managers, judges, and treatment providers. These teams work on behalf of participants throughout their criminal process, and individuals can be referred for MHC qualification by police officers, jail staff, defense lawyers, judges, and sometimes even family or community members. The success of MHCs is dependent on each individual court, however, the most successful appear to have access to community treatment services and mental health resources; utilize an outcome-driven approach through setting specific and empirical goals and benchmarks; use a clinical evaluation survey pre- and post-enrollment; analyze Judge-Participant interaction; and effectively communicate both internally and externally.

The ultimate goal of CIT, JDP, and MHCs – indeed, of every attempt to ameliorate the criminalization of the mentally ill – is to rehabilitate individuals with MHI through mitigating criminogenic risk factors so that they might reintegrate with society. There remains a backlog of incarcerated individuals with MHI, however, who also must be reintegrated into society. The process of reintegration is similar for both incarcerated and non-incarcerated individuals, however, diversion programs are critically important because of the detrimental effects of incarceration on individuals with MHI. That said, successful reintegration is achievable through a mix of psychiatric therapy, appropriate medication, engagement from peers and the community, and holistic support in matters such as housing and employment.
These metrics are what many MHCs want to see before a participant is allowed to graduate, but they are also the most effective way for incarcerated individuals to reintegrate into society upon release from prison or jail. Several programmatic approaches that can provide reintegration support for both incarcerated and non-incarcerated individuals include widely-recognized programs such as the Risk/Need/Responsivity (RNR) and Illness Management and Recovery (IMR) models for rehabilitation. Other programs, such as New York State’s Self-Management and Recovery Training (SMART) Recovery Program, can provide additional support.19

The success rates of diversion programs and reintegration efforts, while unique to each locality and each situation, do share several commonalities critical to their success which are absolutely vital to keep in mind. The first is a wide-spread comprehension of the challenges that individuals with MHI face, as well as empathy towards those individuals, by community and criminal justice system stakeholders, as well by the community at large. The second is effective communication and coordination among engaged stakeholders including but not limited to police departments, mental health professionals and hospitals, judges and court staff, jails, prisons, and political departments and office. Third, and perhaps most important, is active and engaged community support for individuals with MHI: these are people who have most often been outcast from society. Only with society’s acceptance of them as people, regardless of their criminal background, will we begin to carve away the mountain of injustices that have been put upon them.

**Where We Fall Short**

In order to begin this process, we must understand just how monumental the tasks at hand are. Current efforts can only do so much with the resources available to them. In the data-driven world we live in, the scale and magnitude of results determine whether a program should be funded. But when dealing with MHI, it is important to remember that each individual requires individualized treatment, and providing individualized treatment is necessarily expensive. Limited funding for diversion
or reintegration programs thus limits the scale and magnitude of their results, thereby raising questions of their effectiveness. Lack of financial resources breeds a lack of capacity. Lack of capacity results in a lack of financial resources. This vicious cycle of inefficacy ensures that the people who need help the most are the least likely to receive it.

The programs mentioned above are, in many cases, underfunded and understaffed because of this very reason. The Utica Mental Health Hub Court (UMHHC), for example, which now receives cases referred from the over 40 local criminal courts across Oneida County, has seen its enrollment double in the past few years, but it still only has one Case Manager and no funding to expand its staff, making a further increase in enrollment impossible. The UMHHC serves as an example of a court that usually only takes cases where the individual in question is likely to get back on their feet without extensive and ongoing inpatient care, proving the efficacy of the Court. This means that people with more severe mental health issues – bipolar disorder, psychosis, personality disorders, those with untreated developmental disabilities, etc. – are usually disqualified because of the severity of their mental health issues. These same individuals are also the most likely to react violently to police intervention, which can result in a more severe sentencing. However, MHCs can only do so much given limited funding and staffing, and there are environmental factors that can handicap their effectiveness as well. One of the most glaring and most common is the lack of availability of mental health resources in the community.

This is a problem that not only limits the success of MHCs but also of CIT and JDP programs. Local and regional treatment centers serve as the primary providers of treatment and support for individuals with MHI, and their involvement is crucial for the success of any diversion or reintegration program. CIT programs have the potential to mitigate stigmatization and misunderstanding of MHI within local law enforcement, but police officers cannot be expected to serve as health-care givers or therapists. That is not their role, nor should it be. The JDP model offers promise, in areas where co-response is a feasible option, but in places where psychiatric services are limited or geographically distant, it falls seriously short. The same is true for MHCs: if an individual enrolled in an MHC program does not have easy access to a treatment facility, whether through lack of transportation, geographic
distance, or a backlog of patients at available treatment centers, their road to recovery will be severely limited.

Nationally, this is a stark reality for individuals with MHI who do not live in affluent coastal hubs where state-of-the-art psychiatric facilities and mental health awareness is much less of an issue. For these individuals, who live in the Rust Belt, in the Heartland, and the more rural areas of the country, any psychiatric facilities that do exist are likely to be in poor condition and are themselves usually understaffed as the best and brightest emigrate to the coast. The sub-standard condition of inpatient psychiatric facilities, due to deinstitutionalization and capital flight, means that there are not nearly enough beds or psych wards to house, let alone care for, all individuals with severe mental health issues. The lack of therapists, psychiatrists, and psychologists in the areas where they are needed most limits the capacity and effectiveness of even the most well-meaning diversion and reintegration programs. The sad truth is that most areas in this country simply lack the capacity and resources to mount fully-funded reintegration programs.20 For incarcerated individuals with MHI, this is a double bind as state and federal prisons are usually located in geographically remote locations, economically depressed areas, or both.

State and federal prisons also feel the capacity-reducing effects of deinstitutionalization and capital flight, and as a result they do their own part in worsening the condition of incarcerated individuals with MHI, either through solitary confinement or through overmedication. In NYS, for example, prisons can be compensated based on decreases in the number of physical constraints used on inmates, which are reviewed each quarter (see Walther, 2018, for a comprehensive overview of this issue). Individuals with MHI are often overmedicated to the point of sedation due to financial incentives, creating incredibly unhealthy dependencies and preventing the development of healthy habits crucial to reintegration. Not only does their condition worsen due to solitary confinement, overmedication, and other abuses suffered in prison, but if they are released from prison, they then find themselves in areas where reintegration programs are backlogged, if they exist at all.21 These individuals not only tend to recidivate but are disproportionately represented in the prison population: in the general population, 5%
have a serious mental disorder and 16% have a diagnosable mental disorder; in the prison population, these numbers swell to 17% and 50%, respectively.\textsuperscript{22}

The sad irony of this situation is that the financial resources that could be invested in alleviating the problem are otherwise dedicated to the maintenance of jails and prisons. In 2017-2018, U.S. counties alone spent $80 billion on maintaining and expanding local jails.\textsuperscript{23} Meanwhile, in state and federal prisons, solitary confinement – often resorted to by a witlessly overwhelmed prison staff to get individuals with MHI to ‘behave’– costs a staggering $75,000 per inmate per year, compared to $25,000 in a general housing unit. There are roughly 80,000 inmates in solitary at any given time, many with MHI, costing the U.S. $60 billion per year.

The revolving carceral door exposes just how broken this system is. A well-known study, commissioned by the Mental Health Court Project of Miami-Dade County, found that over a five year period, 97 people (primarily homeless men diagnosed with schizoaffective or schizophrenia disorder) were arrested 2,200 times. They collectively spent 27,000 days in county jail and 13,00 days at either a psychiatric facility or in an emergency room, costing the county $13.7 million…with nothing to show for it.\textsuperscript{24} Those 97 individuals do not even account for one-tenth of one percent of the County’s population, yet they recidivated an astonishing number of times. This disproportionate impact illustrates the problem in simple terms: we annually spend billions of taxpayer dollars on repeatedly incarcerating a small segment of our country’s population, subjecting them to human rights abuses and mental degradation. Not only common sense but also our moral duty as American citizens, demands that we do more.

**The Road Ahead**

The problems illustrated above will not be solved overnight. Given the cycle of inefficacy, maintained by the dual handcuffs on program capacity and funding, resolution will only come with a comprehensive investment in mental health programs; including programs designed to prevent individuals with MHI from entering the revolving carceral door, inpatient and community-
based care, and programs to help reintegrate individuals with MHI into society as citizens. Significant attention must also be paid to those individuals whose conditions are too severe to function outside of inpatient care, many of whom find themselves awaiting transfer from correctional facilities to inpatient care centers. The only answer to this specific problem is to re-open enough inpatient psychiatric facilities to cope with the backlog.

Beyond the urgent need for investment, there are three specific initiatives which should be undertaken in order to accomplish prevention, reintegration, and inpatient and community-based care. First, the creation of a national standard by which to measure the success of mental health programs, whether diversionary, rehabilitative, or inpatient care. This will provide a solid basis of comparison that relevant stakeholders can use to make informed decisions about their own community. 

It will also give legitimacy to the second initiative: a national publicity campaign, run by an independent 501(c)3. Such an organization would lend actionable heft and serve as a useful tool for distributing funding to programs that need it most. The publicity campaign itself should focus on the human rights abuses that incarcerated individuals with MHI suffer, what interested individuals and parties can do to get involved, and provide information on the various types of mental health programs that are successful.

The last two are critical for promoting the third initiative: increase community outreach and engagement efforts with local populations in the economically depressed areas that bear the brunt of rehabilitating individuals with MHI. Efforts should include awareness campaigns of the issues that people with MHI face, developing meaningful relations with important community stakeholders and thought-leaders, and organizing broad community support for individuals with MHI. Without wholesale support from the community around them, individuals with MHI will continue to be outcasts, relegated to living on the worst fringes of our society. Such a reality is far from inevitable; if it does occur, it will be because we let it happen.