Mental Disorders and the Criminal Justice System

Mental Disorders and the Criminal Justice System

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Contents

Message to Students

In a criminal justice system that many are eager to improve, one significant group is often overlooked: people who experience mental disorders. Thank you for your interest in this important topic.

The authors of this text have served in multiple professional roles in the overlapping fields of criminal justice and behavioral health. As community college instructors, we sought to share our experience and perspective with students, but recognized that few available textbook resources offered the information we wanted to provide. None offered the inclusive and equity-focused points of view that we prioritize and that today's criminal justice professionals require to meet the needs of their communities with safety, effectiveness, and respect. We have endeavored to create a resource that provides the information we want our students to possess, and we hope that it serves you well.

As you complete your reading of this text, please consider sharing your feedback with the authors. The language and available information on our complex topics is always evolving, even in the midst of this writing. We appreciate your help in correcting any problems and improving this resource.

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About This Book

Accessibility Statement

This book was created in good faith to ensure that it meets accessibility standards wherever possible and to highlight areas where we know there is work to do. It is our hope that by being transparent in this way, we can begin the process of making sure accessibility is top of mind for all authors, adopters, students, and contributors of all kinds on open textbook projects.

If you encounter an accessibility issue, please let your instructor know right away.

Equity Lens

The Open Oregon Educational Resources Targeted Pathways Project seeks to dismantle structures of power and oppression entrenched in barriers to course material access. We provide tools and resources to make diversity, equity, and inclusion (DEI) primary considerations when faculty choose, adapt, and create course materials. In promoting DEI, our project is committed to:

1. Ensuring diversity of representation within our team and the materials we distribute
2. Publishing materials that use accessible, clear language for our target audience
3. Sharing course materials that directly address and interrogate systems of oppression, equipping students and educators with the knowledge to do the same

Designing and piloting openly licensed, intersectional, and antiracist course materials is one starting point among many when addressing inequities in higher education. Our project invites students and educators to engage with us in this work, and we value spaces where learning communities can grow and engage together.

We welcome being held accountable for this statement and will respond to feedback submitted via **our contact page**.

A Note on Language from the Authors

Creating this book has been an enormous undertaking, and the challenge of doing it well started as soon as we began to formulate our first words, namely the title phrase: *mental disorders*.

Acceptable words used to talk about mental illness and disability have changed over time, both in our everyday language and in the language of the law. For example, several years ago, relevant Oregon law replaced the jarring phrase *mental disease or defect*—still used in most state laws—with *qualifying mental disorder*.

Is *mental disorder* still an imperfect choice? Perhaps. However, we are using it in the title of our text and throughout the book as an umbrella term for several reasons. First, it tracks current medical terminology used for diagnostic purposes. Second, it is an inclusive term that could cover all that we wanted to touch on in our text—the array of mental illnesses, developmental disorders such as autism, and acquired conditions such as traumatic brain injury. Finally, alternatives such as *mental health* were inadequate. A per-

son who has an intellectual developmental disorder, for example, may be perfectly, wonderfully healthy. Likewise, a person with a diagnosed personality disorder, who deserves space in this text, might not fall into categories of mental illness or disability. In the end, *disorder* was our most inclusive option.

As we ventured into discussion of particular disorders, we followed the lead of self-advocates in choosing our language. For example, self-advocates in the autism community often prefer identity-first language (autistic individuals), while most mental illnesses are identified with person-first language: a person with schizophrenia.

Language is incredibly powerful, and we feel a significant responsibility to use it correctly, responsibly, respectfully, and humbly. If our choices undermine the populations we are aiming to better support, our work here will fall short. We look forward to feedback and continuing conversation on this topic—and, eventually, to updating our choices to reflect evolution in our understanding.

Thanks so much for sharing this gratifying work with us.

Course Learning Outcomes

Educators, students, and future employers all benefit when course-level learning outcomes guide our shared work. When course-level learning outcomes are public, institutions demonstrate a commitment to equitable student success through the potential for increased collaboration and inclusive course design. This project analyzed learning outcomes across the state of Oregon to identify themes and commonalities. The authors used this analysis as a basis for developing course outcomes that could match the curriculum of multiple institutions in Oregon while still considering their local needs and context.

Course Learning Outcomes

1. Assess the legal and social forces that contribute to the criminalization of mental disorders in the United States.
2. Protect the interests and rights of people who have mental disorders.
3. Evaluate current legal mechanisms that aim to protect people with mental disorders from harm in the criminal justice system.
4. Recommend approaches and interventions that improve outcomes for people with mental disorders in the criminal justice system.
5. Develop the critical thinking and communication skills necessary to increase transparency in the criminal justice system.
6. Demonstrate increased awareness of careers in criminal justice and behavioral health, including the rewards and challenges inherent in these professional roles.

Teaching and Learning Approach

The authors of this book embraced an equity-minded design for structure, scope, and sequence of chapters and chapter content. They sought to honor the needs and experiences of students who are often underserved in higher education in Oregon. Authors considered Transparency in Teaching and Learning (TILT), Universal Design for Learning (UDL), and culturally responsive teaching to design meaningful learning pathways for you. You will find rich images and multimedia in addition to written content. You will also find provocative discussion questions that align with learning outcomes and objectives.

Instructors, please see the Instructor Resources section in the Back Matter for an overview of curriculum design as well as openly licensed course packs and teaching tools.

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CHAPTER

1

Introduction: The History of Mental Disorders

1.1 Chapter Learning Objectives and Overview

LEARNING OBJECTIVES

The following learning objectives tell you what is most important in this chapter. Use these statements as a guide to make sure you get the most out of this chapter.

1. Describe early treatment of mental disorders, including the history of prejudice and discrimination around mental illness and disability.
2. Discuss modern developments and reforms in the treatment of people with mental disorders.
3. Evaluate the institutionalization and deinstitutionalization of people with mental disorders.
4. Recognize discrimination against people with disabilities, and specifically mental disorders, as a barrier to treatment and progress.

KEY TERMS

Look for these important terms in the text in bold. Understanding these terms will help you meet the learning objectives of this chapter. You can find definitions for these terms at the end of the chapter.

- **Antipsychotic medications**
- **Asylum**
- **Behavioral health**
- **Community Mental Health Act**
- **Deinstitutionalization**
- **Dignity of risk**
- **Disability**
- **Disability rights movement**
- **Electroconvulsive therapy (ECT)**
- **Eugenics**
- **Institutionalization**
- **Mental disorders**
- **National Institute of Mental Health**
- **National Mental Health Act**
- **State hospitals**
- **Stigma**
- **Transinstitutionalization**

Chapter Overview

In her book *Being Heumann: An Unrepentant Memoir of a Disability Rights Activist*, the trailblazing civil rights leader Judith Heumann reflects on her life, education, and career. Heumann, who died in 2022 after a lifetime of fighting for the rights of people with disabilities, had quadriplegia as a result of polio she contracted as a toddler. At every juncture in her life, Heumann faced exclusion due to her disability. Heumann shares how she experienced these social, educational, and professional barriers as painful challenges to her sense of belonging: "I was confused and heartwrenchingly sad to the point of numbness. I just couldn't understand what I had to do to be seen as an ordinary person" (Heumann & Joiner, 2021, p. 41).

In this chapter, we consider how people with mental illnesses and disabilities (together, mental disorders) have been marginalized and dehumanized over time, leading up to the present day. People have long been excluded from basic opportunities due to mental disorders—just as Judith Heumann was excluded due to her physical disability. Opportunities denied to people with mental disorders include receiving an education, accessing or getting paid for employment, participating in government, and even living freely in the community. For example, routine confinement in poorly-equipped institutions was the well-accepted lot of people with mental disorders in American society throughout much of the country's history. Discrimination and prejudice against people with mental disorders remain pervasive and do not stop at the doors of the legal system. In fact, these problems are heightened for people who, in addition to their mental disorders, are *also* involved in the criminal justice system. This group of people is the focus of this text.

A theme throughout this text, and a purpose for which it was written, is to highlight and combat the persistent exclusion and mistreatment of people with disabilities generally, and mental disorders in particular, especially as they come into contact with the criminal justice system. The risk of people with mental disorders experiencing harm is exacerbated (inside and outside of the justice system) when impacted people fall into the intersection of multiply-marginalized groups due

to factors such as race, gender identity, or poverty in addition to disability. The existence and impact of these intersections is often noted in this text. As you observe the history shared in this chapter, you will learn about the progress we have made in our treatment of people with mental disorders. You will also see how much work remains to be done as we move forward to a criminal justice system that better serves our focus population and our community as a whole.

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1.2 Historical Perspective on Mental Disorders

In our modern world, it is often noted that jails and prisons are the largest treatment providers for mental disorders in the United States; these facilities house and treat far more people with mental disorders than any other psychiatric facility (Chang, 2018). However, it is difficult to put exact numbers to this reality. According to one government report, for example, more than 40% of state and federal prison and jail inmates have some "mental health" problems. This statistic was gleaned from surveys of people in jail and prison, asking if they had been informed by a mental health professional that they had a mental disorder (Maruschak et al., 2021b). These numbers thus fail to count a presumably significant number of people who lack formal evaluation or diagnosis or, for reasons that are easy to imagine, do not answer that jailhouse question truthfully. It also omits people with substance use disorders and other mental disorders that may not be characterized as "mental health" issues, such as learning disabilities.

However, learning disabilities and related disorders are prevalent in custody and should be counted. Nearly a quarter of all prisoners report having a "cognitive disability," defined as an impairment in thinking, problem-solving, or attention, compared to about 13% of the general population (Maruschak et al., 2021a; Centers for Disease Control and Prevention, 2023). Similarly, about 25% of prisoners report that they were in special education classes in school, meaning that they were identified in childhood as having a **disability** that impacts learning (Maruschak et al., 2021a). Again, these self-reported numbers may not be accurate for various reasons, and it is unclear how many people identify as having multiple mental disorders.

> In this text, the term **mental disorders** is used broadly to include mental illnesses, personality disorders, substance use disorders, and diagnoses such as developmental disorders or brain injuries that may impact a person's functioning.

The presence of large numbers of people with mental disorders in the criminal justice system is a somewhat modern development that is part of the growth of incarceration more generally. Jails and prisons historically held a small fraction of their current population. Over the past 50 years, that population has grown significantly—both overall and for people with mental disorders (Cullen, 2018).

People with mental disorders filling jails and prisons is a real problem on its own, and it is also a slice of a larger problem: the role of the criminal justice system generally—from the point of law enforcement response to community reentry support—in the lives of people with mental disorders. American society and its predecessors have, through time, been unable or unwilling to meet the needs of people with mental disorders—or, often, even properly recognize their humanity. The U.S. criminal justice system is the latest inappropriate landing spot for many people with mental disorders, the culmination of the history outlined in this chapter.

Early Treatment of Mental Disorders

Mental disorders have long been met with negative responses, including denial, fear, frustration, and misinformation. These reactions, dating back to the earliest history of mental disorders, have led to poor treatment of people who experience these disorders. While history is not our primary focus, a look at people with mental disorders over time demonstrates how ignorance and hostility can result in mistreatment. These events are part of our society's history and set the stage for our current approach to mental disorders.

Prior to the spread of more modern scientific understandings of the brain, mental disorders likely felt especially mysterious and daunting. This led to a common belief in ancient times that mental illness or disability was caused by demonic possession. If someone was "possessed," treatment might be focused on releasing the "evil spirits" from that person (Szasz, 1960, as cited in Spielman et al., 2020).

The ancient practice of trephination, for example, is believed by some to have been an early way to manage a person who was beset with this kind of problem. Our understanding of trephination is pieced together from archeological finds, including skulls of children and adults on whom the procedure was performed. Trephined skulls have one or more holes drilled in them (figure 1.1). Some researchers believe trephination may have been used to treat seizures, mental illness, or other events that were perceived as signs of demonic presence. The holes may have been intended to allow the release of evil spirits that were causing pain or illness (Spielman et al., 2020). It has been speculated that the procedure may have been done to treat headaches as well, but one would assume those were very bad headaches! Ancient skulls with trephination holes often show signs of healing where the holes were created, suggesting that some who underwent the surgery survived at least for a time—though their condition or quality of life post-surgery is not known (Faria, 2013).

Figure 1.1. This trephined skull shows multiple holes that have some evidence of healing, indicating the trephination procedure was not always immediately fatal. The pictured skull was recovered in the Middle East and is thought to be from around 2000 BCE.

Another ancient treatment option, originating from early Christian beliefs, was exorcism. If a person was experiencing symptoms like delusions or hearing voices, they might be seen as being possessed by the Devil, who was an enemy of God. The Devil then needed to be removed, or exorcized, to help the person recover. Exorcism (pictured in figure 1.2) involved special prayers and rituals conducted by religious leaders (Spielman et al., 2020). Unfortunately, exorcism has sometimes involved abusive or harmful elements as well, resulting in injury or even death for people who, in all likelihood, were experiencing mental disorders (Thomson, 2021).

Figure 1.2. Pope Pius V performing an exorcism on a woman.

Although the idea of exorcism dates back to New Testament accounts of Jesus expelling demons from the afflicted, this ritual still exists on the edges of church practices today. In 1999, the Catholic church issued guidelines on how to conduct an exorcism in modern times (Stammer, 1999). When the church created the new exorcism rules, it attempted to make clear that the practice should not be viewed as a cure for mental illness. An exorcist is supposed to consider whether a person needs psychiatric help and perhaps "collaborate" with mental health professionals (Religion News Service, 1999).

Amidst stubbornly problematic practices throughout history, there were also reformers and voices of wisdom when it came to mental disorders, even in ancient times. As early as 500 BCE, for example, the Greek physician Hippocrates had begun to treat mental illness as a disease rather than as a punishment from the gods. Likewise, in the early Middle Ages, Muslim Arabs began creating asylums to care for those with mental illness (Tracy, 2019). **Asylums** were places intended as a

refuge for those with mental disorders, and they later emerged in Europe and America as precursors to mental hospitals and psychiatric facilities (Farreras, 2023). Religious influences on the management of mental disorders remained powerful over time, up until much closer to the modern day.

Mental Disorders in the Middle Ages and Early Modern Era

In the later Middle Ages, around the 11th century, the influence of the Roman Catholic church in Europe had grown very powerful. Natural disasters, such as famine and plague, that occurred during this time were thought to be caused by the Devil. Accordingly, during this same period, religious and spiritual explanations for individual problems, such as mental disorders, increased in popularity. Treatments for mental disorders tended toward prayers, confessions, and atonement, or asking for God's forgiveness (Farreras, 2023).

Beginning around the 13th century in Europe, religious leaders began spreading the word that certain people—mostly women, and often marginalized women such as widows—were "witches" (History, 2017; Blumberg, 2022). Witches were believed to have formed a pact with Satan himself, rejecting Jesus and the church and posing a threat to those around them (Lewis & Russell, 2024). So-called "witch hunts" during the next several hundred years, culminating in the 15th to 17th centuries, resulted in more than 100,000 people being burned at the stake (Farreras, 2023). Modern historians are not in complete agreement, but many have concluded that at least some of these supposed witches who were so terribly punished were people suffering from some type of mental disorder. Even during the time of the witch hunts, some scholars attempted to argue that the supposed witches were actually mentally ill women, not women possessed by the Devil. However, the Catholic church effectively silenced these voices by banning their writings (Farreras, 2023).

Meanwhile, beginning in the 1600s, as Europe was emerging from the Middle Ages, a first step toward the modern era of treating mental disorders began with the growth of the early institutions often known as asylums. Asylums were purportedly intended to shelter mentally ill people along with other groups, such as poor, unhoused, and disabled people. In reality, as they increased in prevalence, asylums were used to effectively remove undesirable populations from view—protecting the public *from* asylum occupants—rather than actually helping patients (Farreras, 2023). The conditions inside these early asylums were horrible (figure 1.3).

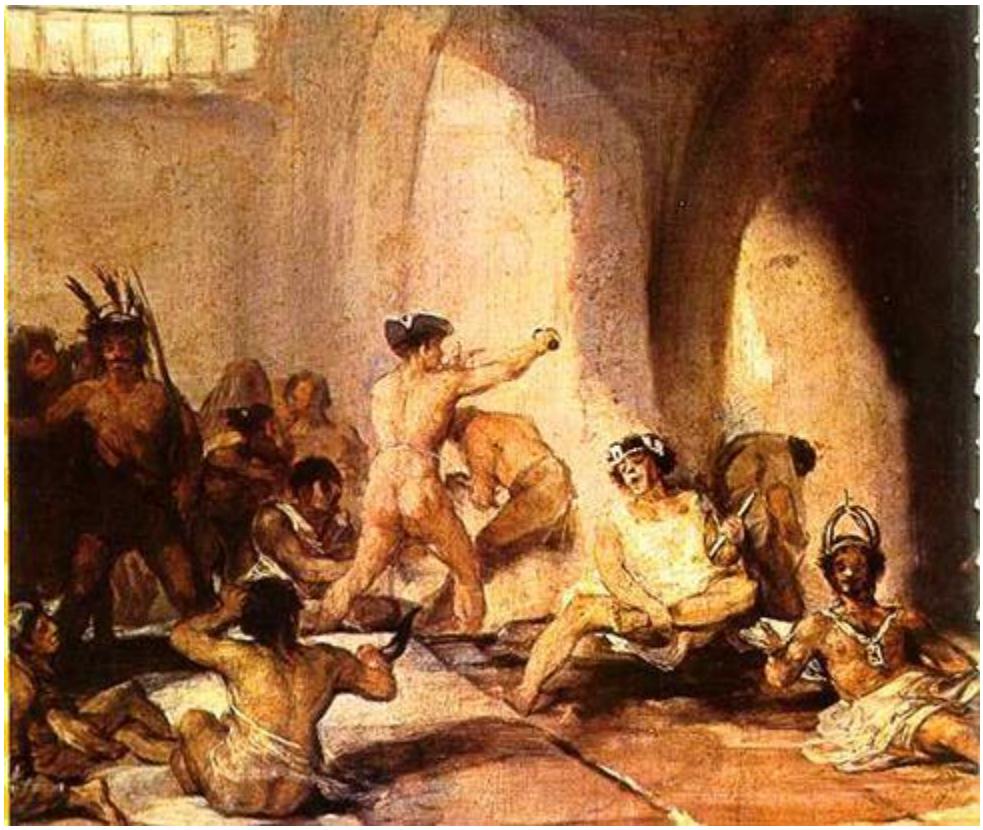

Figure 1.3. This painting by Francisco Goya, called *The Madhouse*, depicts an asylum and its inhabitants in the early 1800s.

Two infamous institutions operating in the 1700s and beyond were the Hospital of St. Mary of Bethlehem in London (figure 1.4) and La Salpêtrière, an asylum for women located in Paris that held thousands of patients (figure 1.5). Both of these institutions were essentially dungeons; mentally ill patients were often chained to walls alongside other unfortunate occupants, including the sick and the poor (Tracy, 2019). Asylum patients throughout Europe were sometimes displayed to the public for a fee (Farreras, 2023). It is telling of the conditions in these asylums that London's Bethlehem hospital was casually called "Bedlam," a name that gave rise to the modern term "bedlam," meaning a wild and chaotic situation (Merriam-Webster, n.d.).

Figure 1.4. William Hogarth's *Scene from Bedlam*, created in 1734, shows the chaos in London's Bethlehem hospital. Formally dressed women in the corner watch the patients and whisper.

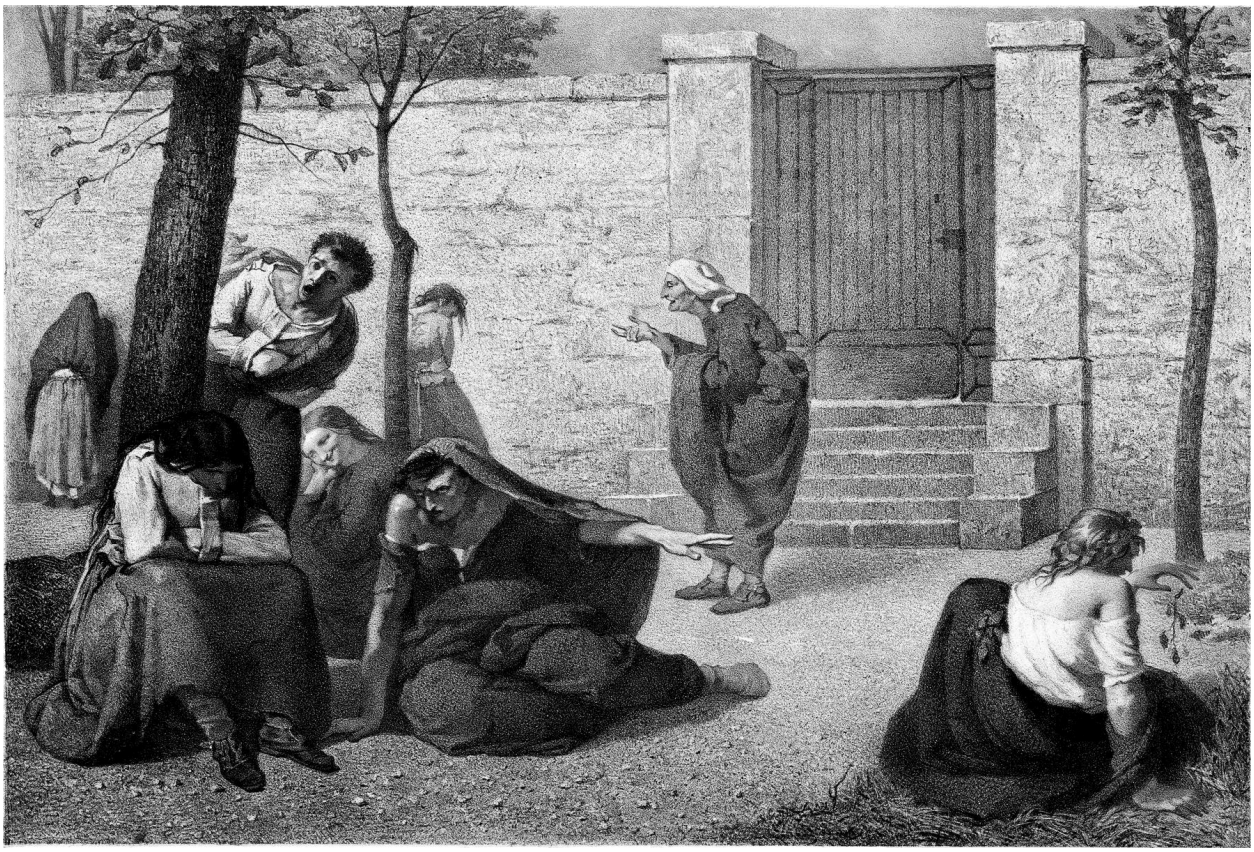

Figure 1.5. Armand Gautier's *Madwomen of the Salpêtrière* is an 1857 lithograph intended to depict various conditions afflicting women found in the Salpêtrière asylum. Each woman seems to be suffering alone, and no caregivers are present.

To the extent that they were offered in early institutions, treatments for patients with mental disorders were extremely primitive. At the time, the medical response to mental disorders was similar to the treatment of physical illnesses (Farreras, 2023). Bloodletting was one example of an early all-purpose treatment: a care provider would cut a nick in a vein or artery to allow the removal of "excess" blood, supposedly increasing the health of the patient (Cohen, 2023).

Although the conditions in early institutions for people with mental disorders can be hard to fathom, they show us something about how this group of people was viewed. Authorities (including medical, legal, and moral leaders) believed that this group of people lacked the capacity to control themselves and that, along with that inability or lack of "reason," it followed that they also lacked sensitivity to pain or misery (Farreras, 2023). This is not so different from the startlingly recent belief that infants don't feel pain—simply because they cannot verbalize or express it in a typically understood or "reasonable" way. This utterly false belief about infants was debunked in recent years with scientific evidence, but even through the 1980s, this misinformation allowed surgeons to operate on young babies without providing any pain relief (University of Oxford, 2015).

Reforming Treatment of Mental Disorders

Fortunately, reformers in early 18th-century Europe began thinking differently about the treatment of people with mental disorders. Some doctors began to experiment with less restrictive practices for their patients. In Italy in the late

1700s, the physician Vincenzo Chiarugi began to unchain his patients at St. Boniface hospital in Florence, encouraging them to practice good hygiene and engage in recreational activity. Around the same time in France, physician Philippe Pinel famously unshackled his patients and actually talked to them at the Salpêtrière hospital in Paris (figure 1.6) (Micale, 1985, as cited in Farreras, 2023).

Figure 1.6. This painting by Tony Robert-Fleury depicts Dr. Philippe Pinel ordering the removal of chains from patients at the Salpêtrière, a Paris asylum for women (Spielman et al., 2020).

Pinel reportedly engaged in "therapeutic conversations" with patients, talking them through, or out of, their delusions. Although psychiatry was not yet an established medical field and Pinel did not have many appealing options for medical treatment, he did recognize the need for treatment and offered what was available at the time: baths, opium, bloodletting, and occasional laxatives. He saw the occupants of institutions as people in need of care, rather than as dangerous threats to society who needed to be restrained. Pinel, who would later be called the "father of modern psychiatry," made lasting contributions to the field by improving conditions in the Salpêtrière and providing a model of a new kind of treatment (Tietz, 2021).

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1.3 Mental Disorders in Modern Times: The Rise of Institutional Treatment

Somewhat later, America had its own "father of psychiatry," Dr. Benjamin Rush, who in 1812 wrote the first psychiatry textbook to be printed in the United States: *Observations and Inquiries Upon the Diseases of the Mind* (Penn Medicine, n.d.-a). In addition to practicing medicine, Rush was a signer of the Declaration of Independence and a civic leader who was outspoken in his opposition to slavery and support of education—including the education of girls (University of Pennsylvania, n.d.). However, some of Rush's voiced beliefs conflicted with his actions, as he is reported to have been a slaveholder for a period (Dickinson College, n.d.). Rush's progressive views, limited as they were, extended to the treatment of patients with mental disorders.

The Creation of State Hospitals

By the early 1800s, American communities following in European footsteps had created some asylums for people with mental disorders. The higher-end asylums followed the lead of the French doctor Pinel, engaging in what was called "moral treatment" of patients. Benjamin Rush was a practitioner of this approach. Moral treatment for people with mental illness was based on the idea that patients could become well if they were treated kindly and in ways that appealed to the supposed "rational" parts of their minds.

Moral treatment specifically rejected the harsh treatments that had previously been used to respond to mental disorders, as well as the negative judgment or thinking that an ill person was somehow "bad" (Penn Medicine, n.d.-b). Instead, the moral approach idealized peace, quiet, and seclusion. American asylums, as opposed to the dungeons of 17th-century Europe, were intended to provide this peaceful atmosphere in hopes of curing their residents (D'Antonio, n.d.).

The active treatments for mental illness offered in American asylums remained very limited in the 1800s. Treatments still included older approaches such as bloodletting, but Dr. Rush also introduced some new innovations. He created a "tranquilizer chair" (figure 1.7) and a "gyrator," which would spin restrained patients to encourage better blood circulation. The tranquilizer chair especially, though obviously troubling by today's standards, was a step forward in that it was intended to calm patients by restraining their heads and bodies

without the use of an even harsher straightjacket (Penn Medicine, n.d.-b).

Figure 1.7. Benjamin Rush's tranquilizer chair was intended to calm patients by restricting their movement, as an alternative to other harsher restraints.

Although more expensive private asylums had incorporated moral treatment approaches by the mid-1800s, many poor American patients with mental disorders still languished in jail-like facilities (D'Antonio, n.d.). This state of affairs inspired a school teacher-turned-reformer named Dorothea Dix (figure 1.8) to push for change, specifically the establishment of what would be known as **state hospitals**. These early state hospitals were psychiatric facilities in the model of the asylum and were funded by the government to serve the public.

Figure 1.8. Dorothea Dix, a reformer and advocate for poor people and those with mental disorders, was instrumental in creating early state hospitals in America.

Dix had reportedly visited jails for religious outreach, leading her to become concerned about incarcerated people with mental illness and then about the treatment of this group generally. Recognizing the mistreatment of people with mental illness as a widespread problem in America, Dix traveled throughout the country during the 1850s and 1860s. She testified to state legislatures and Congress, urging lawmakers to move people with mental illness out of jails and jail-like institutions. She criticized the cruel treatment of people with mental illness, which included putting them in cages and using painful restraints (Parry, 2006).

Dix proposed that states create special, publicly funded hospitals to house this population. These new facilities imagined by Dix would be dedicated to treatment for those with mental illness, and she believed they would offer the opportunity for better treatment and even cures for many patients. Dix's advocacy contributed directly to the creation of more than 30 state hospitals. By 1870, nearly

every state had a public hospital built on the principles of moral treatment (D'Antonio, n.d.; Parry, 2006). Dix's advocacy and results were impressive, especially considering that her activism preceded the passage of the Nineteenth Amendment, which allowed women to vote, by more than 50 years (Parry, 2006).

However, over time it became clear that state hospital facilities promised more than they were able to deliver. In many cases, state hospitals were an improvement over previous facilities, but they offered no actual cure to most of their inhabitants (Tracy, 2019). In fact, the hospitals were increasingly used to house additional populations—such as the elderly or people with various disabilities beyond mental illness—who needed state-funded care but were not moving toward "recovery." The state hospitals, full of patients likely needing care for their entire lives, exceeded their capacities and their limited resources (D'Antonio, n.d.).

By the late 1800s, state hospitals were overwhelmed. They were overcrowded and increasingly filthy, and they offered very little in the way of actual treatment to their residents (Spielman et al., 2020; Farreras, 2023). The practice of **institutionalization**, the segregation and confinement of people with disabilities or mental illness in facilities rather than supporting their integration into communities, was firmly entrenched (Spielman et al., 2020). Ultimately, the new hospitals championed by Dix were simply the latest way to confine and remove the unwelcome population of people with mental disorders in American society.

Stories of the horrors at state hospitals abound. One example, the Willard Psychiatric Center, originally called the Willard Asylum for the Insane, first opened in upstate New York in 1869 and remained open for 130 years (Willard Psychiatric Center Collection, n.d.). At Willard, reported "treatments" included submerging patients in ice-cold baths even as wintertime temperatures in the facility were said to be cold enough to freeze a glass of water left on a table overnight (Spielman et al., 2020).

Willard was not alone in its miserable treatment of patients; rather, it was unfortunately typical of state institutions at the time. Reports on similar hospitals reveal that people were often treated cruelly—including enduring beatings and sexual abuse. Sometimes, experiments were performed on unknowing residents (Brown, 2021). Because every state built an institution for its mentally ill and disabled residents, nearly every state has a history of an abusive institution that existed for decades, at least, extending into recent history. Some of these histories remain more obscure than others, with residents often not able to express and publicize their experiences.

Oregon Institutions

Oregon had its own infamous institutions, including the Fairview Training Center. Over the course of its life, Fairview confined thousands of people, from young children to the elderly, with a range of disabilities that often included mental disorders. Fairview opened in 1908 as "an institution for the feebleminded, idiotic, and epileptic" with 39 "inmates." It eventually became Oregon's largest institution, housing 3,000 residents at its peak. Fairview residents were restrained, whipped, drugged, and locked into small cages. Disabled children often entered Fairview and remained confined there for their entire lives. Thousands of Fairview residents endured forced reproductive sterilizations that continued to occur through the 1970s (James, 2015). Watch the video in figure 1.9 to hear from Fairview residents who were victims of forced sterilization, a practice discussed further in the Spotlight in this section.

This interactive content is not available in this version of the text. It can be accessed online here:
https://player.pbs.org/viralplayer/3050048007/

Figure 1.9. This short video clip from the longer documentary *In the Shadow of Fairview* highlights the story of the over 2,600 Oregonians who underwent forced sterilization due to their disabilities while at, or trying to leave, Fairview Training Center. **Transcript.**

Oregon's Fairview Training Center remained fully operational (and overcrowded) well into the 1980s, despite advocacy by the oppressed residents, sanctions for mismanagement and abuse of the people it housed, and even a U.S. Department of Justice investigation in 1985. Fairview finally began to downsize, but it stubbornly remained open until 2000. The institution housed 1,500 residents in 1986 and was down to 300 by 1996 (Drummond, 2000). For more information on another Oregon institution, see the Spotlight in this chapter on the Oregon State Hospital.

SPOTLIGHT: Carrie Buck and the Practice of Eugenics

Of the many abuses experienced by people with mental disorders, forced sterilization was one of most harmful and lasting violations against this vulnerable population. The story of Carrie Buck, which can be difficult to read, is an infamous example of this abuse.

The reproductive sterilization movement in the United States took off in the 1890s, aimed at removing certain "unfavorable" characteristics from the gene pool. Interference with and control of reproduction for these reasons is called **eugenics**. In eugenics, sterilization was used to perpetuate racism, as well as ableism and misogyny, so groups of immigrants, people of color, and the poor—mostly women—were ready targets. People who had been institutionalized due to mental disorders, such as developmental disorders or medical conditions like epilepsy, were deemed "feebleminded" and were easy victims of eugenics programs (Ko, 2016). Eugenics programs aimed at eliminating this disfavored group of people were reviewed by the U.S. Supreme Court in the 1927 case of *Buck v. Bell*.

In the fall of 1923, Carrie Buck (figure 1.10) was a 17-year-old foster child living in the state of Virginia. When Carrie became pregnant (she was raped by another family member), it was decided that the best thing to do was to institutionalize Carrie for being an unwed teenage mother. Carrie's condition was considered a sign that she was morally delinquent and "feebleminded." Having been born to a "feebleminded" mother, Carrie's baby was considered "feebleminded" upon her birth and was eventually adopted by Carrie's former foster parents. Meanwhile, Carrie was sent to the Virginia State Colony for Epileptics and Feebleminded in Lynchburg, where she was reunited with her mother, Emma Buck, who had also been institutionalized (Antonios & Raup, 2012).

Figure 1.10. Carrie Buck during the time she was institutionalized.

Carrie Buck, just 18 years old, was then ordered to be sterilized under Virginia's 1924 Eugenical Sterilization Act. The order was examined and approved by the Virginia courts and, eventually, by the Supreme Court in *Buck v. Bell* (1927). The Supreme Court endorsed the

sterilization of Carrie Buck and others like her, comparing the procedure to a preventative health measure, like vaccination: "The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes." (*Buck v. Bell*, 274 U.S. at 208).

While Virginia went on to sterilize at least 8,300 people, most other states, including Oregon, had similar programs. Oregon's official Board of Eugenics was formed in 1923. It was later renamed the Board of Social Protection, and it remained intact until 1983. As part of its eugenics program, Oregon forcibly sterilized people with mental disorders at its Fairview Training Center, in addition to other targeted groups: people identified as criminals or homosexuals, youth in reform schools, and young girls considered to be promiscuous.

Although eugenics is officially disfavored today, the *Buck v. Bell* case was never expressly overturned, and the inhumane thinking behind the decision had a far-reaching impact. The *Buck v. Bell* decision served to empower the eugenics movement in America, leading to the sterilization of an estimated 65,000 Americans with mental disorders from the 1920s up through the 1970s (Ko, 2016). Horrifyingly, the American states' eugenics programs are said to have inspired early Nazi sterilization programs intended to rid the German population of "feebleminded" people (Jewish Virtual Library, n.d.).

Racial Segregation in Institutions

Given that institutionalization of people with mental disorders took place during a time of widespread racial segregation in America, there were also state hospitals, or sometimes parts of hospitals—such as basements—dedicated to housing Black patients. Although the Civil Rights Act of 1866 required state hospitals to accept Black patients, many completely refused to do so, and where they were admitted, they were segregated from white patients (Swenson, 2017). Virginia's Central Lunatic Asylum for the Colored Insane, later known as Central State Hospital, was filled in the late 1800s with Black patients housed in primitive and abusive conditions (figure 1.11). All of the women in the facility were guarded by men, based on the thinking that the women needed guards with enough strength to properly control them. Many of the Central State Hospital residents had been deemed mentally ill and fit for institutionalization based on nothing more than accusations by racist whites unhappy with the free status of formerly enslaved people. Some Black residents were declared insane based on their simple desire to be free (Brumfield, 2021). Indeed, during the period of slavery, Black people had routinely been found mentally ill simply for desiring or attempting to escape enslavement (Swenson, 2017).

Figure 1.11. This photograph of Black women in the Central State Hospital shows them engaged in "diversional occupation."

Patients in early American psychiatric institutions rarely received humane care or treatment for mental illness or whatever disorder had led to their confinement, but this failure was especially pronounced for Black patients. These patients endured particularly dehumanizing treatment based on their race. In records from the Central State Hospital, detailed notes about patients were almost always summaries of their "usefulness"—that is, their ability to work. Formerly enslaved people both in and out of institutions were considered valuable only to the extent they could be part of a planned cheap labor force in the post-slavery era (Swenson, 2017).

Treatment of Mental Disorders in the 1900s

During the mid-1900s, treatments offered to patients in state hospitals had expanded beyond bloodletting, but these treatments remained in experimental stages. Mentally ill and disabled people in institutions suffered the burden of trial and error. Modern **electroconvulsive therapy (ECT)**, which involves passing small electric currents through a patient's brain, is performed under anesthesia with safeguards in place. ECT creates changes in brain chemistry that have been highly effective in treating challenging conditions such as severe depression (Mayo Clinic, 2018). However, the original version of this treatment, known as electroshock therapy, induced seizures with large amounts of electricity, but without the advancements of modern medicine. The procedure was done without anesthesia or sensitivity to the patient, and it was terrifying and dangerous. A patient described electroshock therapy at the Missouri state hospital in 1957 as a terrible ordeal:

> Patients were generally on [electroshock] treatment twice a week. . . . Begging, pleading, crying, and resisting, they were herded into the gymnasium and seated around the edge of the room.
>
> Between them and the shock treatment table was a long row of screens. The table on the other side of the screen held as much terror for most of these patients as the electric chair in the penitentiaries did for criminals. . . . In order to save time, one or more patients were called behind the screen to sit down and take off their shoes while the patient who had just preceded them was still on the table going through the convulsions that shake the body after the electric shock has knocked them unconscious.
>
> One attendant stands at the head of the table to put the rubber heel in their mouth so they won't chew their tongue during the convulsive stage. On either side of the table stand three other attendants to hold them down . . . (Office of the Secretary of State, Missouri. (n.d.).

Early brain surgeries to treat mental disorders were, likewise, an ill-advised and often devastating approach. Modern brain surgeries are very promising in treating certain conditions, such as severe epilepsy, but the practices and goals in these early days were quite different. A surgery called a lobotomy, for example, where part of a person's brain was removed with a goal of managing or curing mental illness, was performed on patients up until the 1950s in America (Tracy, 2019).

Rosemary Kennedy, the sister of eventual president John F. Kennedy, was subjected to a lobotomy as a young woman in 1941 (figure 1.12). Rosemary's father, Joseph Kennedy, ordered the lobotomy when Rosemary was in her early 20s. As a result of the surgery, Rosemary was left seriously disabled (John F. Kennedy Presidential Library

and Museum, n.d.). It has been speculated that Joseph Kennedy's request was motivated by Rosemary's disruptive behavior, which caused the family embarrassment and threatened the political careers of the Kennedy men (Gordon, 2015). Rosemary was influential largely because of the impact her experience had on her powerful and famous family, including her brother John, who became President in 1961, and her sister Eunice Kennedy Shriver, who worked to improve the lives of people with developmental disabilities and founded the Special Olympics in 1968. Rosemary herself was hidden from public view and was cared for in an institution away from even her family for most of her life.

Figure 1.12. Rosemary Kennedy, pictured here in 1938, just three years before her lobotomy (John F. Kennedy Presidential Library and Museum, n.d.).

Perhaps the most famous recipient of a lobotomy is a fictional one: Randle McMurphy, the hero of Ken Kesey's 1962 anti-psychiatry novel, *One Flew Over the Cuckoo's Nest*. The novel, set in an Oregon psychiatric institution, tells the story of patients rebelling against oppressive and abusive treatment. In Kesey's story, McMurphy fakes mental illness to avoid criminal responsibility; he ends up both inspiring his fellow hospital residents and suffering along with them. Kesey's book came out as civil rights activists were questioning all aspects of establishment and authority in America—including state hospitals. The book and its 1975 film adaptation, which also depicted a horrifying view of ECT as more torture than treatment, were award-winning pieces of art, and they certainly left a broad group of Americans questioning the value and ethics of psychiatric hospitalization and treatment (Moffic, 2014).

Licenses and Attributions for Mental Disorders in Modern Times: The Rise of Institutional Treatment

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1.4 Modern Developments: The Decline of Institutional Treatment

Significant changes to the American approach to mental disorders and the status quo of institutionalization had already begun to occur in the 1940s. President Harry S. Truman signed the **National Mental Health Act** in 1946, which authorized increased research and funding aimed at improving American mental health care. The Act led to the creation of the **National Institute of Mental Health (NIMH)** a few years later. The NIMH is the leading federal agency for research on mental disorders and is part of the larger National Institutes of Health. The purposes of the NIMH were improved training of mental health professionals, expansion of community-based mental health care, and increased research around mental health issues. Over the next decades, the NIMH significantly expanded America's commitment to use science to understand and treat mental disorders. Eventually, scientific progress would lead to opportunities for the treatment of mental disorders outside of hospitals.

The goal of creating asylums and state hospitals had been to provide care via a sheltering environment. This ideal was not generally realized, but even if it had been, the institutions had the flaw of removing people with mental disorders from their communities. Likewise, while early treatments for mental disorders—such as brain surgeries and shock therapy—had many drawbacks, a fundamental one was that these treatments could not be accessed in the community; recipients were required to be hospitalized. Thus, a revolutionary scientific development in treating mental disorders was the development of psychiatric medications. Unlike previous procedures and treatments that could only be performed in hospital settings, medications that treated mental disorders could be used in the community. When severe symptoms might have required patient confinement,

medications to control symptoms of mental illness alleviated that need for confinement. Just as many activists were beginning to question the routine institutionalization of people with mental disorders, medication management provided an opportunity to end this approach.

SPOTLIGHT: The Oregon State Hospital, Then and Now

After Corvallis-area cult leader Edmund Creffield (figure 1.13) was convicted on charges of adultery, most of the members of the Brides of Christ Church were committed to what was then called the Oregon State Insane Asylum in Salem. The diagnosis was "religious hysteria," and the women were committed by concerned family members. The year was 1904, and the asylum had only been in operation since 1883.

Figure 1.13. Edmund Creffield, shown in an Oregon State Penitentiary photograph around 1904. Feel free to learn more about **Creffield's fascinating story [Website].**

The Oregon State Insane Asylum was, at the close of the 1800s, considered a safe place for people to take their family members for many reasons beyond supposed insanity. Some had committed crimes, others were developmentally disabled, and many others may have simply been seen as a burden to society. A report released by the Oregon State Insane Asylum in 1896 listed the various "causes for insanity" of those admitted between December 1894 and November 1896. Among these reasons were things such as business trouble, financial trouble, loss of sleep, menopause, and even masturbation (Mental Health Association of Portland, n.d.).

Purportedly, asylum patients could receive treatment and rehabilitation and then return to society. Unfortunately, a mental institution's idea of "treatment" back in the 1800s and early 1900s was often more detrimental than helpful, and many abuses occurred. Among these abusive treatments were lobotomies, ice baths, electroshock therapy, straightjackets, sedation, and forced sterilization.

By the middle of the 20th century, it had become apparent that the Oregon State Insane Asylum wasn't large enough to house all of the Oregonians in need of inpatient mental health services. By 1958, the facility was vastly overcrowded with 3,545 patients, worsening the already grim conditions. This led to the opening of several new mental health facilities around the state, and the asylum officially changed its name to the Oregon State Hospital. For more history, photos, and stories from the Oregon State Hospital, you may be interested in exploring the website of the hospital's fascinating **Museum of Mental Health [Website]**.

Fortunately, as science and medicine have made advances, so has our understanding of effective treatments for mental disorders. Psychiatric facilities such as the Oregon State Hospital no longer administer lobotomies or other horrific "treatments" that were once the norm. Treatments for mental disorders now often include medications supplemented by individual and group therapies and activities.

As discussed in more depth in the main text, psychiatric hospitals that remain in operation have improved vastly since the time of their inception. However, the overall mental health system in the United States, including Oregon, has floundered. Recognizing the inadequacy of community mental health support, Oregon has renewed its commitment to this population—at least for the moment—with efforts such as large government investments in Oregon's behavioral health system (Porter, 2022). It will require continued investments and sustained commitment to ensure that Oregonians who need care and social support will be able to access them.

In 1949, lithium was introduced as the very first effective medication to treat mental illness, specifically what is now known as bipolar disorder (Tracy, 2019). Another critical breakthrough occurred in 1952, when the first antipsychotic medication, chlorpromazine, became publicly available. **Antipsychotic medications** treat psychosis, a debilitating aspect of mental illness that impacts a person's ability to distinguish what is real. People experiencing psychosis (discussed further in **Chapter 2** of this text) may have delusions, where they believe something that is not real, or hallucinations, where they see or hear things that do not exist. Antipsychotic drugs treat and help control these symptoms, allowing a person to again perceive reality (National Institute of Mental Health, n.d.). Chlorpromazine, marketed and more commonly known as Thorazine, effectively, though not completely, controlled symptoms of psychosis in many patients (Tracy, 2019).

Fueled by the scientific successes of the late 1940s and 1950s, as well as the growing activism against institutional treatment of mental disorders, Congress passed the **Community Mental Health Act (CMHA)** in 1963. President John F. Kennedy, whose sister had undergone a disastrous lobotomy 22 years earlier, signed it into law (figure 1.14). The CMHA promised federal support and funding for community mental health centers. This legislation (along with some of the other laws discussed in **Chapter 3** of this text) was intended to change how services for mental disorders were delivered in the United States. Specifically, the CMHA meant to shift mental health care to communities, bringing patients along to live safely among friends and family (Erickson, 2021).

Figure 1.14. President John F. Kennedy signs the Community Mental Health Act into law in 1963. Oregon Representative Edith Green is in the background with other lawmakers.

The signing of the CMHA was done with hope and good intentions for reducing the institutionalization of all people with mental disorders. In a speech to Congress promoting his agenda, President Kennedy described a plan that would change the landscape for people with mental disorders:

> I am proposing a new approach to mental illness and to mental retardation. This approach is designed, in large measure, to use federal resources to stimulate state, local, and private action. When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment, and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away (Peters & Woolley, n.d.).

The CMHA anticipated the building of 1,500 mental health centers in communities, which would allow half of the nearly 600,000 people with mental disorders who were then institutionalized in state hospitals to be treated in their homes and communities instead (Erickson, 2021). However, while the CMHA did help connect many people with community-based treatment, and psychiatric hospitalizations decreased drastically in the ensuing years, the law did not meet its full promise. Only half of the expected mental health centers were ever built, and funding proved to be inadequate for the ones that were created. Although the CMHA provided dollars to build the mental health centers, it did not provide continuous funding for running them. Rather, states were expected to step up with support. However, states were quick to reduce their contributions when funding was tight or other priorities were more politically popular (Smith, 2013).

"Mental retardation" was the medical term that predated the modern and preferred terms "intellectual disability" or "intellectual developmental disorder." As "retardation" became used as a slur, drawing on the nearly universal societal disdain for people with intellectual disabilities, the term was rejected by disability self-advocates, and eventually the general public, as well as the legal and medical establishments (Change in Terminology, 2013). If you would like to hear from advocates about the movement to use inclusive language, you can do so at **this Special Olympics page [Website]**.

Critics argue that the CMHA was an example of "optimism without infrastructure" (Erickson, 2021). The CMHA was well-intentioned, hopeful even, but there were failures in executing its plans; in the end, not nearly enough community support was available for people to quickly leave institutions or to get the help they needed when they did leave. This was particularly true for people with more serious or severe mental disorders.

Licenses and Attributions for Modern Developments: The Decline of Institutional Treatment

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Figure 1.14. **Photograph of John F. Kennedy** by **Cecil Stoughton** is in the **public domain**.

1.5 Deinstitutionalization and Disability Rights

Although the law was not a full success, the CMHA was nevertheless a part of the larger movement and process that came to be known as deinstitutionalization. **Deinstitutionalization** was, first, the dramatic downsizing and closure of the large institutions, mainly the state hospitals, that had been housing patients with mental disorders for 100 years. The second half of this process was, or should have been, moving those same people into communities where they could receive care, support, housing—all the things they needed to survive and thrive outside of institutions. On the second front, deinstitutionalization was, at least in part, a disappointment.

As state hospitals across the country reduced their bed space, many people were discharged into their communities, including people who likely never had a significant reason to be hospitalized and people who experienced serious mental illness and significant disabilities. In 1955, there were around 550,000 patients with mental disorders institutionalized at public hospitals. Twenty years later, after the process of deinstitutionalization was well underway, the number was down to 200,000. By 2017, there were less than 40,000 patients in state hospitals. Based on the straight numbers, but especially in light of the significant U.S. population increase during these decades, the percentage of people hospitalized for mental disorders had plummeted (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

As a social movement, and in its best light, deinstitutionalization marked the beginning of treating people with mental disorders as something more than patients or problems to hide away. People who had been confined against their wishes for lengthy periods emerged as people and community members. With medications, treatment, and other supports available outside of institutions, these people finally had the opportunity to live in their own homes and communities. Inherent in this change was the concern that it would cause people to suffer, but the opportunity for growth and independence made that risk worthwhile. Allowing people with mental disorders to seek lives in the community permitted them the **dignity of risk**—that is, the ability to potentially fail that accompanies an opportunity for growth. The concept of dignity of risk was first introduced by scholars in the 1970s and 1980s, but it has become a central tenet of self-advocates who continue today to argue that many forms of perceived "protection" place unacceptable limits on the lives of people with disabilities. The concept and importance of dignity of risk are explained by a self-advocate in the required video linked here (figure 1.15).

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=LUka52lKtdw

Figure 1.15. Watch this short video to hear a self-advocate explain the dignity of risk, and consider how this concept relates to deinstitutionalization. **Transcript.**

Deinstitutionalization was not just a medical development or a legal maneuver. It was also part of a larger change in thinking that was pushed forward by the budding **disability rights movement** taking place in the mid-1900s in America. The disability rights movement was a broad push toward securing equal rights and opportunities for people who experience disabilities. Disability advocates saw other groups, like people of color and women, asserting their rights to fair treatment under the law, and they realized that people with disabilities also needed to claim their rights to participate in society. Groups such as disabled veterans and polio survivors were visible and often sympathetic leaders in this movement, as were parents of disabled children fighting for access to educational opportunities (Anti-Defamation League, 2017).

As part of the disability rights movement, there was increasing discomfort with the previously accepted marginal role of people with disabilities and mental disorders in society. Activists claimed that people with disabilities had rights as free human beings and that barriers would not be tolerated. These activists argued that they were entitled to live in accessible communities and with a degree of autonomy. All of this applied to people with mental disorders as well.

The disability rights movement was first organized and led primarily by people with physical disabilities. People with psychiatric disabilities or intellectual disabilities, and people of color with any disabilities, were less socially favored and often excluded from the mainstream early disability rights movement (Erkulwater, 2018). The disability rights movement was diverse in some ways—bringing together people from all walks of life, children and adults, veterans and hippies—but it struggled to fully integrate all the voices that would have increased its power and traction. According to some, this remains true to the present day, and the reasons are not always clear. One scholar who studies this issue has suggested that comparisons of suffering are harmful to group cohesion and to people of color who need their experiences to be seen fully:

> White activists with disabilities sometimes argued that Blacks had to sit at the back of the bus, but the disabled couldn't even get on the bus. That argument erases Black people with disabilities, whose exclusion is the result of both racism and ableism. When advocating for human rights, it's important to recognize that our movements include people of marginalized identities, and there is value in centering those experiences and perspectives (Erkulwater, 2022).

SPOTLIGHT: Women Who Shaped the Disability Rights Movement

As discussed in the main text of this chapter, and in more depth in **Chapter 3**, the disability rights movement was instrumental to the deinstitutionalization process for people with mental disorders. Despite the many barriers facing female advocates—who due to their gender were prevented from exercising some of the most basic acts of independence well into the modern day—numerous women distinguished themselves as disability advocates, even as they contended with additional barriers created by race and disability.

Figure 1.16. Bessie Blount, creator of assistive technology to increase disabled people's independence.

- **Bessie Virginia Blount** (1914–2009) was born in Hickory, Virginia (figure 1.16). As a child of free Black people, she was sent to a very small segregated school that only taught through sixth grade. She had no opportunities to further her education until she was accepted to Union Junior College in Cranford, New Jersey. She studied nursing and later became a licensed physiotherapist. During World War II, Blount volunteered at military hospitals and realized that helping those with disabilities was her passion. She is credited with developing early forms of assistive technology—including self-feeding tools for people who had lost limbs, allowing them the power and dignity of controlling and managing their own intake (Lemelson-MIT, n.d.).
- **Johnnie Lacy** (1937–2010) was born in racially segregated Huttig, Arkansas, but moved to California when she was young (figure 1.17). At the age of 19, Lacy contracted polio, which left her paralyzed. After being treated in a rehabilitation facility, she was able to go to college and earn a degree, though she was forced to fight to gain entrance to school and was denied full participation. Lacy eventually helped found the influential Center for Independent Living in Berkeley and later served as the executive director of Community Resources for Independent Living in Hayward, California, from 1981 to 1994. Lacy's struggles illustrate the intersectional impacts of racism, sexism, and disability, and they show the importance of her advocacy and accomplishments (The Center for Learner Equity, 2021).

Figure 1.17. Activist and advocate Johnnie Lacy.

- **Judith Heumann** (1947–2022) was diagnosed with polio at just 18 months old (figure 1.18). Initially denied entrance to public school, it wasn't until fourth grade that Judy was able to attend a school for disabled children. Later, while attending Long Island University, Heumann became active in increasing the rights of people with disabilities. She organized rallies and protests. After college, she continued her work in activism and politics. A highlight of her work occurred in 1977 when she staged a sit-in protesting the U.S. Secretary of Health, Education, and Welfare's refusal to implement Section 504 of the Rehabilitation Act of 1973, which protected civil rights for people with disabilities (discussed in more detail in **Chapter 3**). To this day, the Section 504 sit-in, lasting 28 days, is the longest-ever sit-in at a federal building (Heumann & Joiner, 2021).

Figure 1.18. Disability activist Judith Heumann.

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Figure 1.17. Photograph of Johnnie Lacy from The Center for Learning Equity is included under fair use.

1.6 Mental Disorders Post-Deinstitutionalization

Today, the dehumanizing asylums that were a part of America's earlier history no longer exist. Now, reformed state hospitals are psychiatric hospitals run by state governments, and they are not simply repositories for unwanted people. These hospitals are focused on short-term care, and people are hospitalized only if they pose a significant threat to themselves or others (Spielman et al., 2020). Lengthy psychiatric hospitalizations occur only under specific circumstances and with careful safeguards, as discussed in Chapter 9. People are not legally locked up in institutions simply because they experience a mental disorder.

In the wake of deinstitutionalization, many people with mental disorders were able to live happier and more fulfilling lives, with greater dignity and independence than would have been possible during the heyday of state hospitals. These are people who were able to secure sufficient housing, treatment, and community support; for these people and their loved ones, deinstitutionalization was an enormous victory.

Inadequate Community Alternatives

However, as we have learned, the story of deinstitutionalization is not an entirely happy one. Lack of adequate community opportunities, care, and support for people with mental disorders has led to new challenges. There are not enough community-based mental health centers, and they are often in need of resources. Funding is an often-cited issue, but underfunding is not the only problem. Staffing can be difficult as well, with not enough dedicated professionals entering and staying in critical behavioral health fields. **Behavioral health** is a broad term that includes all mental health and substance use care and treatment. Behavioral health professionals can include therapists, social workers, medical providers, and others who treat people with mental disorders and mental health problems. A recent government report from Oregon, which has a very high rate of unmet behavioral health needs, outlines numerous problems contributing to staffing shortages,

including an inadequate workforce overall; low numbers of providers of color in all workforce roles, depriving consumers of culturally responsive care; and poor work environments due to low pay, unmanageable workloads, and workplace stress—all of which lead providers to exit the field (Zhu et al., 2022).

The shortage of practitioners is not the only barrier to providing community services. Behavioral health staff may not be adequately trained, have the resources they need, or be able to find collaborative partners to handle the needs of people with serious mental disorders. There is also insufficient provision made for the other services people require to be able to access care: housing, food, and job training (Spielman et al., 2020).

Hardest hit by system failures are people who already have additional barriers to success, including people of color, immigrants, and sexual and gender minorities. These are populations that, even in the best of circumstances, are likely to face discrimination in accessing community services, housing, and education, and that have faced greater challenges post-deinstitutionalization in making their homes in the community (Deas-Nesmith & McLeod-Bryant, 1992). These marginalized and underserved groups are at significant risk of becoming homeless and justice-involved (Spielman et al., 2020).

Links to Homelessness and Incarceration

Some observers, noting the current housing crisis, as well as overflowing jails and prisons, are quick to blame deinstitutionalization for these problems. Indeed, a large portion of the unhoused population has one or more mental disorders. An estimated 20% to 30% of unhoused individuals have a serious mental illness such as schizophrenia (figure 1.19), and a startling 50% are thought to have traumatic brain injuries—far beyond the numbers found in the general population (Padgett, 2020). Likewise, jails and prisons began to fill to critical levels around the same time state hospitals were emptying, and correctional facilities are now the largest providers of mental health services in America.

Figure 1.19. This graphic illustrates an estimate from the federal government suggesting that one in five unhoused individuals experience serious mental illness (e.g., schizophrenia, bipolar disorder) that greatly impacts their capacity to sustain relationships, work, and provide self-care.

Other observers point out that deinstitutionalization did not *cause* homelessness, nor did it deprive people of treatment in their communities. Rather, the initial wrong that had to be righted was institutionalization. Then, shortages of care, housing, and other services followed and failed to be addressed. Additionally, stigma surrounding people with mental disorders contributes to the marginalization of this population. **Stigma** refers to persistent and unfounded negative attitudes aimed at categories of people, and it is a foundation for prejudice and discrimination. It is harder for people who experience mental disorders to find housing, get jobs, and otherwise succeed in the face of these barriers. Denial of opportunities based on a person's disability status may be illegal, but it is common and persistent (Ponte, 2020).

The deinstitutionalization movement also did not *require* the growth of jails and prisons. In fact, the "war on drugs" of the 1970s and 1980s and the "get tough on crime" movements of the 1980s and 1990s are more direct causes of mass incarceration in America. The supposed shift of people directly from state hospitals into jails and prisons is sometimes referred to as **transinstitutionalization**, a hypothesis suggesting that the same group of people simply moved from one institution (hospitals) to another (prisons). However, while people with mental disorders are indeed disproportionately found in jails and prisons, this is for many reasons that go beyond the simple assumption that people with mental disorders simply had to be moved from one institution to another (Prins, 2011).

For example, aside from reasons for increased initial incarceration, there is the significant factor of continued or repeated incarceration. Studies indicate that people with mental disorders get "stuck" in jail and prison significantly longer than other people: they are denied pretrial release more frequently, and they receive longer sentences more often. Additionally, once in prison, people with mental disorders are often not provided with adequate or effective treatment, leading them to incur new charges or fail to qualify for parole, which keeps them in prison. Alternately, if released untreated, people with mental disorders are less likely to succeed upon release; they are at high risk of reoffending and cycling back into the criminal justice system (Ponte, 2020).

There is also strong evidence that simply putting more people into psychiatric hospitals—a re-institutionalization of sorts—would be a very expensive and otherwise problematic reaction that would not significantly decrease the number of people with mental disorders in the criminal justice system. Rather, solutions like providing housing and other community support are far more effective in preventing criminal system involvement (Prins, 2011).

Licenses and Attributions for Mental Disorders Post-Deinstitutionalization

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1.7 Chapter Summary

- Mental disorders include mental health diagnoses as well as intellectual and developmental disorders. Although some mental disorders are not disabling, many people with mental disorders are part of the larger population of people with disabilities who struggle to have equal access to opportunities.
- Measures meant to treat or manage mental disorders throughout history have ranged from exclusionary to cruel, and even murderous, revealing a societal disdain for people with mental disorders that, to some extent, continues into the modern day.
- Reforms over time have sometimes reduced obvious abuses of people with mental disorders, but they have also created new problems. For example, shifting people with mental disorders into state hospitals to be "cured" ushered in a century of institutionalizing people, taking them away from community and family, to the detriment of all.
- Institutions meant to shelter people with mental disorders devolved into overcrowded, prison-like facilities with rampant abuse and use of techniques, such as forced sterilization, that thoroughly dehumanized their occupants.
- The closure of institutions for people with mental disorders in the process called deinstitutionalization brought both an enormous victory for people with mental disorders and a new set of challenges.

- Criminal justice facilities are the largest facilities for treating mental disorders in the United States. This is a result of a lengthy and complex history of failure to meet the needs of this population in humane and productive ways, as well as other events that have increased incarcerated populations overall.
- Deinstitutionalization collided with a rise in substance use in American communities, a problem that was met with an increase in criminal prosecution and incarceration. This punitive approach to the drug problem—along with housing shortages and healthcare unavailability—added substantially to the mentally ill and disabled population in America's criminal justice system.

KEY TERM DEFINITIONS

- **Antipsychotic medications:** Medications that treat psychosis, a debilitating aspect of mental illness that impacts a person's ability to distinguish what is real.
- **Asylums:** Facilities that were originally intended as a refuge for confinement and care of those with mental disorders and served in Europe and America as precursors to mental hospitals and psychiatric facilities.
- **Behavioral health**: A broad term that includes all mental health and substance use care and treatment. Behavioral health professionals can include therapists, social workers, medical providers, and others who treat people with mental disorders and mental health problems.
- **Community Mental Health Act:** A 1963 act that was intended to provide federal funding to shift mental health care from institutional to community settings.
- **Deinstitutionalization:** The dramatic downsizing and closure of large institutions, such as state hospitals, that housed people with mental disorders.
- **Dignity of risk:** The ability and power to potentially fail that comes along with an opportunity for self-determination and growth.
- **Disability**: Any condition or impairment of a person's body or mind that makes it more difficult for that person to engage or participate in activities.
- **Disability rights movement:** A broad push toward securing equal rights and opportunities for people who experience disabilities.
- **Electroconvulsive therapy (ECT):** A medical procedure that involves passing small electric currents through a patient's brain, creating changes in brain chemistry that have been highly effective in treating conditions such as severe depression.
- **Eugenics:** An American movement beginning in the 1890s that encouraged practices such as forced sterilization to remove "unfavorable" characteristics in the gene pool. Eugenics became disfavored in the late 20th century.
- **Institutionalization**: Confining people with disabilities or mental illness in facilities rather than supporting their integration into communities.
- **Mental disorders:** A mental illness, substance use disorder, or disability that impacts a person's cognitive, emotional, or behavioral functioning.

- **National Institute of Mental Health (NIMH):** The leading U.S. agency for research on mental health issues, founded in 1949 under the National Mental Health Act as part of the National Institutes of Health (NIH). The NIH is composed of 27 research institutes and centers and is part of the U.S. Department of Health and Human Services.
- **National Mental Health Act:** A 1946 act that authorized research and care for mental health and significantly expanded America's commitment to use science to understand and treat mental illness.
- **State hospitals:** Originally, state-funded institutions in the model of asylums intended to house people with mental disorders. Modern state hospitals are psychiatric facilities that provide care and treatment, usually on a short-term basis.
- **Stigma:** Persistent and unfounded negative attitudes toward categories of people, including those with conditions such as mental disorders. Some people object to this term on the grounds that it may perpetuate negative ideas, and they prefer the terms "prejudice and discrimination" to describe societal attitudes and actions that reinforce negative stereotypes and policies.
- **Transinstitutionalization:** A hypothesis suggesting that people in need of care during the deinstitutionalization movement were simply moved from one institution (hospitals) to another (prisons).

DISCUSSION QUESTIONS

- Are there any particular parts of the history relayed in this chapter that you found surprising? What, if any, elements of this history help you to better understand the challenges facing people with mental disorders in today's society and in your own community?
- Consider the concept of "dignity of risk" as discussed in the video in figure 1.15, and discuss how this concept might inform the goals of people with disabilities generally and people with mental disorders specifically. How does this concept relate to the ideals of deinstitutionalization?
- What do you think of the term "transinstitutionalization"? Describe the complex reasons why people with mental disorders are overrepresented in the criminal justice system.
- When future students look back on our current practices regarding mental disorders—especially in the criminal justice system—are there things you believe will make them wonder: how could humans do this to other humans?

Licenses and Attributions for Chapter Summary

1.8 References

Anti-Defamation League. (2017, March 5). *A brief history of the disability rights movement*. https://www.adl.org/resources/backgrounder/brief-history-disability-rights-movement

Antonios, N., Raup, C. (2012, January 1). *Buck v. Bell (1927)*. Arizona State University, Embryo Project Encyclopedia. https://embryo.asu.edu/pages/buck-v-bell-1927

Blumberg, J. (2022, October 24). A brief history of the Salem witch trials. *Smithsonian Magazine.* https://www.smithsonianmag.com/history/a-brief-history-of-the-salem-witch-trials-175162489/

Brown, S. (2021, September 27). *Mass. locked up people with mental illness for decades. Now advocates want their stories told* [Radio broadcast transcript]. WBUR. https://www.wbur.org/news/2021/09/27/bill-commission-state-hospital-mental-illness

Brumfield, D. M. (2021). *Racist origins: Central State was built to imprison black people in nightmarish conditions*. The Progress Index. https://www.progress-index.com/story/news/local/2021/07/27/central-state-hospitals-history-and-social-control-blacks/5381100001/

Buck v. Bell, 274 U.S. 200 (1927). https://supreme.justia.com/cases/federal/us/274/200/

The Center for Learner Equity. (2021, February 25). *Johnnie Lacy—An advocate for independent living*. https://www.centerforlearnerequity.org/news/johnnie-lacy-an-advocate-for-independent-living/

Centers for Disease Control and Prevention. (2023). *Disability impacts all of us. https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html*

Chang, A. (2018). 'Insane': America's largest psychiatric facilities are jails. *Shots Health News from NPR.* https://www.npr.org/sections/health-shots/2018/04/25/605666107/insane-americas-3-largest-psychiatric-facilities-are-jails

Change in Terminology: "Mental Retardation" to "Intellectual Disability," 78 Fed. Reg. 46,499 (Sept. 3, 2013). https://www.federalregister.gov/d/2013-18552

Cohen, J. (2023, March 28). *A brief history of bloodletting.* https://www.history.com/news/a-brief-history-of-bloodletting.

Cullen, J. (2018, July 20). *The history of mass incarceration*. The Brennan Center for Justice. https://www.brennancenter.org/our-work/analysis-opinion/history-mass-incarceration

D'Antonio, P. (n.d.). *History of psychiatric hospitals*. Penn Nursing, University of Pennsylvania. https://www.nursing.upenn.edu/nhhc/nurses-institutions-caring/history-of-psychiatric-hospitals/

Deas-Nesmith, D., & McLeod-Bryant, S. (1992). Psychiatric deinstitutionalization and its cultural insensitivity: Consequences and recommendations for the future. *Journal of the National Medical Association*, *84*(12), 1036–1040.

Dickinson College. (n.d.). *Benjamin Rush, race, slavery, and abolitionism*. https://www.dickinson.edu/info/20043/about/3480/benjamin_rush

Drummond, D. (2000, April). *Farewell Fairview: Oregon's largest institution is closed for good*. Independence Northwest. https://independencenw.org/clarionfairview/

Erickson, B. (2021). Deinstitutionalization through optimism: The Community Mental Health Act of 1963. *American Journal of Psychiatry Residents' Journal*, *16*(4), 6–7. https://doi.org/10.1176/appi.ajp-rj.2021.160404

Erkulwater, J. L. (2018). How the nation's largest minority became white: Race politics and the disability rights movement, 1970–1980. *Journal of Policy History*, *30*(3), 367–399. https://doi.org/10.1017/S0898030618000143

Erkulwater, J. (2022, April 22). *People of color have been missing in the disability rights move-*

ment—looking through history may help explain why. The Conversation. http://theconversation.com/people-of-color-have-been-missing-in-the-disability-rights-movement-looking-through-history-may-help-explain-why-181228

Faria, M.A. (2013, March). *Violence, mental illness, and the brain – A brief history of psychosurgery: Part 1 – From trephination to lobotomy.* Surgical Neurology International. https://surgicalneurologyint.com/surgicalint-articles/violence-mental-illness-and-the-brain-a-brief-history-of-psychosurgery-part-1-from-trephination-to-lobotomy/

Farreras, I. G. (2023). History of mental illness. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. Retrieved from http://noba.to/65w3s7ex

Gordon, M. (2015, October 11). Family Secret. [Review of the book *Rosemary: The hidden Kennedy daughter* by Kate Clifford Larson]. *The New York Times Book Review 12*. https://www.nytimes.com/2015/10/11/books/review/rosemary-the-hidden-kennedy-daughter-by-kate-clifford-larson.html

Heumann, J. E. & Joiner, K. (2021). *Being Heumann: An unrepentant memoir of a disability rights activist*. Beacon Press.

History. (2017). *History of witches: Real origins, hunts & trials*. https://www.history.com/topics/folklore/history-of-witches

James, T. (2015, July 3). *The Fairview Training Center may have the darkest history in Oregon*. That Oregon Life. https://thatoregonlife.com/2015/07/the-fairview-training-center-may-have-the-darkest-history-in-oregon/

Jewish Virtual Library. (n.d.). *Nazi persecution of the mentally & physically disabled*. The American-Israeli Cooperative Enterprise. https://www.jewishvirtuallibrary.org/nazi-persecution-of-the-mentally-and-physically-disabled

John F. Kennedy Presidential Library and Museum. (n.d.). *Rosemary Kennedy*. https://www.jfklibrary.org/learn/about-jfk/the-kennedy-family/rosemary-kennedy

Ko, L. (2016, January 29). *Unwanted sterilization and eugenics programs in the United States.* Independent Lens. https://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states/

Lemelson-MIT. (n.d.). *Bessie Blount electronic feeding device.* https://lemelson.mit.edu/resources/bessie-blount.

Lewis, I. M. and Russell, J. B. (2024, March 29). Witchcraft. Encyclopedia Britannica. https://www.britannica.com/topic/witchcraft

Maruschak, L., Bronson, J., & Alper, M. (2021a [March]). Disabilities reported by prisoners: Survey of prison inmates, 2016. *Bureau of Justice Statistics. https://bjs.ojp.gov/content/pub/pdf/drpspi16st.pdf*

Maruschak, L., Bronson, J., & Alper, M. (2021b [June]). Indicators of mental health problems reported by prisoners: Survey of prison inmates, 2016. *Bureau of Justice Statistics.* https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/imhprpspi16st.pdf

Mayo Clinic. (2018). *Electroconvulsive therapy (ECT).* https://www.mayoclinic.org/tests-procedures/electroconvulsive-therapy/about/pac-20393894

Mental Health Association of Portland. (n.d.). *The history of the Oregon State Hospital from 1883-2012*. http://www.mentalhealthportland.org/wp-content/uploads/2012/04/The-History-of-the-Oregon-State-Hospital-from-1883-2012.pdf

Merriam-Webster (n.d.). Bedlam. In *Merriam-Webster.com dictionary.* https://www.merriam-webster.com/dictionary/bedlam

Micale, M. S. (1985). The salpetriere in the age of charcot: An institutional perspective on medical history in the late nineteenth century. *Journal of Contemporary History*, *20*(4), 703–731. https://www.jstor.org/stable/260404

Moffic, H. S. (2014). We are still flying over the cuckoo's nest. *Psychiatric Times*. *31*(7).

https://www.psychiatrictimes.com/view/we-are-still-flying-over-cuckoos-nest

National Institute of Mental Health. (n.d.). *Schizophrenia.* U.S. Department of Health & Human Services. https://www.nimh.nih.gov/health/topics/schizophrenia

Office of the Secretary of State, Missouri. (n.d.). *1930-1950: New Treatments*. Quest for a cure: Care and treatment in Missouri's first state mental hospital. https://www.sos.mo.gov/archives/exhibits/quest/treatment/1930-1950

Padgett, D. K. (2020). Homelessness, housing instability and mental health: Making the connections. *BJPsych Bulletin*, *44*(5), 197–201. https://doi.org/10.1192/bjb.2020.49

Parry, M. S. (2006). Dorothea Dix (1802–1887). *American Journal of Public Health*, *96*(4), 624–625. https://doi.org/10.2105/AJPH.2005.079152

Penn Medicine. (n.d.-a). *History of Pennsylvania Hospital, Psychiatry*. https://www.uphs.upenn.edu/paharc/collections/exhibits/psych/

Penn Medicine. (n.d.-b). *Turning points: The transition of the treatment of the mentally ill from late 18th century to early 20th century* [Prepared by Lauren Plested]. https://www.uphs.upenn.edu/paharc/history-day/mental-illness/

Peters, G., & Woolley, J.T. (n.d.). *John F. Kennedy, Special message to the congress on mental illness and mental retardation.* [Speech transcript]. The American Presidency Project. https://www.presidency.ucsb.edu/node/236899 (Original speech 1963, February 5)

Ponte, K. (2020, March 11). *The many forms of mental illness discrimination.* NAMI. https://www.nami.org/Blogs/NAMI-Blog/March-2020/The-Many-Forms-of-Mental-Illness-Discrimination

Porter, L. (2022, April 1). *Straight talk: Lawmakers call a $1.25 billion investment in Oregon's behavioral health system the beginning of turning around a neglected system.* KGW8. https://www.kgw.com/article/entertainment/television/programs/straight-talk/straight-125-billion-investment-oregon-behavioral-health-system-historic/283-e81b49d7-8b4c-4705-9b87-61b5e6a3f046

Prins, S. J. (2011). Does transinstitutionalization explain the overrepresentation of people with serious mental illnesses in the criminal justice system? *Community Mental Health Journal*, *47*(6), 716–722. https://doi.org/10.1007/s10597-011-9420-y

Religion News Service. (1999, January 1). *Vatican revises the rite of exorcism to fit new conception of the devil*. https://religionnews.com/1999/01/01/news-story-vatican-revises-the-rite-of-exorcism-to-fit-new-conception-of-th/

Smith, M. R. (2013, October 22). 50 years later, Kennedy's vision for mental health not realized. *The Seattle Times*. https://web.archive.org/web/20131023010233/http://seattletimes.com/html/nationworld/2022091710_mentalhealthxml.html

Spielman, R.M., Jenkins, W.J., and Lovett, M.D. (2020, April 22) Mental health treatment: Past and present. In *Psychology 2e.* https://openstax.org/books/psychology-2e/pages/16-1-mental-health-treatment-past-and-present

Stammer, L. B. (1999, January 27). In a new age, exorcists get a new rule book. *Los Angeles Times.* https://www.latimes.com/archives/la-xpm-1999-jan-27-mn-2213-story.html

Substance Abuse and Mental Health Services Association [SAMHSA]. (2019). *Civil commitment and the mental health care continuum: Historical trends and principles for law and practice*. Office of the Chief Medical Officer. https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf

Swenson, C. (2017, May 17). *Seeking asylum. A story of reconstruction, race and mental health*. Clara Barton Museum. https://clarabartonmuseum.org/asylum/

Szasz, T. S. (1960). The myth of mental illness. *American Psychologist*, *15*(2), 113–118. https://doi.org/10.1037/h0046535

Thomson, J. (2021, December 26). Exorcism: The history of purging demons, from the New Testament to today. *Big Think*. https://bigthink.com/thinking/history-of-exorcism/

Tietz, T. (2021, April 20). *Philippe Pinel—the father of modern psychiatry.* https://scihi.org/philippe-pinel-modern-psychiatry/

Tracy, N. (2019). *The history of mental illness*. HealthyPlace. (n.d.). https://www.healthyplace.com/other-info/mental-illness-overview/the-history-of-mental-illness

University of Oxford. (2015, April 21). Babies feel pain "like adults": Most babies not given pain meds for surgery. *ScienceDaily*. https://www.sciencedaily.com/releases/2015/04/150421084812.htm

University of Pennsylvania. (n.d.). *Penn People: Benjamin Rush 1746 – 1813*. Penn Libraries, University Archives and Records Center. https://archives.upenn.edu/exhibits/penn-people/biography/benjamin-rush/

Willard Psychiatric Center Collection. (n.d.). New York Heritage Digital Collections. https://nyheritage.org/collections/willard-psychiatric-center-collection

Zhu, J. M., Howington, D., Hallett, E., Simeon, E., Amba, V., Deshmukh, A. & McConnell, K. J. (2022, February 1). *Behavioral health workforce report to the Oregon Health Authority and State Legislature*. https://www.oregon.gov/oha/ERD/SiteAssets/Pages/Government-Relations/Behavioral Health Workforce Wage Study Report-Final 020122.pdf

CHAPTER

2

Mental Disorders in the Criminal Justice System

2.1 Chapter Learning Objectives and Overview

LEARNING OBJECTIVES

The following learning objectives tell you what is most important in this chapter. Use these statements as a guide to make sure you get the most out of this chapter.

1. Explain the classification system used to diagnose mental disorders in the United States.
2. Describe some mental disorders and behavioral considerations that may be of interest to criminal justice professionals.
3. Evaluate the importance of accurate information, proper care, and negating stigma for people experiencing mental disorders who interact with the justice system.
4. Discuss barriers to proper care and treatment for mental disorders, inside and outside of the criminal justice system.

KEY TERMS

Look for these important terms in the text in bold. Understanding these terms will help you meet the learning objectives of this chapter. You can find definitions for these terms at the end of the chapter.

- **Anosognosia**
- **Anxiety disorders**
- **Cognitive behavioral therapy (CBT)**
- **Co-occurring mental disorder**
- **Culturally competent**
- *Diagnostic and Statistical Manual of Mental Disorders* **(DSM)**
- **Dialectical behavior therapy (DBT)**
- **Dissociative disorders**
- **LGBTQIA+**
- **Malingering**
- **Mood disorders**
- **Neurocognitive disorders**
- **Neurodevelopmental disorders**
- **Paraphilic disorders**
- **Personality disorders**
- **Post-traumatic stress disorder**
- **Psychotic disorders**
- **Psychopathy**
- **Psychosis**
- **Serious mental illness**
- **Substance use disorders**
- **Trauma**

Chapter Overview

On a January day in 2013, a 26-year-old man named Ethan Saylor, accompanied by a caregiver, sat for a showing of *Zero Dark Thirty* in a Maryland movie theater. When their movie ended, Ethan's caregiver asked him to wait for her while she went to get the car. While the caregiver was gone, Ethan returned to his seat in the theater and thought he might like to watch the movie a second time. Ethan, who loved church, guitars, and police officers, had Down syndrome, a genetic disorder that causes intellectual and developmental disability (figure 2.1) (The Road We've Shared, 2024).

Figure 2.1. Ethan Saylor.

The theater manager contacted mall security, which was staffed by three sheriff's deputies working a special detail on that day. The deputies told Ethan he needed to leave, but Ethan verbally resisted. As the situation escalated, Ethan's caregiver—an 18-year-old woman—asked deputies to stop, to avoid touching Ethan, and to allow her to assist. She was ignored (The Road We've Shared, 2024). Instead, the deputies forced Ethan, who hated being touched, out of his seat and proceeded to arrest him. Witnesses reported that one deputy had his knee in Ethan's back as they tried to handcuff him. Ethan called out "Mommy" before he eventually stopped breathing. Ethan's death was ruled a homicide due to asphyxiation. Medical reports revealed his larynx was fractured (Perry, 2013; Vargas, 2023). A grand jury declined to issue charges against the deputies who killed Ethan, and the deputies were cleared of wrongdoing by an internal investigation. At least one of the deputies was later hired to work for the police department in the very same community where he had killed Ethan (Vargas, 2020).

Led by Ethan's devastated family, a movement to increase awareness and education around the treatment of people with intellectual and developmental disabilities within the law enforcement community followed Ethan's death. One focus of the **Ethan Saylor Alliance [Website]** is ensuring that people with developmental or intellectual disabilities are advising and participating in training programs for law enforcement officers. Feel free to visit the website if you would like to learn more.

As discussed in **Chapter 1** of this text, people with mental disorders are more likely to be involved with the criminal justice system than people without mental disorders. This includes public encounters gone awry like Ethan Saylor's, as well as cases where people have been charged with or convicted of crimes, in addition to interactions with victims, witnesses, and other system participants. Thus, students of criminal justice must consider and have a basic understanding of mental disorders that may impact the people they will encounter. As you read this chapter, consider how Ethan Saylor's encounter might have ended differently if the deputies responsible for his death had been prepared and capable of responding appropriately to Ethan.

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2.2 Identification and Treatment of Mental Disorders

According to the World Health Organization, a mental disorder is a condition that involves disturbances in thinking, emotions, or behavior that impact or challenge daily functioning (World Health Organization [WHO], 2022). As used in our text, the term *mental disorder* encompasses mental illnesses, substance use disorders, and developmental disorders, all of which are discussed in this chapter. Mental disorders can affect how we understand the world, relate to others, and make choices (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023a). It is estimated that one in five adults in the United States experiences a mental disorder (National Alliance on Mental Illness [NAMI], n.d.-a).

Some mental disorders are quite rare, while others are common. Some involve a single episode, while others are likely to recur; still others are lifelong conditions that exist from birth or early childhood. The symptoms of mental disorders may fall anywhere on a spectrum from mild to very serious. The descriptor of a **serious mental illness** refers to a small subset of mental disorders: mental illnesses with symptoms that substantially impact major life activities. Some of the disorders described in this chapter, such as schizophrenia, are typically considered serious mental illnesses (SAMHSA, 2023b).

Diagnosing Mental Disorders

A first step in understanding mental disorders is appreciating how mental health professionals determine whether a person has a mental disorder. Those professionals must identify and label sets of symptoms to determine if a mental disorder is present and to arrive at the right diagnosis, or name, for that disorder. The diagnostic process enables people to use a common language when discussing mental disorders, and it guides the way for professionals to determine effective treatments. For these reasons, classification systems that systematically organize mental disorders are necessary.

The ***Diagnostic and Statistical Manual of Mental Disorders*** **(DSM)** is one such classification system, and it is the one used by most mental health professionals in the United States. The DSM describes numerous categories of disorders (e.g., anxiety disorders) and then lists particular disorders within each category (e.g., general anxiety, social anxiety). Listed disorders in a category are described in detail with criteria, or specific elements, that allow a person to be diagnosed with that disorder. Diagnostic criteria typically include the symptoms that are experienced or observed (e.g., agitation, difficulty sleeping) and the length of time (e.g., minimum six months) these symptoms must continue to qualify for a particular diagnosis.

The first edition of the DSM was published by the American Psychiatric Association in 1952, and it has undergone numerous revisions and editions as indicated by the numbers in the title: the DSM-3, DSM-4, and so on. In 2022, the most recent revision resulted in the publication of the DSM-5-TR, an updated "text revision" of the DSM-5 (figure 2.2) (American Psychiatric Association, 2024a). Information from the 2022 version is used in this text.

Figure 2.2. This image shows the cover of the latest version of the DSM at the time of this writing: the DSM-5-TR.

Each new edition of the DSM reflects changes to the understanding and management of mental disorders. Updates include adding new diagnoses and removing others, as well as reorganization of categories. Over time, the details and descriptions of diagnoses have expanded. Some changes demonstrate evolving social perspectives. For example, being gay was considered a disorder in the original DSM scheme, and it was not until several revisions later, in 1987, that this was fully removed. The recent DSM-5-TR underwent multiple equity-focused reviews to help bring it into the modern age. Committees focused on culture and gender issues and a workgroup on ethnoracial equity were tasked with looking at problems such as racism and stigmatizing language (American Psychiatric Association, 2024a). Some positive results are evident in the latest version, such as the modification of gender-focused language, which resulted in the terms *experienced gender* and *gender-affirming medical procedure* replacing outdated and stigmatizing terms. Nevertheless, it is widely acknowledged that more work needs to be done in terms of guiding safe and effective diagnostic approaches for people of color and other marginalized groups (White, 2022).

Caring for People with Mental Disorders

Throughout this chapter, specific mental disorders are identified and briefly described, including mention of treatments available to help impacted individuals. Because mental disorders can arise from many causes—biology, childhood experience, sociocultural factors—there are many different treatment approaches for problems that may arise from them (Spielman et al., 2020a). Seeking treatment for mental disorders can be confusing and daunting, as pursuing help often requires navigating options as well as facing stigma (figure 2.3) (Spielman et al., 2020a).

Figure 2.3. A patient speaks to a healthcare professional in a treatment setting.

While many effective treatments for mental disorders do exist, most people with mental disorders ultimately lack access to these options (WHO, 2022). Even when treatments are available generally, they may not be properly tailored to the person who needs them. A person's identity and culture impact how the person will experience a mental disorder and what supports will work best to help (NAMI, 2024a). Care that factors in and positively uses understanding of a person's background and life experiences is considered **culturally competent** care. A care provider who recognizes and engages in the ongoing process of learning about and respecting others' cultures, including examining the provider's own biases, would be exhibiting the related value of cultural humility (Fountain House, n.d.). Cultural considerations are critical to proper care for many who experience mental disorders, yet they are too often lacking.

Individuals in Indigenous/Native communities in the United States, for example, have significant rates of mental disorders that are understood to be related to generations of trauma from violence, displacement, and destruction of their culture when their land was colonized by Europeans. Yet, critical mental health care is drastically weakened for these communities due to several factors, including lack of proper funding, geographical isolation, language barriers (words like "depressed" do not have ready translations in some Native languages), and understandable community mistrust of government. Compounding these barriers is a general lack of cultural competence to serve this group adequately and difficulties in providing training to correct that problem (NAMI, 2024a).

Throughout this text, we will be considering how the criminal justice system is intertwined with deficits in care for people with mental disor-

ders. Certainly, a lack of effective care is a critical factor that leads many people with mental disorders into contact with the criminal justice system and causes that contact to be sustained (SAMHSA, 2022a).

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Figure 2.3. "Brittany Brooks, MD, speaks with a patient" by Nina Robinson/Getty Images/Images of Empowerment is licensed under CC BY 4.0.

2.3 Introduction to Specific Mental Disorders

Although criminal justice professionals do not diagnose mental disorders, they should certainly expect to interact respectfully, in various capacities, with people who experience one or more of these disorders. Indeed, as we will discuss further in Chapter 10 of this text, many criminal justice professionals are at heightened risk of developing certain mental disorders themselves. For these reasons, all students in the criminal justice field will benefit from familiarity with the diagnoses introduced in this chapter.

> To further explore any of the disorders touched upon in this chapter, take a look at the National Institute of Mental Health (NIMH) [Website]. The NIMH, a federal agency for research on mental disorders, offers current information on specific disorders and provides the content for much of this chapter.

The summaries of disorders presented in this chapter are necessarily brief and are intended for criminal justice students. Students who intend to work directly with people accessing behavioral health services will want to learn more about these disorders. There are some very interesting disorders omitted here: eating and sleeping disorders, specific learning disorders, and others that relate to every aspect of life. Included in this chapter are

some diagnoses that are more likely to be encountered in the criminal justice system or that may be of particular interest to the criminal justice student.

Anxiety Disorders

Occasional anxiety about matters such as health or family is a normal part of life. Many people identify as worriers. But anxiety disorders involve more than temporary worry or fear. For people with an **anxiety disorder**, the worries or fears are excessive and do not go away, interfering with daily activities such as jobs and relationships.

There are several specific types of anxiety disorders, including generalized anxiety disorder, panic disorder, and social anxiety disorder. Specific fears or aversions, called phobias, also fit under this category. The distinctions between these diagnoses are beyond the scope of this text, but if you are interested, take a look at the **National Institute of Mental Health page on the topic of anxiety disorders [Website]**. Note that a person can have multiple forms of anxiety disorder or an anxiety disorder alongside other disorders.

Anxiety disorders are usually treated with psychotherapy (also known as "talk therapy"), medication, or both. One specific therapeutic technique often used to help people with anxiety disorders—as well as many of the other disorders in this chapter—is **Cognitive behavioral therapy (CBT)** (figure 2.4). CBT is a set of therapeutic techniques that teaches people different ways of thinking, behaving, and reacting to situations. Exposure therapy, during which a person confronts their fears while engaging in relaxation exercises, would be an example of a CBT approach used to treat anxiety. CBT has been well studied and is considered the gold standard for psychotherapy.

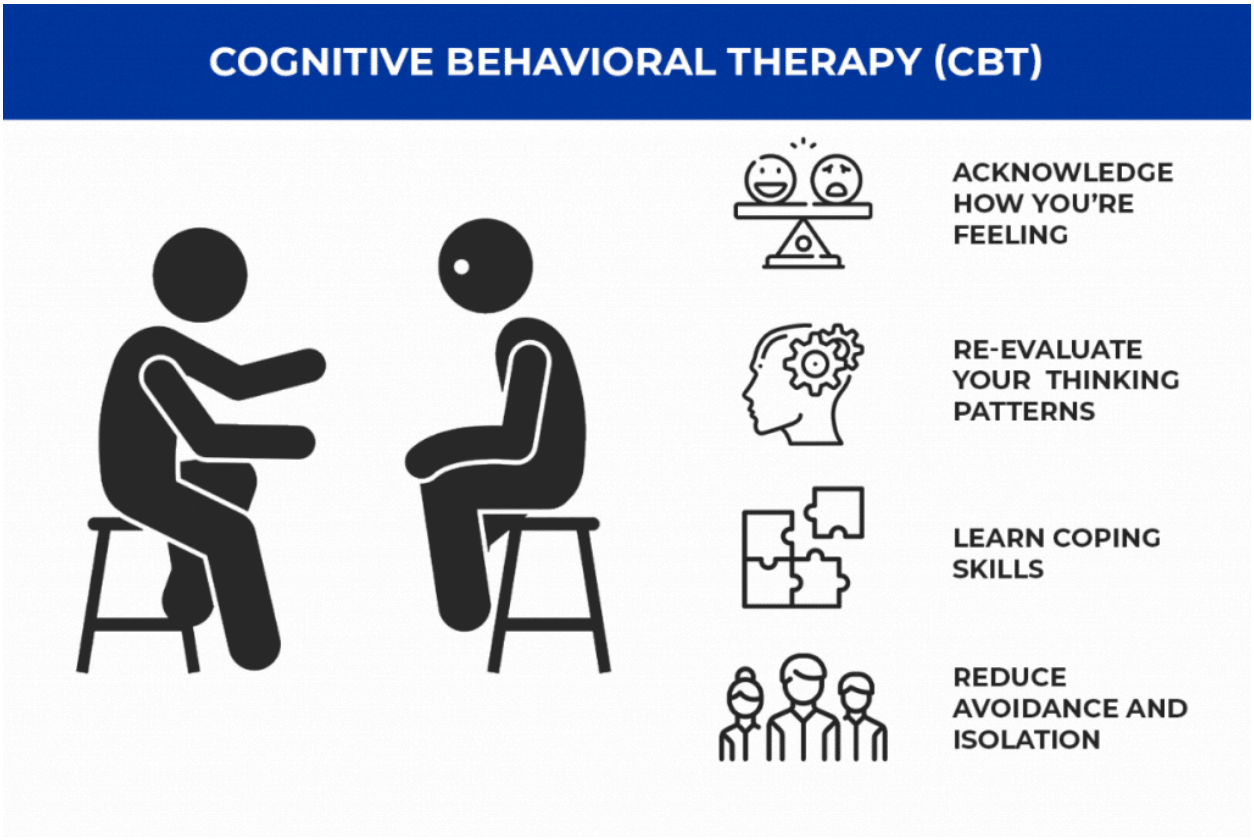

Figure 2.4. This illustration of Cognitive Behavioral Therapy depicts some of the key aspects of this approach: acknowledgment of feelings, understanding thinking patterns, development of coping skills, and reducing isolation. These steps are intended to increase the well-being of the participant.

Another treatment for anxiety is medication. Medications do not cure anxiety disorders, but they can help relieve symptoms. The most common medications prescribed for anxiety are antidepressants, anti-anxiety medications (such as benzodiazepines), and beta-blockers.

Trauma and Stressor-Related Disorders

The DSM-5-TR (like the DSM-5) categorizes a few disorders under the heading of Trauma and Stressor-Related Disorders. **Trauma** refers to a situation that physically or emotionally harms a person to the extent that it impacts their well-being. Trauma-related disorders are unique in being triggered by the person's exposure to stressful events. The most well-known of this group of disorders is post-traumatic stress disorder (PTSD) (Anushka et al., 2017).

Post-traumatic stress disorder (PTSD) develops in some people who have experienced a shocking, scary, or dangerous event. This includes combat veterans and people who have experienced or witnessed an assault or a disaster. Sometimes, learning that a friend or family member experienced trauma can cause PTSD. People who work as first responders, such as police officers, can develop PTSD based on exposure to trauma in the course of their work, a topic discussed more in Chapter 10 of this text (American Psychiatric Association, 2022c). While it is natural to feel afraid during and after a traumatic situation, most people recover over time. Those who continue to experience problems may be diagnosed with PTSD. While about 6 out of every 100 people overall will experience PTSD at some point in

their lives, women are more likely to develop PTSD than men.

Diagnosis of PTSD requires that a person experience a set of symptoms that start after trauma and linger over time, interfering with aspects of daily life, such as work or relationships (figure 2.5). Specific symptoms can vary, but the diagnosis requires symptoms from four categories: *reexperiencing* (e.g., flashbacks or dreams); *avoidance* (e.g., refraining from acts or places that are reminders), *reactivity* (e.g., being easily startled, always distracted), and *thinking or mood* (e.g., memory challenges or negative thoughts).

Figure 2.5. A word cloud conveying many of the symptoms and concepts associated with PTSD.

Typical treatments for PTSD are psychotherapy and/or medication. Effective PTSD therapy works toward the identification of triggers and management of symptoms; it may also help people make sense of their traumatic experience and deal with misplaced feelings of guilt or shame. Medications can address some symptoms such as sadness or sleeplessness. Occasionally, people with PTSD experience ongoing trauma, such as in an abusive relationship. For them, treatment should address both the source of trauma and the symptoms of PTSD.

It is important to emphasize that not everyone who experiences trauma goes on to develop PTSD. Certain types of trauma, like interpersonal violence, are more likely to cause PTSD than other traumas, like natural disasters. Social support and a sense of community are protective factors that can reduce the risk of PTSD (Spielman et al., 2020b). Certain groups of people are more likely to develop PTSD because they are more likely to bear the strain of isolating events that will lead to PTSD. Black men, for example, are more likely to witness and personally experience violent victimization than non-Black males, and they are more

likely to have PTSD (Kilpatrick et al., 2017). Women who are incarcerated in prison are also much more likely to have PTSD than the general population, with a prevalence estimated at over 20% (Facer-Irwin et al., 2019). If you would like to know a little more about PTSD, you may watch the video linked here (figure 2.6).

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=uoJBvXAUvA8

Figure 2.6. This short video produced by the American Psychiatric Association offers a summary of the symptoms and presentation of PTSD. **Transcript.**

SPOTLIGHT: What Is Trauma?

Bessel van der Kolk, psychiatrist and author of *The Body Keeps the Scor*e, is an expert on the impact of trauma on people's lives. Watch the 7-minute video clip in figure 2.7 where van der Kolk describes trauma and discusses its effects. Pay particular attention to van der Kolk's observations about the importance of societal support and personal relationships in mediating the impact of trauma. Does the video impact your understanding of the concept of trauma? What changes can you imagine in your community or in the larger world that would reduce problems associated with trauma?

This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=BJfmfkDQb14**

Figure 2.7. "What Is Trauma? The Author of *The Body Keeps the Score* Explains." **Transcript.**

Dissociative Disorders

Dissociative disorders involve an individual becoming separated, or dissociated, from their core sense of self, resulting in disturbance of their memory and identity. The DSM specifies that to qualify as a disorder, this "disturbance" cannot be related to a cultural practice, such as a spiritual practice that involves being "possessed" and is accepted in the person's community. This clarification in the diagnostic criteria exemplifies the effort in the updated DSM to avoid the medicalization and stigmatization of a range of healthy human experiences (American Psychiatric Association, 2022a).

Dissociative disorders listed in the DSM-5-TR include dissociative amnesia—the total forgetting of events, often traumatic ones—and dissociative identity disorder (DID)—a rare but intriguing disorder (American Psychiatric Association, 2022a). DID, which was formerly called "multiple personality disorder," may be diagnosed when a person exhibits two or more separate and distinct personalities or identities that alternately take control of the person (NAMI, 2023a). The person with DID will experience memory gaps, such as not recognizing belongings, and display differences in attitudes and preferences as their identities shift back and forth. The symptoms of DID can cause significant distress and problems in daily functioning (American Psychiatric Association, 2022a). DID has long been a controversial diagnosis, partly because it was highly popularized in the book *Sybil*, a best-selling 1970s "true story" about a woman with 16 different personalities (figure 2.8). The media attention from the book, and a later movie starring Sally Field, led to a public fascination with—and a vast overdiagnosis of—multiple personality disorder. Before *Sybil* was published, only about one hundred cases of the disorder had ever been recorded, but thousands were diagnosed in the decade after the book's publication. As it turned out, much of Sybil's story was likely embellished, if not outright untrue (Haberman, 2014).

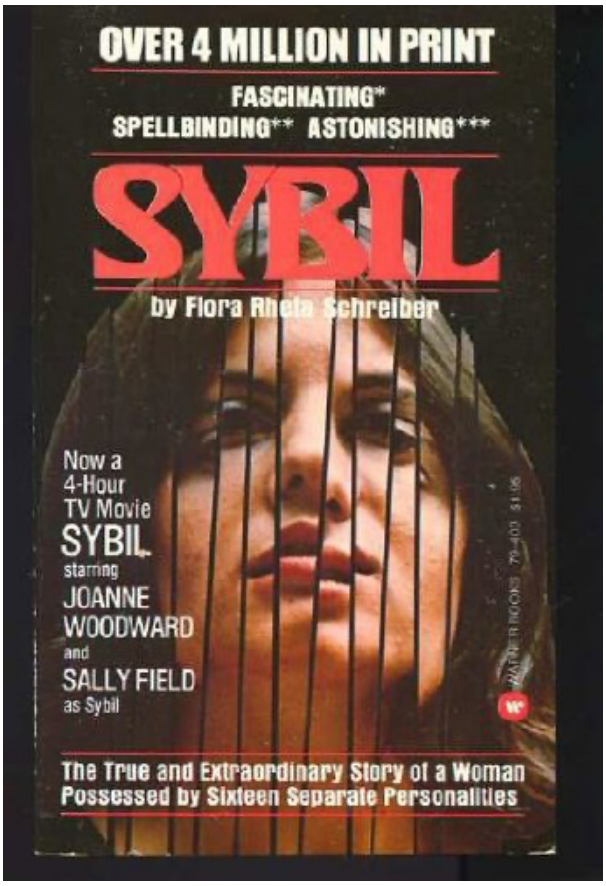

Figure 2.8. The cover of the bestselling 1973 book *Sybil*, which led to popular fascination with what was then called multiple personality disorder.

Aside from the drama around *Sybil*, dissociative identity disorder is in the DSM as a legitimate—though exceedingly rare—diagnosis that is tied to a history of severe childhood abuse and trauma and that mainly impacts women. People who develop PTSD due to trauma can sometimes exhibit dissociative symptoms without a full diagnosis of dissociative disorder (American Psychiatric Association, 2022a). Treatment for dissociative disorders or symptoms generally involves therapy and occasionally hypnosis. Medications do not treat the disorder itself but can be used to deal with symptoms such as depression (American Psychiatric Association, 2022a).

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Figure 2.4. CBT Veterans by JourneyPure Rehab is licensed under CC BY 2.0.

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Figure 2.7. What is trauma? The author of "The Body Keeps the Score" explains | Bessel van der Kolk | Big Think by BigThink is licensed under the Standard YouTube License.

Figure 2.8. Image of *Sybil* is used under fair use.

2.4 Psychotic Disorders

Psychotic disorders are mental disorders that involve thinking and perceptions that are disconnected from reality. This group of disorders includes the diagnoses of schizophrenia, schizoaffective disorder, and delusional disorder, among others. These disorders are considered serious mental illnesses, and they are characterized by the presence of psychosis. **Psychosis** refers to a collection of symptoms that affect the mind, causing a person to have difficulty recognizing what is real and what is not. Psychotic symptoms may include hallucinations (sensing things that are not really there, such as hearing voices) and delusions (having strong beliefs that are not true and may seem irrational to others, such as believing that people on television are sending special messages). Psychosis is a hallmark of psychotic disorders, but it can also appear in other disorders, such as mood disorders and substance use disorders, both discussed later in this section.

Early treatment is associated with the best long-term outcomes for people experiencing psychosis, and the federal government maintains a **list of providers who offer treatment for first-episode psychosis [Website]**. Take a look if you are interested in more information about the topic of first-episode psychosis, which is often preceded by gradual changes in thinking, mood, and social functioning (SAMHSA, 2022b).

Schizophrenia

Schizophrenia is estimated to impact less than 1% of the overall population in the United States, though like many disorders it is more prevalent in the criminal justice system and affects as much as 4% of prison inmates (American Psychiatric Association, 2020; Watson, 2022).

People with schizophrenia are usually diagnosed between the ages of 16 and 30 after the first episode of psychosis. Alongside psychotic symptoms, which may be characterized as *positive symptoms*, a person with schizophrenia may experience *negative symptoms* (e.g., loss of motivation, lack of personal hygiene, and difficulty showing emotions) as well as cognitive symptoms (e.g., problems in attention, concentration, and memory) (SAMHSA, 2023b). The symptoms of schizophrenia can be very upsetting and frightening for the individual who experiences them and for their loved ones (NIMH, n.d.-b.).

Schizophrenia cannot be cured, but effective treatments focus on helping people manage their symptoms so that they can improve their daily functioning and achieve their goals. Where a person with schizophrenia also has a substance use disorder, known as a co-occurring disorder, it is important that treatment programs address these issues as well. People with schizophrenia typically benefit from the use of psychiatric medications, as well as therapy, education, and community support.

All psychiatric medications require a prescription by a qualified medical provider—often a psychiatrist or psychiatric nurse practitioner (roles that are discussed in **Chapter 10**). These medications can ease the symptoms of a disorder to improve quality of life, as well as allow the person to more effectively engage in other therapies. There are many psychiatric medications available, including several antipsychotic medications that specifically treat psychosis symptoms such as those that appear in schizophrenia. All medications have different risks, benefits, and levels of efficacy. Oftentimes, patients will need to try several medications to find the one or combination that they can take consistently to provide them with relief (NAMI, n.d.-c).

Patients must balance the effectiveness of medications against problems like side effects and lack of accessibility. Some antipsychotic medications are available in pill or liquid formulations, while others are offered in long-acting injectable forms that can be taken as infrequently as every few months. Injectable formulations can be extremely helpful for people who have challenges taking daily medications (NAMI, n.d.-c). Some medications may be more effective than others at treating symptoms but come with downsides. For example, one newer antipsychotic medication is a drug called clozapine. While clozapine can be remarkably effective at reducing symptoms of schizophrenia, it can also have serious health impacts that must be closely monitored with regular blood draws, which can be a burdensome and even intolerable requirement for some patients (NAMI, 2023b).

Watch the short video in figure 2.9 to hear some information about schizophrenia (diagnosis, symptoms, and treatments) from a representative of NAMI, the National Alliance on Mental Illness.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=WS1TXT3cGyw

Figure 2.9. This video from NAMI shares some key information about the diagnosis of schizophrenia. **Transcript.**

Schizoaffective Disorder

Schizoaffective disorder may be diagnosed when a person displays symptoms of schizophrenia, including psychosis, in addition to symptoms of a mood disorder (described in the next section), such as depression or mania (NAMI, 2015). Schizoaffective disorder is often misdiagnosed and can be difficult to treat (NAMI, n.d.-b). Watch the short video in figure 2.10 for a mental health professional's description of schizoaffective disorder, as well as a discussion of positive versus negative symptoms in psychotic disorders.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=ydxe6HI6wvs

Figure 2.10. This video from a treatment provider distinguishes schizophrenia and schizoaffective disorder, which are both psychotic disorders, and details some symptoms of each. **Transcript.**

Delusional Disorders

A delusional disorder may be diagnosed where a person has at least one delusion, a fixed belief that is not objectively true or reality-based, that lasts at least a month. Delusional disorders are different from schizophrenia and schizoaffective disorders in that they usually first appear in midlife or later in life, and the delusions occur without the other symptoms of psychotic disorders. An impacted person may function quite well in areas of their life not related to the delusion (Tamminga, 2022).

A person with a delusional disorder can experience different types of delusions, some of which could occur in real life (e.g., being followed or poisoned) and others that are inconsistent with reality (e.g., an internal organ has been removed from their body) (Tamminga, 2022). Delusions are classified in the DSM based on the type of belief that is involved in the delusion. A *grandiose delusion*, for example, might involve a belief that the person holds special powers, while a *persecutory delusion* might cause someone to believe that others are spying on them (Tamminga, 2022). Psychotherapy is most useful in treating delusional disorders, and antipsychotic medication can sometimes be helpful as well (Tamminga, 2022).

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Figure 2.10. The Difference In Symptoms Between Schizoaffective Disorder and Schizophrenia by BrightQuest Treatment Centers is licensed under the Standard YouTube License.

2.5 Mood Disorders

Mood disorders are mental illnesses where the underlying problem primarily affects the person's emotional state or mood. Mood disorders include bipolar disorders and depressive disorders, both of which are discussed in this section.

Bipolar Disorders

Bipolar disorders (formerly called manic depression) are mental illnesses that cause unusual shifts in a person's mood and accompanying energy and activity levels. Moods range from extremely "up," elated or energized periods (known as manic episodes) to very "down," sad or hopeless periods (known as depressive episodes). These shifts can cause difficulty in carrying out day-to-day tasks.

Bipolar I disorder is defined by manic episodes that last for at least 7 days or by manic symptoms that are so severe that the person needs immediate medical care. Usually, depressive episodes occur as well. Experiencing four or more episodes of mania or depression within 1 year is called "rapid cycling."

Bipolar II disorder involves a pattern of depressive episodes and hypomanic episodes, which are less severe than the manic episodes in bipolar I disorder. During a hypomanic episode, a person may feel very good and be able to get things done, and they may not feel that anything is wrong. Family or friends, however, may recognize changes in mood or activity levels as possible symptoms of a disorder.

Sometimes people having severe manic or depressive episodes also have symptoms of psychosis, which may include hallucinations or delusions that tend to match the person's extreme mood. For example, someone having psychotic symptoms during a depressive episode may falsely believe they are financially ruined, while someone having psychotic symptoms during a manic episode may falsely believe they are famous or have special powers.

Bipolar disorder is a lifelong diagnosis that can be treated with medications and therapy. Episodes of mania and depression typically come back over time. Between episodes, many people with bipolar disorder are free of mood changes, but some people may have lingering symptoms. Mood stabiliz-

ing medications, such as lithium, can help prevent mood episodes or reduce their severity. Although bipolar depression is often treated with antidepressant medication, a mood stabilizer must be taken as well—taking an antidepressant without a mood stabilizer can trigger a manic episode or rapid mood changes in a person with bipolar disorder.

Watch the short video in figure 2.11 in which a person diagnosed with bipolar disorder shares their perspective on diagnosis and treatment.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=zj4s532wTxE

Figure 2.11. **This video clip from SAMHSA** provides a first-person perspective on the experience of living with bipolar disorder, noting the challenges and benefits of treatment adherence. **Transcript.**

Depressive Disorders

Depression is a mood disorder with symptoms that include feelings of sadness, hopelessness, and loss of interest in activities. Depression can also cause physical symptoms such as aches, pains, and digestive problems. Because depression tends to make people think more negatively about themselves and the world, some people experiencing depression may have thoughts of suicide or self-harm. Depression is also very common; an estimated 21 million adults (more than 8% of all adults) in the United States had a major depressive episode in 2021 (NIMH, n.d.-a).

A diagnosis of major depressive disorder, which is considered a serious mental illness, requires the presence of depression symptoms for at least 2 weeks. Symptoms can vary, and depression can have different triggers, which can lead to more specific diagnoses. When a major depressive episode occurs in the context of pregnancy, for example, that is called *perinatal depression*. This condition is familiar to many under the name of postpartum depression, but the DSM now uses terminology recognizing that depression symptoms often begin during, not after, pregnancy. Perinatal depression is thought to impact one in every seven women (American Psychiatric Association, 2023). A severe depressive episode that includes symptoms of psychosis, such as delusions or hallucinations, is called depression with psychotic features (Smith, 2021).

Although people of all genders can feel depressed, how they express and cope with their symptoms may differ. For example, because men may be less likely to recognize, talk about, and seek help for their feelings or emotional problems, they are at greater risk than women for depression symptoms being undiagnosed or undertreated (Beharry & Ogrodniczuk, 2017). The incidence of depression varies based on gender as well. Data shows higher rates of depression, as well as anxiety, among members of the **LGBTQIA+** community, which includes people who are lesbian, gay, bisexual, transgender, queer, intersex, and asexual. (Marlay et al., 2022). Transgender youth in particular are reported to have a much greater risk of experiencing depression compared to non-transgender peers. Mental health symptoms within this group can relate to the general stigma and discrimination that they experience, as well as the daily barriers they may face, such as bathroom access (Human Rights Campaign Foundation, n.d.).

Watch the short video in figure 2.12 to hear one man's account of his severe depressive disorder.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=1clEHAj-eRE

Figure 2.12. This video clip from SAMHSA briefly describes major depression and the negative misinformation, or stigma, that surrounds it. **Transcript.**

Depression, even in the most severe cases, can be treated. The earlier treatment begins, the more effective it is. Depression is usually treated with medication, psychotherapy, or a combination of the two. If treatments like medication and psychotherapy do not reduce depressive symptoms or if the need for rapid relief from symptoms is urgent, brain stimulation therapy may be an option. Brain stimulation therapies, including electroconvulsive therapy (ECT), activate or inhibit the brain with electricity. Modern ECT is very different from the barbaric-seeming predecessor practices described in **Chapter 1** of this text, but it remains in the category of last-resort treatments, in part due to its stigmatizing history. If you are interested in learning more about brain stimulation therapies, particularly modern ECT from a first-person perspective, watch the optional five-minute video linked in figure 2.13.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=qk_FjhitKDI

Figure 2.13. This video about ECT explains how ECT is conducted in modern medical settings and features the perspective of two people who have used this treatment to improve their mental health. **Transcript.**

Anosognosia in Mood and Psychotic Disorders

Sometimes, a person who has one of the mental disorders discussed in this section will experience a lack of insight into, or awareness of, their mental illness. This lack of insight, which may involve rejection of the diagnosis or treatment, can appear to be willful resistance. However, it may be a challenging aspect of the underlying disorder called **anosognosia**. Anosognosia is quite common in both psychotic and mood disorders, and it is a common reason that people with these disorders discontinue treatment (Treatment Advocacy Center, 2018).

Anosognosia can, in some cases, lead to criminal justice system involvement. Someone with anosognosia may be inconsistent with their medication regimen, believing it unnecessary, and engage in conduct that places them at risk of problems such as homelessness or contact with police (NAMI, 2024b).

Watch the video in figure 2.14 if you are interested in hearing more about anosognosia from a self-advocate who has experienced this condition.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=R3d_kybSfOc

Figure 2.14. A person living with schizophrenia provides a first-person account of the experience of anosognosia. **Transcript.**

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Figure 2.14. What is Anosognosia?by Living Well with Schizophrenia is licensed under the Standard YouTube License.

2.6 Personality Disorders and Paraphilic Disorders

Personality disorders and paraphilic disorders together have a few important characteristics that distinguish them, legally, from other groups of disorders in this chapter. First, neither of these sets of disorders provides a defense to someone who engages in criminal conduct due to the disorder. While some of the other disorders discussed in this chapter (e.g., psychotic and mood disorders) may, in some cases, excuse criminal conduct that is caused by the disorder, most state laws specify that criminal conduct driven by a personality disorder or paraphilic disorder will not be a basis for the insanity defense (discussed more in Chapter 6 of this text). Oregon, for example, excludes as a criminal defense any mental disorder that essentially consists of repeated antisocial conduct (for example, pedophilia, a paraphilic disorder that could cause a person to abuse children) and any personality disorder (Or. Rev. Stat. § 161.295). Another important distinction between these disorders and others is that, while therapy can be used to treat personality disorders or paraphilic disorders, these are patterns of behavior that are not considered treatable with medications in the same way psychotic or mood disorders may be (American Psychiatric Association, 2022b).

Personality Disorders

A person's personality is their unique way of thinking, behaving, and feeling that makes them different from others. Personality is shaped by genetics and environment (American Psychiatric Association, 2022b). Ideally, a person's personality is flexible and allows them to adapt to new sit-

uations, improve relationships, and build healthy coping skills (Mayo Clinic, 2023).

A **personality disorder** indicates that a person has personality traits that are less functional, causing them an array of problems in relating and responding to others. These problems, such as anger and impulsivity, may disrupt work and relationships, leading to social isolation and sometimes legal problems (Mayo Clinic, 2023).

There are 10 different personality disorders listed in the DSM-V-TR. Discussed here are three that are commonly seen in the criminal justice field.

Antisocial Personality Disorder

Antisocial personality disorder can be diagnosed when a person has a long-term pattern of manipulating, exploiting, or violating the rights of others. Genetic factors and environmental factors, such as child abuse, are believed to contribute to the development of this disorder. Intentional fire-setting and cruelty to animals during childhood are linked to the development of antisocial personality, but a person must be at least 18 years old to receive the diagnosis.

A person with antisocial personality may present as witty and charming, enabling them to manipulate others. However, the person is likely to disregard the safety of others and engage in acts such as stealing and fighting without guilt or remorse. Antisocial personality disorder (figure 2.15) is far more common in men than women, and it is vastly overrepresented in the criminal justice population. It is estimated that at least half—and maybe up to 75%—of incarcerated men have this disorder, compared to just about 5% or less of the general population (Schnittker, et al., 2020).

Figure 2.15. Several of the signs or symptoms of antisocial personality disorder.

Antisocial personality disorder can be difficult to treat. Typically, individuals with this condition don't seek treatment on their own. However, treatments that reward appropriate behavior and have negative consequences for negative behavior may work for some people.

Narcissistic Personality Disorder

A person with narcissistic personality disorder (figure 2.16) displays grandiosity (a sense that they are unique, extra-special, and important), a constant need for admiration, and a lack of empathy toward others. Together, these characteristics may lead to the person exploiting others due to a sense of entitlement (American Psychiatric Association, 2022b).

Figure 2.16. Several of the signs or symptoms of narcissistic personality disorder.

People with narcissistic personality disorder are more likely to have additional diagnoses of mood disorders and substance use disorders. Like antisocial personality disorder, this disorder is relatively rare, impacting less than 5% of the general population and appearing more frequently in men (Psychology Today, 2022a). However, rates of narcissistic personality disorder among people who have been convicted of crimes are thought to be much higher—especially among sexual offenders (Arbanas, 2022).

Borderline Personality Disorder

Borderline personality disorder (figure 2.17) is another personality disorder that is characterized by chaotic relationships, explosive emotions, and high rates of self-harm (Psychology Today, 2021a). People with borderline personality disorder are often uncertain about their identity. As a result, their interests and values can change rapidly. They tend to view things in terms of extremes: either all good or all bad. Their views of other people can change quickly, admiring a person one day and disdaining them the next. These suddenly shifting feelings often lead to intense and unstable relationships. Other symptoms include intense fear of abandonment, inability to tolerate being alone, engagement in risky behavior (e.g., substance use or gambling), and repeated crises or acts of self-harm. Borderline personality disorder carries a significant risk of suicidal behavior.

Genetics and social factors may play a role in the development of borderline personality disorder, as risk factors include childhood abandon-

ment and abuse. Borderline personality disorder tends to occur more often in women than men.

Figure 2.17. Several of the signs or symptoms of borderline personality disorder.

Paraphilic Disorders

Paraphilic disorders are conditions where a person's sexual arousal involves intense and atypical urges that cause distress or harm to the person or someone else. There are several paraphilias, including exhibitionistic disorder, pedophilic disorder, and sexual sadism disorder. Authors of the DSM added the term "disorder" to each of these diagnoses to clarify and emphasize that the experience of an unusual sexual interest (e.g., sadism) in itself does not amount to a disorder, and people engaging in consensual sexual conduct should not be improperly diagnosed with a disorder. Instead, atypical sexual urges are part of the diagnosis of a mental disorder only when the urges result in significant harm to that person or someone else (Psychology Today, 2022b; American Psychiatric Association, 2013).

Pedophilic disorder is the most well-known of the paraphilic disorders. Pedophilic disorder involves a continuing sexual attraction—signified by fantasies, urges, or behaviors—to prepubescent children, generally aged 13 or younger, of any gender. Diagnosis of pedophilic disorder requires more than simple experience of these sexual urges; the person must act on their urges or have serious distress or difficulty related to their urges (Psychology Today, 2022c).

Acting on urges related to a paraphilia may lead a person to engage in criminal behaviors (for example, the paraphilia of exhibitionism might cause a person to expose themself to an unsuspecting person on the bus). However, most sexual offenders with adult victims do not have paraphilic disorders; rather their behavior is driven by other factors and is often associated with other disorders such as antisocial personality disorder (Eher, et al., 2019).

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2.7 Mental Disorders Identified in Childhood

Some mental disorders typically present in childhood and are identified when there is a disruption or recognizable difference in typical child development. If childhood disorders do not resolve, they may evolve into adult disorders, persist into adulthood, or remain unidentified until adulthood.

Disruptive, Impulse-Control, and Conduct Disorders

This group of disorders, often called disruptive disorders because they involve the "disruption" of the child's environment, includes a number of specific conditions. Three of the more common disorders included in this group are briefly discussed in this section: oppositional defiant disorder (ODD), conduct disorder, and intermittent explosive disorder. The rare disorders of *pyromania* and *kleptomania*, which relate to fire-setting and stealing, are also in this category. Disruptive disorders can be challenging to treat; however, focusing on these disorders while a person is still a child or adolescent is helpful (American Psychiatric Association, 2024b).

Each of these disorders, except kleptomania, is more frequently diagnosed in males than females (American Psychiatric Association, 2024b). Caution must be exercised when considering a diagnosis of any of the disruptive disorders, as studies reveal racial discrepancies in these diagnoses due to systemic and provider biases. White children are more likely than Black or Hispanic children to receive diagnoses of Attention-Deficit/Hyperactivity Disorder (ADHD), a neurodevelopmental disorder discussed later in this chapter, while Black children are significantly more likely to be diagnosed with disruptive disorders (Fadus et al., 2020). Black children are also less likely to be diag-

nosed with trauma, anxiety, or depression, even though those symptoms are often at the root of perceived behavior issues that are misunderstood by white authority figures and mental health professionals (Richtel, 2022). Misdiagnoses perpetuate racist stereotypes, improperly label children, and impair effective treatment—all problems with lasting and damaging consequences.

Oppositional Defiant Disorder

ODD may be diagnosed in children receiving mental health care for excessive behavior problems. Symptoms of ODD, which typically appear in young childhood (preschool or early elementary school), include anger or irritability and defiant or vindictive behavior that is upsetting and disruptive, but not aggressive. Most children grow out of this disorder, but some are later diagnosed with a more serious version of the disorder: conduct disorder (American Psychiatric Association, 2024b).

Conduct Disorder

Conduct disorder can be based on behaviors seen as early as preschool age, but these more serious behaviors typically emerge later in childhood. Symptoms of conduct disorder may include aggressive behavior directed at people or animals, destruction or theft of property, and serious rule violations, such as running away from home. These behaviors cause significant problems in all areas of life and may involve law-breaking behaviors. About 40% of children with conduct disorder eventually meet the criteria for an antisocial personality disorder diagnosis (American Psychiatric Association, 2024b).

Take a look at the video in figure 2.18 to hear a child psychologist very briefly summarize the diagnosis of conduct disorder.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=g58qUHEq6fU

Figure 2.18. This 2-minute video highlights information about childhood conduct disorder. Transcript.

Intermittent Explosive Disorder

Intermittent explosive disorder involves impulsive, angry outbursts—such as temper tantrums or fights—that are out of proportion to the triggering event. The outbursts are reactive and unplanned, rather than goal-directed, and often last a for short time. Outbursts typically involve physical aggression or property destruction. Children diagnosed with this disorder must be at least 6 years old, but the behavior is generally observed a bit later, often in adolescence (American Psychiatric Association, 2024b).

Neurodevelopmental Disorders

Neurodevelopmental disorders are disorders involving brain function that present at the developmental stage in a person's life—typically in early childhood. These disorders can cause differences in social, cognitive, and emotional functioning (Blain, 2022). Attention-deficit/hyperactivity disorder, autism, and intellectual developmental disorder are all examples of neurodevelopmental disorders.

Attention-Deficit/Hyperactivity Disorder

Attention-deficit/hyperactivity disorder, commonly known as ADHD, is a neurodevelopmental disorder diagnosed when a person has significant problems with inattention or impulsivity. Many people experience some lack of focus, but for people with ADHD, the problem interferes with daily functioning. Examples of inattention may include difficulty following through on instructions and avoiding tasks that require mental concentration to complete.

ADHD symptoms can appear as early as preschool age and can continue through adulthood. Symptoms of ADHD may be mistaken for emotional or disciplinary problems, or they may be missed entirely, preventing proper diagnosis. Adults with untreated ADHD may have a history of poor academic performance, problems at work, or difficult or failed relationships.

Available treatments for ADHD (medications, therapy, and education) are effective in reducing symptoms and improving functioning.

Autism Spectrum Disorder

Autism spectrum disorder is a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave. Although autism can be diagnosed at any age, it is considered a developmental disorder because signs generally appear in the first two years of life. People of all genders, races, and ethnicities can be diagnosed with autism, though misunderstandings about the disorder present a barrier to proper diagnosis in some groups, including females and people of color (Autistic Self Advocacy Network, 2024a). Autism is known as a "spectrum" disorder because there is wide variation in the type of autism traits that people experience.

People with autism may present as having difficulty with social communication and interaction, as well as having restricted interests and repetitive behaviors. An autistic person, for example, may avoid eye contact or display facial expressions that do not "match" what is being said. Repetitive behaviors may appear as repeating words and phrases, for example. People with autism may be particularly sensitive to changes in routine or to sensory input (e.g., clothing or sounds). The neurodiversity movement, which recognizes and celebrates that all peoples' brains operate differently, reminds us that these differences are certainly not always negative (Autistic Self Advocacy Network, 2024b). Consider how many autistic traits may be seen as strengths, such as passion and focus (figure 2.19). If you are interested in learning more about autism, consider exploring the **informative web page of the Autistic Self-Advocacy Network (ASAN) [Website]**, whose motto is "nothing about us without us."

Figure 2.19. An illustration created by an autistic person sharing some of the common traits of autism.

Intellectual Developmental Disorder (Intellectual Disability)

Intellectual developmental disorder, formerly known as intellectual disability, starts any time before a child turns 18 and is characterized by differences in intellectual ability or intelligence, including learning or problem-solving, and in everyday life skills (often called adaptive behaviors) (National Institutes of Health, n.d.). Generally, intellectual developmental disorder is diagnosed when a person has an I.Q. below 70 and significant limitations in their daily functioning. The most common causes of intellectual developmental disorder are genetic causes, such as Down Syndrome, or events during pregnancy or birth that impact brain development. Intellectual developmental disorder is the most common developmental disorder (Special Olympics, n.d.).

People with intellectual developmental disorders are vastly overrepresented as both victims and offenders in the criminal justice system (Prison Policy Initiative, 2024). This group is especially vulnerable to wrongful convictions. This is for myriad reasons, including the fact that many individuals with this diagnosis may not be able to understand their legal rights (such as the right to refuse to speak with authorities without a lawyer present) and may have a compromised ability to communicate with counsel or participate in their own defense. Additionally, people with intellectual disability may have adaptively become accustomed to pleasing authority figures, including police, placing them at risk of offering false confessions (Davis, n.d.). As we saw in Ethan Saylor's story, which introduced this chapter, people with intellectual disabilities and other developmental disorders are certainly vulnerable to victimization by police—with terrible outcomes—when they interact or respond to directives by authority figures in atypical ways.

Fetal Alcohol Spectrum Disorders

Fetal alcohol spectrum disorder (FASD) is an umbrella term for a range of physical, cognitive, and behavioral disorders caused by prenatal alcohol exposure. These conditions can impact a diagnosed person in different ways, and impacts can range from mild to severe. Neurological impairments commonly found in FASD include learning disabilities, impulsivity, hyperactivity, and poor judgment. Physical problems might cause unusual facial features and impact systems including vision and hearing.

It is estimated that approximately 1 to 5 percent of U.S. first-grade children have FASD, but this disorder is significantly overrepresented in the criminal justice system. Some studies indicate people with FASD may be 40 times more likely to have criminal justice involvement than people without FASD (Brown et al., 2022).

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Figure 2.18. What Is Conduct Disorder? | Child Psychology by Howcast is licensed under the Standard YouTube License.

2.8 Neurocognitive Disorders

Neurocognitive disorders are defined in the DSM as disorders involving cognitive impairment that is acquired due to an event or medical condition, rather than emerging as part of the developmental process. Neurocognitive disorders thus represent a decline from a previous level of mental functioning (Sachdev et al., 2014). Two examples of neurocognitive disorders are discussed in this section: traumatic brain injury and dementia.

Traumatic Brain Injury

Traumatic brain injury (TBI) is an injury to the brain that affects how the brain works (Centers for Disease Control and Prevention [CDC], 2024a). Falls, blunt trauma accidents, and injuries from assaults (like gunshot wounds) are among the leading causes of TBI (CDC, 2024a).

TBI is a major cause of death and serious injury in the United States. Symptoms vary depending on the severity of the TBI, but moderate to severe injuries come with a vastly shortened life expectancy and a seriously reduced quality of life. Survivors may experience impaired understanding and thinking, anger and aggression, impulsivity, and depression (CDC, 2024b).

Anyone can get a TBI, but certain groups of people are more likely to experience one, including men, older people, and those in military service. Significantly, some groups, including people of color, people who are unhoused, and survivors of intimate partner violence, are less likely to receive proper treatment when they do experience a TBI, leading to worse outcomes from these injuries (CDC, 2024c). People in the criminal justice system may have survived multiple violent encounters, including childhood abuse and violent victimization—any of which can cause TBI. Regardless of cause, TBI incidence is startlingly high in the criminal justice system. According to the CDC, up to 87% of jail and prison inmates report a head injury or TBI, in contrast to just about 8% to 9% of the general population (National Center for Injury Prevention and Control, 2007). Additionally, TBI symptoms, like so many mental disorders discussed in this text, are likely to impair a person's ability to succeed in incarceration or rehabilitation environments. Typical symptoms of TBI can easily be perceived as defiance or deliberate lack of cooperation rather than as a product of this mental disorder, giving rise to disciplinary actions and recidivism, or return to the criminal justice system (Chan et al., 2022).

It is best practice for people in high-risk populations (e.g., homeless shelters or prisons) to be screened for TBI. This can be done by a simple questionnaire asking whether the person has ever received a blow to the head or lost consciousness. Of course, it is then critical that the person receive further diagnostic evaluation followed by necessary treatment and support (Dams-O'Connor et al., 2016). Treatment for TBI depends upon the severity of the injury. A more serious TBI can require significant rehabilitation and long-term care (CDC, 2024b).

Dementia

Dementia is a general term that refers to the loss of thinking abilities—like remembering and reasoning—to a degree that impairs a person's ability to function. There are several different types of dementia, including Alzheimer's disease and stroke-related dementia (CDC, n.d.). Many people are familiar with dementia from experience with family or loved ones, as it is common among aging people; as many as one-third of all people aged 85 or older may have some form of dementia (National Institute on Aging, n.d.). The CDC estimates that by the year 2060, 14 million people over the age of 65 will have a diagnosis of dementia (CDC, n.d.).

As dementia becomes more prevalent in the overall population, it increases in the criminal justice system as well—perhaps to an even greater degree. The marginalized groups that make up the U.S. prison population, for example, have more health problems than the general population overall, including an increased tendency to develop dementia:

> The high risk [of dementia among incarcerated people] is because of challenges faced in prison life—and inmates' experiences before incarceration. Prisoners are often marginalized members of society with less access to health care, poorer diet, issues with alcohol or drug misuse, mental health problems, and potential traumatic brain injuries—all factors that increase the likelihood of developing the condition (Novak, 2022).

Dementia is a criminal justice problem of growing enormity. As inmates with this disorder increase in number, often facing long sentences, they require significant supervision and care (Novak, 2022). Prisons are turning to various solutions to manage this growing population, ranging from creating memory care-type wards within prisons to allowing fellow prisoners to serve as caregivers or volunteer helpers to affected patients (figure 2.20) (Belluck, 2012).

Figure 2.20. An inmate in a California prison makes the bed of an older, disabled prisoner. Volunteers, as well as the recipients of their help, can benefit from these arrangements.

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Figure 2.20. Andrew Burton/ USA: Aging Prisoners Make Up Fastest Growing Segment Of Nation's Prison Population via Getty Images.

2.9 Substance Use and Co-Occurring Disorders

Substance use disorders are mental disorders that involve recurrent use of alcohol and/or drugs, despite significant impairment or problems—including health, home, or work problems—caused by the substance use. The use of substances does not constitute a disorder. Rather, diagnosis depends on problems associated with the use: physical dependence on the substance, risky substance use, social problems related to substance use, and/or impaired control related to use (Hartney, 2023a). Symptoms can range from moderate to severe, with addiction being the most severe form of substance use disorder.

The DSM-5-TR recognizes substance use disorders related to ten different classes of drugs, including alcohol, caffeine, opioids, and inhalants (Hartney, 2023a). The substances that are abused in our communities vary by the demographics of users as well as by influencing factors, such as popularity and accessibility of various substances, as well as enforcement and support efforts. Most recently, for example, fentanyl (a powerful synthetic opioid) has become widely abused. Fentanyl overdose deaths have wreaked havoc in many locations. Attempts to address this problem have driven harm reduction and overdose prevention efforts aimed at this specific issue (National Institute on Drug Abuse, 2021).

It is common for people with substance use disorders to have other diagnoses as well (figure 2.21). A **co-occurring mental disorder** exists where someone is diagnosed with multiple mental disorders of any type (e.g., schizophrenia and a personality disorder), but the term is most frequently used where a person has both a mental disorder and a substance use disorder. The term *dual diagnosis* was formerly used to describe this common situation (Psychology Today, 2021b).

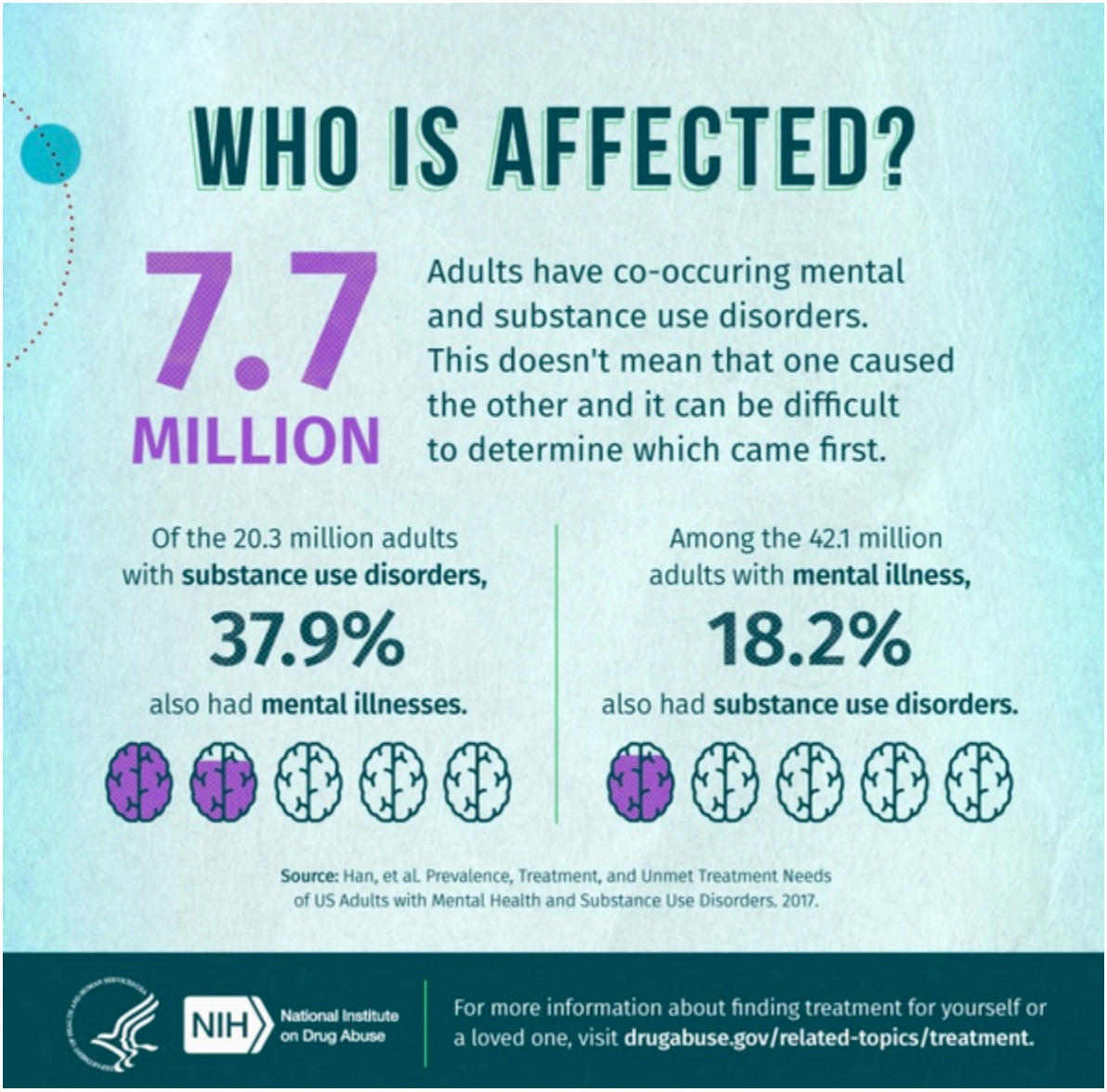

Figure 2.21. This illustration from the National Institute on Drug Abuse illustrates the common diagnosis of co-occurring mental health and substance use disorders, which impact about 7.7 million American adults. Almost 40% of people with substance use disorders also have another mental health diagnosis.

Research suggests several explanations as to why substance use disorders and other mental disorders so frequently occur together. There are common risk factors: both can run in families, for example, suggesting genetic roots. Environmental factors like stress or trauma may contribute to the development of a mental disorder or a substance use disorder. Additionally, people with mental disorders may use drugs or alcohol as a form of self-medication. Finally, substance use can contribute to the development of other mental disorders by triggering changes in brain structure and function that make a person more likely to develop another mental disorder.

Occasionally, these connections and interactions between substance use, mental health, and disability can make it very challenging to determine if particular symptoms are attributable to substance use or a different mental disorder, and, if both are present, which came first. Research

increasingly indicates that certain substances (amphetamines and cannabis, for example) are closely related to the development of early psychosis and may exacerbate underlying psychotic disorders or even cause psychotic symptoms (Hartney, 2023b). The DSM clearly recognizes that certain disorders can be attributed directly to substance use with diagnoses such as substance-induced psychotic disorder and substance-induced neurocognitive disorders. The correct diagnosis can have important implications for treatment, as well as for criminal justice proceedings where the cause of a person's behavior often determines legal outcomes.

Medications have emerged as a very effective treatment for substance use disorders; these medication-based approaches are discussed more in Chapter 8. A number of behavioral therapies are also helpful in treating individuals with substance use disorders, as well as co-occurring disorders. Cognitive behavioral therapy, which was discussed earlier in this chapter, is an effective treatment, as is **dialectical behavior therapy (DBT)** (figure 2.22). DBT uses concepts of mindfulness and acceptance—encouraging a person to be aware of and attentive to their current situation and emotional state—and other coping skills that help participants manage intense emotions, reduce self-destructive behaviors, and improve relationships. DBT can also be useful in treating several of the other mental disorders described in this chapter.

Figure 2.22. This illustration highlights some key aspects of DBT therapy: use of mindfulness techniques, regulating emotions, tolerating distress, and managing relationships.

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Figure 2.21. "Who is affected" is adapted from Comorbidity: Substance Use and Other Mental Disorders by The National Institute on Drug

Abuse is in the **public domain**. Modifications: cropping image for pedagogical impact.

Figure 2.22. "**Dialectical Behavior Therapy Skills**" by **MissLunaRose12** is licensed under **CC BY-SA 4.0**.

2.10 Additional Behavioral Considerations

The vast majority of people who experience mental disorders never find themselves negatively involved in the criminal justice system. This text, of course, is focused on the people who do come into contact with this system, appropriately or not.

When people with mental disorders do become involved in the criminal justice system, this can sometimes be related to harmful or antisocial behaviors that are separate from symptoms of a mental disorder but may be perceived as or related to a mental disorder. Two important considerations when working with the criminal justice-involved population are described in this section: malingering and psychopathy. Both of these issues can impact diagnoses of mental disorders and understanding of a person's conduct.

Malingering

Malingering occurs when a person fakes or greatly exaggerates symptoms of a medical or mental health condition for some sort of personal gain, such as avoiding a responsibility or attaining some benefit (Psychology Today, 2019). There are many situations where this may occur. A person with a substance use disorder, for example, may falsely report pain to obtain a drug from a medical provider. There are numerous occasions when malingering may occur within the criminal justice system, and some estimates suggest up to 20% of justice-involved people engage in malingering to some degree (Psychology Today, 2019).

Malingering may occur in lower-stakes criminal justice situations, such as when a person exaggerates mental health symptoms to gain access to special housing in a prison or jail. Of greater public concern are situations when a person reports wholly false information to appear mentally ill and avoid responsibility for criminal actions. However, successfully avoiding criminal responsibility via malingering is quite rare, given the caution around malingering and the resistance of the criminal justice system overall to excusing behavior that is attributable to mental disorders, even when that might be appropriate.

An infamous example of an apparent malingerer was Los Angeles's "Hillside Strangler," Kenneth Bianchi (figure 2.23), who horribly tortured and murdered at least 10 young women in the late 1970s. Although he convincingly claimed to have the rare diagnosis of dissociative disorder, or multiple personality disorder, Bianchi was disbelieved by skeptical law enforcement officials. Bianchi's defense story was debunked with a later evaluation, and he eventually pled guilty to his crimes (Biography, 2023).

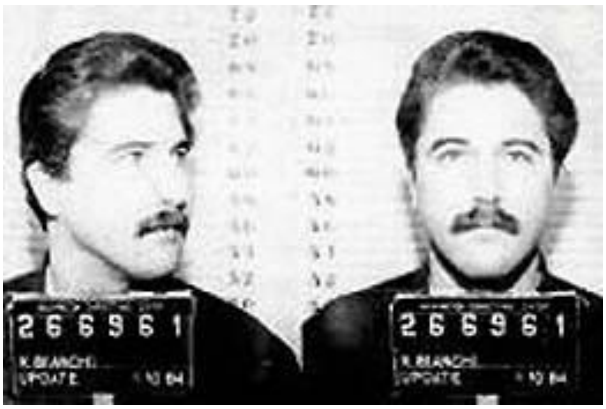

Figure 2.23. Kenneth Bianchi in his 1979 mugshot.

Psychopathy

Psychopathy is a condition or set of traits that is clinically recognized, but it is not a DSM diagnosis. Examples of psychopathic traits include a lack of empathy, callousness, deceitfulness, and grandiosity (Burton & Saleh, 2020). It is important to be familiar with these traits when working in the criminal justice system, where they are found in much higher numbers than in the general population. According to the American Psychological Association, "About 1.2% of U.S. adult men and 0.3% to 0.7% of U.S. adult women are considered to have clinically significant levels of psychopathic traits. Those numbers rise exponentially in prison, where 15% to 25% of inmates show these characteristics" (DeAngelis, 2022).

Dr. Robert Hare created the Hare Psychopathy Checklist-Revised (PCL-R), a tool that screens for these traits to aid in diagnosis. The tool is essentially a "checklist" of various traits related to an overall "score" of psychopathy. Traits reviewed by the checklist include things like superficial charm and cunningness (Encyclopedia of Mental Disorders, 2024). Generally, the PCL-R is used by mental health professionals working with forensic populations (incarcerated people or people involved in the criminal justice system) to determine their level of risk, because people who exhibit these traits are more likely to engage in criminal activity (Risk Management Authority, 2019).

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2.11 Chapter Summary

- The DSM-5-TR is the most recent classification of mental disorders used by mental health professionals for diagnosis.
- This chapter provides introductory information about several mental disorders that are of interest to criminal justice students, including anxiety disorders, trauma-related disorders, psychotic disorders, mood disorders, personality disorders, paraphilic disorders, childhood and developmental disorders, neurocognitive disorders, and substance use disorders.
- Treatment for mental disorders (including education, medication, and therapy) is critical, but it is often lacking, particularly for groups who are marginalized by factors such as poverty, race, and gender.

- Criminal justice professionals will encounter behavioral issues that can exist alongside or separately from diagnosable mental disorders. These include malingering and psychopathy.

KEY TERM DEFINITIONS

- **Anosognosia:** A lack of awareness or insight into one's own mental disorder diagnosis and related needs.
- **Anxiety disorders:** A category of disorders characterized by excessive and persistent fear and related disturbances in behavior. There are multiple types of anxiety disorders.
- **Cognitive behavioral therapy (CBT)**: A set of therapeutic techniques aimed at adjusting someone's mental processes (e.g., thinking or perceiving) to promote behavior change.
- **Co-occurring mental disorder:** A mental disorder diagnosed in a person who also experiences (an)other mental disorder(s), most frequently referring to a mental disorder along with a substance use disorder.
- **Culturally competent:** A descriptor applied to behavioral health care that factors in and positively uses understanding of a person's background and life experiences to provide them with care that meets their needs. Cultural competence may be bolstered by cultural humility or a willingness to engage in ongoing cultural learning and introspection as to personal biases.
- *Diagnostic and Statistical Manual of Mental Disorders* **(DSM):** A classification system for mental disorders that is used for diagnostic purposes by most U.S. mental health professionals.
- **Dialectical behavior therapy (DBT):** A therapeutic approach that uses concepts such as mindfulness and acceptance to help control intense emotions, reduce self-destructive behaviors, and improve relationships.
- **Dissociative disorders:** A category of mental disorders that involve the separation of a person from their core self, impairing the person's memory and identity.
- **LGBTQIA+:** Acronym for lesbian, gay, bisexual, transgender, queer, intersex, and asexual, plus other gender and sexual identities not encompassed in the acronym letters.
- **Malingering**: When a person fakes or exaggerates symptoms for secondary gain, such as avoiding a consequence or obtaining a benefit.
- **Mood disorders:** A category of mental disorders impacting mood and emotion, including depressive disorders and bipolar disorders.
- **Neurocognitive disorders:** Disorders characterized by acquired cognitive impairment due to a medical condition, such as Alzheimer's disease, or an event, such as a brain injury.
- **Neurodevelopmental disorders:** Disorders involving differences in brain function that first present in childhood during the developmental period.
- **Paraphilic disorders:** Disorders involving harmful impacts (distress, impaired functioning, or victimization of others) due to intense and atypical sexual urges specified in the DSM-5-TR (e.g., sadism, pedophilia, exhibitionism).

- **Personality disorders:** Disorders involving a person's atypical thinking and behavior that cause them to have trouble functioning and relating to others. Examples include antisocial personality disorder and narcissistic personality disorder.
- **Post-traumatic stress disorder** (PTSD): Disorder caused by exposure to a traumatic event or series of events causing ongoing symptoms such as intrusive thoughts and nightmares.
- **Psychotic disorders:** Disorders that cause thinking and perceptions that are disconnected from reality (psychosis), including schizophrenia, schizoaffective disorder, and delusional disorders.
- **Psychopathy:** A set of traits (not a diagnosis) that may include a lack of empathy, callousness, deceitfulness, and grandiosity.
- **Psychosis**: A collection of symptoms that affect the mind, causing a person to have difficulty recognizing what is real and what is not (for example, delusions and hallucinations).
- **Serious mental illness:** A diagnosable mental illness with symptoms that substantially impact major life activities. Bipolar disorder, major depressive disorder, schizophrenia, and schizoaffective disorder are examples of diagnoses that are typically considered serious mental illnesses.
- **Substance use disorder:** A mental disorder that involves recurrent use of alcohol and/or drugs, despite significant impairment or problems, including health, home, or work problems, caused by the substance use.
- **Trauma:** A situation that physically or emotionally harms a person to the extent that it impacts their well-being.

DISCUSSION QUESTIONS

- As you have learned about a number of specific diagnoses, can you imagine how these might present in the criminal justice system?
- What barriers are there to the diagnosis and treatment of these disorders outside of and within the criminal justice system?
- For disorders that present in childhood, what approaches might be used to prevent people with these diagnoses from becoming involved in the criminal justice system?
- What are the risks and benefits of being formally diagnosed with a mental disorder?

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2.12 References

American Psychiatric Association. (2013). *Paraphilic disorders.* https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Paraphilic-Disorders.pdf

American Psychiatric Association. (2020). *What is schizophrenia?* https://www.psychiatry.org/patients-families/schizophrenia/what-is-schizophrenia

American Psychiatric Association. (2022a). *What are dissociative disorders?* https://www.psychiatry.org/patients-families/dissociative-disorders/what-are-dissociative-disorders

American Psychiatric Association. (2022b). *What are personality disorders?* https://www.psychiatry.org/patients-families/personality-disorders/what-are-personality-disorders

American Psychiatric Association. (2022c). *What is posttraumatic stress disorder (PTSD).* https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd

American Psychiatric Association. (2023). *What is perinatal depression?* https://www.psychiatry.org/patients-families/peripartum-depression/what-is-peripartum-depression

American Psychiatric Association. (2024a). *DSM history*. https://www.psychiatry.org/psychiatrists/practice/dsm/about-dsm/history-of-the-dsm

American Psychiatric Association. (2024b). *What are disruptive, impulse control and conduct disorders?* https://www.psychiatry.org/patients-families/disruptive-impulse-control-and-conduct-disorders/what-are-disruptive-impulse-control-and-conduct

Anushka, P., Suris, A. M. & North, C.S. (2017, February 13). Posttraumatic stress disorder in the DSM-5: Controversy, change, and conceptual considerations. *Behavioral Sciences, 7*(1), 7. https://doi.org/10.3390/bs7010007

Arbanas, G. (2022, November). Personality disorders in sex offenders, compared to offenders of other crimes. *The Journal of Sexual Medicine*, *19*(4 [Issue Supplement]). https://doi.org/10.1016/j.jsxm.2022.08.022

Autistic Self Advocacy Network. (2024a). *About autism.* https://autisticadvocacy.org/about-asan/about-autism/

Autistic Self Advocacy Network. (2024b). *What we believe*, *Our motto: What is "Nothing About Us Without Us"?* https://autisticadvocacy.org/about-asan/what-we-believe/

Beharry, J. & Ogrodniczuk, J. (2017, April 21). *Depression is an illness, not a weakness*.

National Association of Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/April-2017/Depression-is-an-Illness-Not-a-Weakness

Belluck, P. (2012, February 25). Life, with Dementia. *New York Times*. https://www.nytimes.com/2012/02/26/health/dealing-with-dementia-among-aging-criminals.html

Biography. (2023, October 3). *Who is Kenneth Bianchi?* https://www.biography.com/crime-figure/kenneth-bianchi

Blain, T. (2022, March 31). *What are neurodevelopmental disorders?* https://www.verywellmind.com/neurodevelopmental-disorders-definition-symptoms-traits-causes-treatment-5221231

Brown, J., Jozan, A., & Carter, M. (2022, July 6). *Interview considerations–Fetal alcohol spectrum disorder, A beginner's guide for criminal justice interviewers*. Police Chief Online. https://www.policechiefmagazine.org/interview-considerations-fetal-alcohol-spectrum-disorder/

Burton, B. & Saleh, F. M. (2020, October 30). *Psychopathy: Insights for general practice, 37*(10). https://www.psychiatrictimes.com/view/psychopathy-insights-general-practice

Centers for Disease Control and Prevention [CDC]. (n.d.). *Alzheimer's disease and health aging, About dementia.* https://www.cdc.gov/aging/dementia/index.html

Centers for Disease Control and Prevention [CDC]. (2024a). *Facts about TBI.* https://www.cdc.gov/traumatic-brain-injury/data-research/facts-stats/index.html

Centers for Disease Control and Prevention [CDC]. (2024b). *About moderate and severe TBI*. https://www.cdc.gov/traumatic-brain-injury/about/moderate-severe-tbi.html

Centers for Disease Control and Prevention [CDC]. (2024c). *Health disparities in TBI.* https://www.cdc.gov/traumatic-brain-injury/health-equity/index.html

Chan, V., Estrella, M. J., Syed, S., Lopez, A., Shah, R., Colclough, Z., Babineau, J., Beaulieu-Dearman, Z. & Colantonio, A. (2022, January, 16). Rehabilitation among individuals with traumatic brain injury who intersect with the criminal justice system: A scoping review. *Frontiers in Neurology*, *13*. https://doi.org/10.3389/fneur.2022.1052294

Dams-O'Connor, K., Cantor, J. B. Brown, M., Dijkers, M. P., Spielman, L. A. & Gordon, W. A. (2016, August 15). *Screening For Traumatic Brain Injury: Findings and Public Health Implications.* PubMed Central. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4985006/

Davis, L.A. (n.d.). *People with intellectual disabilities in the criminal justice systems: Victims & suspects*. https://thearc.org/wp-content/uploads/forchapters/Criminal%20Justice%20System.pdf

DeAngelis, T. (2022, March 1). *A broader view of psychopathy. New findings show that people with psychopathy have varying degrees and types of the condition*, *53*(2). American Psychological Association. https://www.apa.org/monitor/2022/03/ce-corner-psychopathy#:~:text=What%20is%20psychopathy%3F,F.%20M.%2C%20Psychiatric%20Times%2C%20Vol

Eher, R., Rettenberger, M., & Turner, D. (2019). The prevalence of mental disorders in incarcerated contact sexual offenders. *Acta psychiatrica Scandinavica*, *139*(6), 572–581. https://doi.org/10.1111/acps.13024

Encyclopedia of Mental Disorders. (2024). *Hare Psychopathy Checklist Forum*. https://www.mind-disorders.com/Flu-Inv/Hare-Psychopathy-Checklist.html

Facer-Irwin, E., Blackwood, N. J., Bird, A., Dickson, H., McGlade, D., Alves-Costa, F., & MacManus, D. (2019, Sept 26). PTSD in prison settings: A systematic review and meta-analysis of comorbid mental disorders and problematic behaviours. *PLOS ONE*, *14*(9). https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0222407

Fadus, M. C., Ginsburg, K. R., Sobowale, K., Halliday-Boykins, C. A., Bryant, B. E, Gray, K. M., & Squeglia, L. M. (2020). Unconscious bias and the diagnosis of disruptive behavior disorders and ADHD in african american and hispanic youth. *Academic Psychiatry*, *44*(1). https://doi.org/10.1007/s40596-019-01127-6

Fountain House. (n.d.). *From cultural competency to cultural humility.* https://www.fountainhouse.org/resources/cultural-humility

Haberman, C. (2014, November 24). Debate persists over diagnosing mental health disorders, long after 'Sybil'. https://www.nytimes.com/2014/11/24/us/debate-persists-over-diagnosing-mental-health-disorders-long-after-sybil.html

Hartney, E. (2023a). *DSM 5 criteria for substance use disorders*. https://www.verywellmind.com/dsm-5-criteria-for-substance-use-disorders-21926

Hartney, E. (2023b). *What you need to know about substance-induced psychotic disorder*. https://www.verywellmind.com/what-is-substance-medication-induced-psychotic-disorder-21938

Human Rights Campaign Foundation. (n.d.). *Mental health and the LGBTQ community.* https://988lifeline.org/wp-content/

uploads/2017/07/LGBTQ_Mental-Health_OnePager.pdf

Kilpatrick, D. G., Badour, C. L., & Resnick, H. S. (2017). Trauma and posttraumatic stress disorder prevalence and sociodemographic characteristics. In Gold (Ed.), *APA handbook of trauma psychology: Foundations in knowledge*. American Psychological Association. https://doi.org/10.1037/0000019-004

Marlay, M., File, T. & Scherer, Z. (2022, December 14). *Mental health struggles higher among LGBT adults than non-LGBT adults in all age groups.* U.S.Census Bureau. https://www.census.gov/library/stories/2022/12/lgbt-adults-report-anxiety-depression-at-all-ages.html

Mayo Clinic. (2023). *Personality disorders, Symptoms & causes*. https://www.mayoclinic.org/diseases-conditions/personality-disorders/symptoms-causes/syc-20354463

National Alliance on Mental Illness [NAMI]. (n.d.-a). *Mental health conditions.* https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions

National Alliance on Mental Illness [NAMI]. (n.d.-b). *Schizoaffective disorder*. https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Schizoaffective-Disorder

National Alliance on Mental Illness [NAMI]. (n.d.-c). *Mental health medications.* https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications

National Alliance on Mental Illness [NAMI]. (2015). *Schizoaffective disorder*. https://nami.org/NAMI/media/NAMI-Media/Images/FactSheets/Schizoaffective-Disorder-FS.pdf

National Alliance on Mental Illness [NAMI]. (2023a). *Dissociative disorders*. https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Dissociative-Disorders

National Alliance on Mental Illness [NAMI]. (2023b). *Clozapine (Clozaril and Versacloz).* https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication/Clozapine-(Clozaril-and-Versacloz)

National Alliance on Mental Illness [NAMI]. (2024a). *Identity and cultural dimensions.* https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions

National Alliance on Mental Illness [NAMI]. (2024b). *Anosognosia*. https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Anosognosia

National Center for Injury Prevention and Control (U.S.). Division of Injury Response. (2007). *Traumatic brain injury in prisons and jails: an unrecognized problem.* https://stacks.cdc.gov/view/cdc/11668

National Institute of Mental Health [NIMH]. (n.d.-a). *Major depression.* https://www.nimh.nih.gov/health/statistics/major-depression

National Institute of Mental Health [NIMH]. (n.d.-b). *Schizophrenia.* https://www.nimh.nih.gov/health/topics/schizophrenia

National Institute on Aging. (n.d.). *What is dementia? Symptoms, types, and diagnosis.* https://www.nia.nih.gov/health/what-is-dementia

National Institute on Drug Abuse. (2021, June). *What is Fentanyl? Fentanyl drug-Facts.* https://nida.nih.gov/publications/drug-facts/fentanyl

National Institutes of Health. (n.d.). *About intellectual and developmental disabilities (IDDS)*. https://www.nichd.nih.gov/health/topics/idds/conditioninfo

Novak, S. (2022, September 27). *Dementia in prison is turning into an epidemic: The U.S. penal system is badly unprepared*. Scientific American. https://www.scientificamerican.com/article/dementia-in-prison-is-turning-into-an-epidemic-the-u-s-penal-system-is-badly-unprepared/

Or. Rev. Stat. § 161.295 (2023). https://www.oregonlegislature.gov/bills_laws/ors/ors161.html

Perry, D. M. (2013, August 29). Justice for Down syndrome man who died in movie theater. *CNN*. https://www.cnn.com/2013/08/29/opinion/perry-down-syndrome-death/index.html

Prison Policy Initiative. (2024, February 15). *Disability*. https://www.prisonpolicy.org/research/disability/

Psychology Today. (2019). *Malingering*. https://www.psychologytoday.com/us/conditions/malingering

Psychology Today. (2021a). *Borderline personality disorder*. https://www.psychologytoday.com/us/conditions/borderline-personality-disorder

Psychology Today. (2021b). *Co-occurring disorders.* https://www.psychologytoday.com/us/conditions/co-occurring-disorders

Psychology Today. (2022a). *Narcissistic personality disorder*. https://www.psychologytoday.com/us/conditions/narcissistic-personality-disorder

Psychology Today. (2022b). *Paraphilias*. https://www.psychologytoday.com/us/conditions/paraphilias

Psychology Today. (2022c). *Pedophilia*. https://www.psychologytoday.com/us/conditions/pedophilia

Richtel, M. (2022, December, 13). When black psychiatrists reach out to teens of color. https://web.archive.org/web/20221214061909/https://www.nytimes.com/2022/12/13/health/adolescents-mental-health-psychiatry.html

Risk Management Authority. Reducing Serious Harm. (2019, August). *Psychopathy Checklist Revised (PPCL-R)*. https://www.rma.scot/wp-content/uploads/2023/01/Psychopathy-Checklist-Revised-PCL-R.pdf

The Road We've Shared. (2024). *A brief summary of the story*. https://theroadweveshared.com/justice-for-ethan/a-brief-summary-of-the-story

Sachdev. P. S., Blacker, D., Blazer, D. G., Ganguli, M., Jeste, D. V., Petersen, R. C. & Paulsen, J. S. (2014). Classifying neurocognitive disorders: The DSM-5 approach. *Nature Reviews, Neurology, 10.* 634-642. http://www.nature.com/doifinder/10.1038/nrneurol.2014.181

Schnittker, J., Larimore, S. H., & Lee, H. (2020, November). Neither mad nor bad? The classification of antisocial personality disorder among formerly incarcerated adults. *Social Science & Medicine*, *264*, 113288. https://doi.org/10.1016/j.socscimed.2020.113288

Smith, A.D. (2021, October 4). Major depressive disorder can include psychotic features. *Psychology Today.* https://www.psychologytoday.com/us/blog/and-running/202110/major-depressive-disorder-can-include-psychotic-features

Special Olympics. (n.d.). *What is intellectual disability?* https://www.specialolympics.org/about/intellectual-disabilities/what-is-intellectual-disability

Spielman, R. M., Jenkins, W. J., & Lovett, M. D. (2020a). Introduction, Psychology 2e. *OpenStax*. https://openstax.org/books/psychology-2e/pages/16-introduction

Spielman, R. M., Jenkins, W. J., & Lovett, M. D. (2020b). Posttraumatic stress disorder. Psychology 2e. *OpenStax*. https://openstax.org/books/psychology-2e/pages/15-6-posttraumatic-stress-disorder

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2022a). *About criminal and juvenile justice.* https://www.samhsa.gov/criminal-juvenile-justice/about

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2022b). *Early serious mental illness treatment locator.* https://www.samhsa.gov/esmi-treatment-locator

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2023a). *Living well with serious mental illness. What are serious mental illnesses?* https://www.samhsa.gov/serious-mental-illness

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2023b). *Schizophrenia*. https://www.samhsa.gov/mental-health/schizophrenia

Tamminga, C. (2022, April). *Delusional Disorder.* Merck Manual Consumer Version. https://www.merckmanuals.com/home/mental-health-disorders/schizophrenia-and-related-disorders/delusional-disorder

Treatment Advocacy Center. (2018). *Anosognosia*. https://www.treatmentadvocacycenter.org/anosognosia/

Vargas, T. (2020, August 5). A police department quietly hired a deputy involved in the death of a man with Down syndrome. Then one man decided to make noise. *The Washington Post*. https://www.washingtonpost.com/local/a-police-department-quietly-hired-a-deputy-involved-in-the-death-of-a-man-with-down-syndrome-then-one-man-decided-to-make-noise/2020/08/05/f0af5940-d73e-11ea-930e-d88518c57dcc_story.html

Vargas, T. (2023, January 7). The unnecessary death of Ethan Saylor and what has changed in 10 years. *The Washington Post*. https://www.washingtonpost.com/dc-md-va/2023/01/06/ethan-saylor-decade-legacy/

Watson, S. (2022, May 02). *Schizophrenia in the Prison System.* WebMD. https://www.webmd.com/schizophrenia/schizophrenia-prison-system

White, T. (2022, March 17). *What the new DSM-5-TR updates could mean for your mental health.* PsychCentral. https://psychcentral.com/news/dsm-5-updates-2022

World Health Organization. (2022). *Mental disorders*. https://www.who.int/news-room/fact-sheets/detail/mental-disorders

CHAPTER

3

Disability Activism and the Rights of People with Mental Disorders

3.1 Chapter Learning Objectives and Overview

LEARNING OBJECTIVES

The following learning objectives tell you what is most important in this chapter. Use these statements as a guide to make sure you get the most out of this chapter.

1. Identify laws and court decisions that reflect changing values in American society and shape the treatment of people who experience a range of disabilities, including mental disorders.
2. Discuss the role of activism in establishing and expanding the legal rights of people with disabilities, including people with mental disorders, in the United States.
3. Describe how the Americans with Disabilities Act and other key legislation may apply in the criminal justice system.
4. Discuss government and private enforcement of the rights of people with disabilities, particularly mental disorders, in the criminal justice system.

KEY TERMS

Look for these important terms in the text in bold. Understanding these terms will help you meet the learning objectives of this chapter. You can find definitions for these terms at the end of the chapter.

- **Ableism**
- **Americans with Disabilities Act (ADA)**
- **Civil rights**
- **Civil Rights of Institutionalized Persons Act (CRIPA)**
- **Deliberate indifference**
- **Discrimination**
- **Failure to accommodate**
- **Failure to train**
- **Individuals with Disabilities Education Act (IDEA)**
- **Medical model of disability**
- **Reasonable accommodations**
- **Section 504 of the Rehabilitation Act of 1973**
- **Social model of disability**
- **U.S. Department of Justice**
- **Wrongful arrest**

Chapter Overview

Lois Curtis spent most of her life institutionalized against her wishes. This was not because she was dangerous or because she was unable to live outside of an institution; neither of these things were true. Rather, Curtis, a Black artist who had diagnoses of schizophrenia and intellectual disability, was confined because she needed state services and support, and an institution is where the state of Georgia preferred to provide those. It was not until 1999 that the U.S. Supreme Court was able to rely upon the Americans with Disabilities Act (the ADA), a law that prohibits discrimination against people based on disability, to declare Curtis's segregation illegal, allowing her to rejoin the larger community. Because of the ADA, and a lot of advocacy, Curtis was able to spend the remainder of her life enjoying her freedom and making art in her own home in Georgia until her death in 2022 (figure 3.1).

Figure 3.1. Lois Curtis displays her art with a smile.

Challenges for people living with mental disorders persist, even today, in all aspects of American life. These challenges stem from misinformation, discrimination, and barriers that have been built into our society and its institutions over time. However, laws such as the ADA and rulings made by courts like the one in Lois Curtis's case have empowered many people to assert and protect their rights to live and access opportunities in the same ways that people without disabilities do. Through decades of activism, people with disabilities fought for and won many of the laws you will learn about in this chapter, beginning with the fundamentals of financial security and access to education and moving on to equitable health care, transportation, and housing. With every step, it was further established that people with disabilities, including people with mental disorders, are entitled to fully engage in our society. When disability-related laws are applied in and around the criminal justice system, they impact the population that is the focus of this text—justice-involved people with mental disorders—the professionals who work in that system, and our larger communities. In this chapter, you will learn about the activism behind the legal rights of people with disabilities and about some of the most important laws and legal decisions that affect individuals with mental disorders in the criminal justice system.

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Figure 3.1. **Lois Curtis displaying her art** © **Robin Rayne** is all rights reserved and included with permission.

3.2 Overview of Federal Disability Law

In **Chapter 1** of this text, we discussed how past attempts to eradicate mental disorders and the mistreatment and confinement of people with mental disorders came to be challenged by both evolving social ideas and by scientific and legal developments that helped make change possible. As social activists were criticizing overflowing state hospitals, scientific advancements (e.g., the development of psychiatric medications) and legal progress (e.g., the passage of the Community Mental Health Act) were improving logistics for people with mental disorders to function outside of hospitals. Together, social, scientific, and legal forces led to the reduction and closure of institutions, which increased the number of people with mental disorders living in their communities.

Although the movement towards deinstitutionalization in the 1960s (discussed in **Chapter 1**) signaled an end to routine confinement of people with mental disorders, there was still a lot of work to do. At that time, people with disabilities might be allowed to live in the community, but they had limited opportunities to achieve financial or other forms of independence. People with disabilities had no protection for their **civil rights**, which are personal rights that should be guaranteed and protected by law. Civil rights include things like the right to vote, gain an education, or enter public establishments. **Discrimination**, the different or unfair treatment of a person based on their status, was still perfectly legal when based on disability. Children with disabilities had no right to access public school, and adults with disabilities were often excluded from jobs, housing, and services like restaurants or stores. For example, a person who used a wheelchair often could not get in the door of a business, use public transportation, or find an accessible toilet. Some barriers were especially burdensome to those with mental disorders. For example, medical insurance was not required to cover mental health needs, making necessary treatment out of reach for most people.

Over the next several decades, more progressive thinking about people with disabilities, coupled with legislation and court decisions interpreting the laws, began to change the outlook for people with mental disorders. As part of the disability rights movement in the 1970s and beyond, advocates fought to end discrimination and achieve access and inclusion for people with disabilities, including people with mental disorders. The Spotlight in this section lists some of the legislative highlights. Links are provided for your information if you would like to learn more about a particular piece of legislation.

SPOTLIGHT: Timeline of Important Disability Laws

1956 – Social Security Act Amended [Website]: This law provided monthly benefits to disabled workers over 50 and allowed benefits for disabled children of workers, even after the child was over 18.

1963 – Community Mental Health Act (CMHA) [Website]: This John F. Kennedy-driven legislation provided federal funding for the development of local/community mental health resources with the intent to shift care from institutions to homes and communities. See more information about the CMHA in **Chapter 1**.

1964 – Civil Rights Act [Website]: This landmark law prohibited discrimination based on race, religion, or national origin. This law did not protect people with disabilities, but it provided a model for eventual legislation recognizing the civil rights, or personal legal rights, of disabled people.

1965 – Medicaid [Website]: This part of the Social Security Act provided some coverage of medical expenses for people with disabilities.

1973 – Section 504 of the Rehabilitation Act of 1973 [Website]: This provision was the first legal recognition of the civil rights of disabled people. Section 504 prohibits recipients of federal funds (including hospitals, government offices, and schools) from denying access to or discriminating against disabled people. This law is still used to allow students with disabilities, including mental disorders, to demand access to school via "504 plans." The federal government resisted implementing this law until protests forced them to do so in 1977.

1975 – Education for All Handicapped Children Act: This law provided, for the first time, that children with disabilities were entitled to public education alongside nondisabled peers. It was renamed the **Individuals with Disabilities Education Act (IDEA) [Website]** in 1990.

1980 – Civil Rights of Institutionalized Person Act (CRIPA) [Website]: This law gives the U.S. Department of Justice the power to take legal action against state and local authorities when there is a pattern of rights being violated in an institutional setting (prisons, juvenile facilities, nursing homes, and state hospitals). An example would be a prison repeatedly denying required mental health care to incarcerated people.

1988 – Fair Housing Act Amendments [Website]: This law expanded the 1968 Fair Housing Act, which prohibited race discrimination in housing sales and rentals, to include a prohibition on disability discrimination.

1990 – Americans with Disabilities Act (ADA) [Website]: The ADA is a civil rights law modeled after the Civil Rights Act of 1964. The ADA prohibits discrimination and requires large parts of American society to increase accessibility. This act is discussed in greater detail later in this chapter.

1996 – Mental Health Parity Act [Website]: This law requires insurance plans to offer the same level of coverage for mental disorders as physical disorders. This law was strengthened in 2010 by the **Affordable Care Act [Website]**, which requires most insurers to offer mental health and substance use treatment coverage.

1996 – Air Carrier Access Act [Website]: This Act fills in a hole left by the ADA, forbidding discrimination based on disability in air travel.

2008 – ADA Amendments [Website]: Amendments to the ADA resolved disputes among the courts by clarifying that certain mental disorders (including intellectual disability, bipolar disorder, and depression) were included as "disabilities" under the law (Accessibility.com, n.d.; Temple University, n.d.; Morgan, 2020; Social Security Administration, n.d.).

Some of the most important disability-related laws, especially the earlier ones, focused on the freedom and financial viability of people with disabilities. These laws (Social Security, the CMHA, and Medicaid) were the first steps in allowing a degree of independence and community opportunity for people with a variety of disabilities. Though it was an enormous and celebrated step to prohibit discrimination against people based on race and gender, the Civil Rights Act of 1964 did not address discrimination based on disability (figure 3.2). Discrimination against people who experienced mental disorders and other disabilities remained legal and unchecked for many more years. That began to change in 1973 with the passage of Section 504 of the Rehabilitation Act.

Figure 3.2. The Civil Rights Movement predated the later push for disability rights that resulted in the recognition of the civil rights of people with disabilities.

Section 504 of the Rehabilitation Act of 1973, known as "Section 504," was the very first law that recognized the civil rights of people with disabilities. The language in Section 504 prohibited discrimination against disabled people by the federal government and by state entities that received federal funding (U.S. Department of Health and Human Services, 2006). The law was passed by Congress in 1973 in what was reportedly an under-the-radar insertion of revolutionary language into an otherwise uncontroversial piece of legislation (Heumann & Joiner, 2021). Once it became clear that the new law would have a huge impact (e.g., requiring places like government buildings to become accessible), three presidents (Nixon, Ford, and Carter), one after the other, resisted signing the regulations needed to put the law into action. Section 504 sat dormant. Focused advocacy, culminating in a month-long sit-in at a federal office building in San Francisco, along with shorter sit-ins in other locations, protested the delay. The San Francisco protest was led by a

group that included Judith Heumann (figure 3.3), introduced in Chapter 1 of this text, and her friend Kitty Cone, another disability activist involved in the Berkeley Center for Independent Living.

Figure 3.3. Activist Judith Heumann, seated in a wheelchair, alongside prominent disability rights attorney Barbara Ransom, is pictured here in 2019.

As a child, Heuman, a wheelchair user, had been denied entry to kindergarten as a "fire hazard"—only the first of many times she faced dehumanizing discrimination (Heumann & Joiner, 2021). Kitty Cone, who had muscular dystrophy, had already been active in protesting race and gender discrimination when she became involved in the disability rights movement in the 1970s (figure 3.4). An openly gay woman, Cone faced additional discrimination based on her gender and sexuality (Disability Rights Education & Defense Fund. n.d.).

Figure 3.4. Disability activist Kitty Cone, who helped organize the Section 504 protests.

Supporting the Section 504 demonstrations, including the federal building sit-in, was an unexpected group of experienced civil rights activists: the Black Panthers. The Black Panthers had formed to empower Black people, especially in protest against police brutality, and they now lent their voices, skills, and power to the disability rights movement (Connelly, 2020). Longtime Black Panther Party leader Bradley Lomax (pictured in figure 3.5) had developed multiple sclerosis, which gave him a personal view into the myriad challenges of being a disabled Black man in America (Connelly, 2020).

Figure 3.5. Bradley Lomax, center, a member of the Black Panther Party and a disability rights activist, is pictured next to activist Judith Heumann at a rally in 1977 at Lafayette Square in Washington.

Lomax's personal experience drew him to the disability rights movement. When he joined the Section 504 protests along with a few other Black disabled activists, he inspired the involvement of other Black Panthers. The Panthers kept showing up to feed and supply the disabled protesters occupying the federal building for their nearly month-long protest. The Panthers were a critical source of support for the Section 504 sit-in (Connelly, 2020). Additionally, according to Kitty Cone, the disability protestors felt a strong connection with the Black activists who had inspired them and now supported them: "We felt ourselves the descendants of the civil rights movement of the '60s" (Cone, n.d.).

In the face of lengthy protests and other pressure from the disabled community and their allies, the required regulations were finally implemented, and Section 504 went into effect in 1977. Although Section 504 applied only to select federally-funded entities, not state or private ones, its reach was incredibly significant. Symbolically, the law was the first to establish the civil rights of people with disabilities, prohibiting discrimination and exclusion based on disability (Heumann & Joiner, 2021). Practically, Section 504 began to be used—and is still used—to secure access to places that were previously inaccessible. For example, Section 504 is often viewed as the law that allows children with disabilities to get in the door and stay at school. It empowers a student to demand that a school create an accommodation plan to eliminate disability-related barriers to school attendance. For example, a 504 plan might provide alternate reading materials for a student with dyslexia or allow breaks in the day to help a

child manage an anxiety disorder so they can participate in school. Importantly, Section 504 served as something of a "warm-up" for the later laws discussed here—especially the Americans with Disabilities Act (ADA).

The Education for All Handicapped Children Act of 1975, later renamed the **Individuals with Disabilities Education Act (IDEA)**, was passed in its original form just a few years after Section 504. The IDEA established "special education" services for children who experience disabilities (including mental disorders) that impact their ability to learn and function in school. While Section 504 might allow a child to *be* at school, the IDEA goes a step further and requires that the child be provided with an *education* at school.

The IDEA requires that the government provide a "free and appropriate" public education to all disabled children, just as is provided to nondisabled children. Plans for the education of a disabled child must be outlined in an individualized education program, commonly known as an IEP. The IDEA explicitly disfavors segregation of children due to disability, preferring that all children be educated together when possible (figure 3.6). Today, school systems still regularly engage in the segregation and educational neglect of disabled children, but families can use these laws to advocate for appropriate and inclusive education in light of their child's disability. Before the passage of Section 504 and the IDEA, children with disabilities quite simply had no right to public education at all.

Figure 3.6. A child receives individual support from an adult in a classroom.

Other important disability-related laws—the inclusion of disabled people specifically in the Fair Housing Act of 1988, as well as the Mental Health Parity Act and the Air Carrier Access Act, both passed in 1996—are remarkable for staking out basic opportunities (housing, health insurance,

and air travel) for people with disabilities in very recent history. Likewise, the Americans with Disabilities Act (ADA), which is discussed in detail in the next section, was passed in 1990. The year 2008 in the United States is likely better known for the history-making election of Barack Obama as America's first Black president, but it was also the year that the ADA was amended to ensure protection from discrimination for people with disability stemming from mental disorders (such as mental illness or intellectual disability) or brain-related disorders (such as epilepsy).

The Criminal Justice System in Context

You may wonder: how do access to education, employment, and other activities relate to our topic of people with mental disorders in the criminal justice system? They relate because the criminal justice system is part of our larger world. People who find themselves in the criminal justice system were not always there, and most will not always be there. The people who are now justice-involved are also products of our educational system and past or future participants in the job market, the healthcare system, and the housing market. These community experiences are intertwined with a person's involvement in the criminal justice system. How people are treated and supported in their communities impacts whether or not they will become engaged in the criminal justice system and whether they will be successful when they leave it. You can likely imagine many examples of this connection, but we know that school "failure" due to unmet educational needs—a frequent problem for students with mental disorders—is an enormous risk factor for justice system involvement, and this effect is even more pronounced for children with less social privilege, such as students of color or students in the foster care system (Leone et al., 2003). Education-system handling of mental disorders is very much related to criminal justice system makeup and outcomes.

Likewise, people who work in the criminal justice system—whether they are law enforcement officers, lawyers, corrections staff, or in any other role—are all part of our larger society. Their view of people with disabilities, including mental disorders, is shaped at home and school and refined as they continue into adulthood. If, for example, a young student is led to believe that people with mental disorders do not belong or are not welcome in typical classrooms at school, how might that same person, now a law enforcement officer, treat a person with a mental disorder who they encounter in the course of their work? Will that officer understand that the person with a mental disorder is deserving of respect and is entitled to inclusion in their community and that they need accommodations to do so? Alternatively, if a victim advocate has ridden the bus to work every day alongside a neighbor who experiences an intellectual disability, might that advocate be more able to appreciate the needs of a similarly situated person who appears in their office needing help? Although the specific focus of this textbook is the criminal justice system, that system has to be considered in the context of our larger society, of which it is both a part and a product.

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3.3 The Americans with Disabilities Act

Likely the most significant law impacting disabled people in the United States is the **Americans with Disabilities Act (ADA)**, codified at 42 U.S.C. 12101 *et seq*. The ADA is long and detailed, but the very first section outlining the findings of Congress and the purposes of the law is worth reading to get a sense of its ambitions and the powerful reasons it was passed. You can learn more about **the first section of the ADA [Website]** if you would like to take a look. Simply, the ADA, like Section 504, is a civil rights law that prohibits discrimination against people on the basis of disability. The ADA, however, applies much more broadly than Section 504. The ADA governs all areas of public life, not just federally-funded ones, including the justice systems in every state. This section outlines the history of the ADA and explains its general requirements, including its application to mental disorders.

The ADA was first introduced in Congress in 1988. It was modeled after the Civil Rights Act of 1964, striving to provide access to opportunities for people with disabilities that is equal to that enjoyed by people without disabilities. An important goal of the drafters of the ADA was allowing people with disabilities to achieve greater levels of independence in their lives. While this seems like an uncontroversial goal, passage of the ADA was not without problems that, occasionally, threatened to derail its progress. Even some disability advocates had issues with the bill initially, including concerns about its intent and origins. However, many activists eventually fought for its passage, just as they had done for Section 504 of the Rehabilitation Act (Burgdorf, n.d.).

Activism and Ableism

Dozens of disabled activists joined a climactic demonstration in favor of the ADA in March 1990, just months before the act was finally signed into law. The "Capital Crawl" demonstration was intended to illustrate the barriers faced by disabled people; protesters left their wheelchairs and other mobility aids to crawl up the steps of the U.S. Capitol. One of the demonstrators was Michael Winter, a wheelchair user with a genetic disorder. At the protest, Winter shared the many events in his life where he experienced segregation and discrimination, including being excluded from a regular school, denied access to public transportation, and refused service at restaurants. Another protester was an 8-year-old girl with

cerebral palsy, Jennifer Keelan (pictured in figure 3.7), who led the crawl and remains a disability advocate today (Kaufman, 2015).

Figure 3.7. Eight-year-old Jennifer Keelan leads physically disabled protesters on the March 12, 1990, "Capitol Crawl." If you would like to learn more about **Jennifer (now Keelan-Chaffins) [Website]**, including the children's book she inspired and helped create, follow the link to her webpage.

In 2022, 32 years after she participated in the Capitol Crawl, activist and disability community leader Maria Palacios (pictured in figure 3.8) shared her impressions of the event in a newspaper interview. Palacios was only 24 years old when she participated in the demonstration. She felt "insignificant and yet so important at the same time" to be taking part in a historic event that, after years of struggle for the disability rights community, made such a big difference in people's lives. Palacios recalled that, prior to the passage of the ADA, "we could just be denied access to life." But during the Capitol Crawl, she truly felt for the first time "that we deserve[d] to make those demands, that we deserve[d] to say: 'We are here. We deserve to be here.'"

Palacios today observes lingering discrimination against or devaluation of people with disabilities, a problem known as **ableism**: "I hate to say this, but because of ableism—and it's so deeply rooted in the social structure of our culture—very little has changed" (figure 3.9). Palacios, who self-identifies as a "brown, disabled immigrant" and a "queer mother" also notes that the disability rights movement at the time of the passage of the ADA still marginalized women and people of color (Cabrera & Ybarra, 2022).

Figure 3.8. Activist Maria Palacios in a wheelchair decorated with colorful signs and stickers.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=OdK9Av9XgjE

Figure 3.9. Watch the short video linked here to learn a little more about ableism and to hear from people who are impacted by ableism. **Transcript.**

The ADA officially became law in July 1990, when it was passed by Congress and signed by President George H.W. Bush. People with disabilities had long been excluded from so many aspects of life, and the ADA was poised to open the door to real change. Notably, the law's focus was on eliminating barriers in the environment where disabled people were living, working, or traveling—whether those barriers were in the form of negative attitudes or inaccessible facilities. Many people with disabilities observe that it is not so much their perceived "impairments" that cause them problems—rather, it is a world that is often hostile to their differences. This understanding is called the **social model of disability**, in contrast to the **medical model of disability** (as shown in figure 3.10), which attributes problems to a person's disability itself rather than to the environment (Kurtsikidze, 2017). The social model of disability is the far more practical approach to understanding barriers because the environment is what *can* be changed. That is what the ADA sets out to do.

Figure 3.10. This graphic illustrates the medical model of disability, which conceives of disability as a personal challenge requiring an individual solution, versus the social model of disability, which understands disability as part of the human condition that should be considered in constructing environments.

SPOTLIGHT: Section 504 and Disability Activism

Collective activism was critical to the conception, passage, and enforcement of the ADA and other laws discussed in this chapter. Prior to the protests that forced the implementation of the Section 504 civil rights provisions, much disability advocacy was done at an individual level—such as parents seeking access to education for their children. Significantly, the Section 504 protests brought together many groups of people with various disabilities from different demographics in pursuit of one goal: recognition of their right to participate as equals in society (figure 3.11). If you would like to know more about—and see powerful footage of—the Section 504 protests, consider watching the 18-minute documentary **"The Power of 504" [Streaming Video]**, produced by the Disability Rights and Education Defense Fund.

Figure 3.11. A button worn by protesters and allies at the Section 504 demonstrations. The term "handicapped" was used by the protesters at the time but is a less favored term today, as it is understood to suggest a disadvantage or problem associated with a person's disability, rather than with an inaccessible environment.

At the culmination of the Section 504 protests, victory was announced as the legal regulations that protesters wanted were finalized. At the celebration, organizer Kitty Cone's speech to the gathered crowd expressed the importance of collective action—both in getting results and in allowing protestors to connect with like-minded others, emerging from the isolation that affects so many people with disabilities. You may listen to **Kitty Cone's speech here [Recording]** if you would like. This short **Smithsonian video "How Did Kitty Cone Change Disability Rights?" [Streaming Video]** also reflects on the Section 504

demonstrations, and it speaks in particular to the importance and inspiration of Cone's work as a lesbian disability activist.

If you are interested in an engaging and fascinating story of the larger disability rights movement and a view into the particular challenges of being a disabled female activist, please read Judith Heumann's exceptional book, *Being Heumann: An Unrepentant Memoir of a Disability Rights Activist* **[Website]**. Heumann reflects on the importance of diversity in the success of the Section 504 protests—noting that the joint efforts of all impacted people were required to truly communicate the need for systemic change and to codify those changes in the law. Disability activism was empowered by gender diversity, racial diversity, and disability diversity. If you want a quick glimpse of Heumann in her own words, this **10-minute interview with Trevor Noah on the Daily Show [Streaming Video]** includes stories from Heumann's book as well as her thoughts on the ongoing need for people with invisible disabilities, such as mental disorders, to get support and overcome stigma.

Finally, consider watching and being inspired by the award-winning film produced by Barack and Michelle Obama (preview linked in figure 3.12) about the young people who were part of the grassroots disability rights movement: *Crip Camp: A Disability Revolution* **[Streaming Video]**.

This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=XRrIs22plz0**

Figure 3.12. This optional video is a collection of clips from the full *Crip Camp* documentary. **Transcript.**

Coverage of the ADA

The ADA contains five different sections, called *titles*, that cover different aspects of life where discrimination based on disability is prohibited:

- Title I: **Employers** must offer people with disabilities equal opportunities—equivalent to those offered to nondisabled people—in hiring, training, pay, and other work-related areas.
- Title II: **State and local governments** (e.g., health care, social services, courts) must provide people with disabilities equal opportunity to benefit from programs, services, and activities.
- Title III: **Public transit systems** (e.g., buses, trains) must provide people with disabilities equal opportunity to benefit from public transportation.
- Title IV: **Businesses** (e.g., restaurants, doctors' offices, taxis, office buildings) must provide people with disabilities equal opportunity to access their goods or services.
- Title V: **Telephone companies** must provide accessible service to people with hearing and speech disabilities (Americans with Disabilities Act, n.d.)

Note that the ADA covers most, but not all, aspects of life. Some bans on discrimination against disabled people were addressed in separate, more targeted laws, such as the Fair Housing Act and the Air Carriers Access Act mentioned earlier in this chapter (figure 3.13).

Figure 3.13. Legislation following the passage of the ADA expanded the rights of people with disabilities into areas that weren't previously covered, such as air travel. Service animals who are trained to perform disability-related tasks are permitted on flights under the Air Carriers Access Act.

In each of the areas covered by Titles I through V, the ADA prohibits discrimination against people with disabilities by ensuring that their access to public settings (places, events, services, and opportunities) is equivalent to that of people without disabilities. This is accomplished, as the social model suggests, by changing the environment, where feasible. There are endless examples of barriers that can occur for people with disabilities, and these barriers are often substantial and exclusionary for the person with a disability. However, many barriers are relatively easily removed by the

organization or facility that contains the barrier. If the barrier, whatever it is, is too burdensome to change, then that change is not required by the ADA; only *reasonable accommodations* (discussed more in the next section) are required by the ADA.

For example, ensuring access for a physically disabled person might require a building manager to widen a doorway or rearrange furniture. Sometimes activities might simply be relocated to a more accessible space in a particular building. An employer who is meeting ADA obligations would have to identify and remove other sorts of barriers as well. For example, employers cannot require that a person be able to do things (e.g., work without breaks) if that is not, in fact, an essential element of a particular job. Rather, an employer must consider what qualifications or abilities are actually related to job performance, and the employer must advertise, hire, and promote accordingly. When done properly, this approach opens many job opportunities to people with many types of disabilities.

Mental Disorders as ADA Disabilities

A person falls under ADA protection if they have a *disability* as defined within the ADA. Generally, if a person does not have a disability, the person is not protected under the ADA. One exception to this is a person who is a known close associate (such as a parent caregiver) of a person with a disability. This limited group of people is protected as well, lest employment or other opportunities be denied to them based on their connection to disability or responsibilities arising from their association.

Disability is defined under the ADA as a *physical or mental impairment* that *substantially limits* one or more *major life activities*.

- *Substantially limits* is applied broadly and includes any real limitation beyond, for example, inconvenience imposed by a mild pollen allergy.
- *Major life activities* is also applied broadly and includes eating, walking, thinking, reading, and basic bodily functions

(Americans with Disabilities Act, n.d.; U.S. Department of Justice, Civil Rights Division, n.d.).

But what counts as a *physical or mental impairment*? Physical disabilities, such as those requiring a mobility device like a wheelchair, are often front of mind when thinking about accessibility and inclusion under the ADA because those disabilities are more obvious to outside observers. Many accommodations for physical disabilities (e.g., ramps into buildings, elevators between floors, and lifts onto buses) are commonly observed and used by people with and without disabilities.

The ADA also protects those who experience less obvious or invisible disabilities, such as many mental disorders. However, this fact was not always clear. Courts interpreting the ADA when it was newly passed in the 1990s were quick to exclude many mental disorders from the ADA definition of *disability*, thereby narrowing the scope of the law and excluding a large swath of disabled people from ADA protection (figure 3.14).

Figure 3.14. People with disabilities may need accommodations in the form of equipment or other adjustments. Disabilities requiring accommodation may not always be observable by others.

As applied to people with mental illness, courts began interpreting the ADA in an especially troublesome way. Some courts wanted to link ADA disability status for people with mental illness to their use of and potential to benefit from medication. According to these courts, if a person's condition was subject to improvement, or mitigation of symptoms, through the use of medication, perhaps that person wasn't actually impaired under the ADA. Thus, a person who could effectively treat the symptoms of a serious mental illness with psychiatric medications would not be considered disabled and would not qualify for ADA accommodations. Likewise, a person who could (but did not) take medications—perhaps due to lack of access or intolerable side effects—might be considered "wilfully" impaired, rather than disabled under the law. People with treatable mental illness were caught in a no-win situation: they could lose ADA protection either by taking medication or by not taking medication (Jackson, 2012).

Congress eventually took action to address several ADA issues, including the narrowing of the definition of disability for those with treatable mental illness. The 2008 amendments to the ADA ensured that common mental disorders were specifically included in ADA protections. The amendments also clarified that these conditions would be evaluated in their "unmitigated," or unmedicated, state. It is now understood that serious mental illnesses like bipolar disorder are impairments, regardless of the use or impact of medication. In other words, whether or not a person is taking medication for their bipolar disorder, and whether or not their bipolar disorder is well-managed by medications, they are considered to have a disability under the ADA based on their

diagnosis (U.S. Department of Justice, Office of the Attorney General, 2016).

Current ADA regulations list numerous specific disabilities that are covered, but the list is not exhaustive; other conditions can qualify as well. Disabilities that trigger ADA protection include diabetes, HIV, cerebral palsy, deafness, blindness, and epilepsy. Some examples of covered disorders especially relevant to this text (and discussed in more detail in Chapter 2) are anxiety disorders, PTSD, autism, intellectual developmental disorder, mood disorders (such as bipolar disorder), and traumatic brain injuries. Any of these mental disorders may be identified as a *psychiatric disability* or a *behavioral health disability* when discussing the application of the ADA or other disability-specific laws (Americans with Disabilities Act National Network, 2018).

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Figure 3.11. Image of protest button from the National Museum of American History, Smithsonian Institution, Smithsonian Learning Lab, retrieved September 10, 2023, is included under fair use.

Figure 3.12. CRIP CAMP: A DISABILITY REVOLUTION | Official Trailer | Netflix | Documentary by Netflix is licensed under the Standard YouTube License.

Figure 3.13. Photo of Black Dog Wearing Yellow Bandana in Front of a Plane by Jeswin Thomas on Unsplash.

Figure 3.14. Photo of a Woman with Autism by Alexander Grey on Unsplash.

3.4 The ADA in the Criminal Justice System

The early disability-related legislation that preceded the ADA (shown in the Spotlight in the previous section) certainly shapes participants in the criminal justice system by impacting how this population lived and will live outside of that involvement. However, the ADA has a consistent, direct impact on the operation of the criminal justice system and the treatment of all of the people in the system.

ADA Title II: Regulation of State and Local Governments

The ADA (Title II specifically) regulates state and local government services. Government services include all aspects of a state's criminal and juvenile justice systems. Title II of the ADA prohibits all justice system entities—police, jails, lawyers, courts, community corrections, and pris-

ons—from discriminating against people with disabilities. All of these entities must ensure that people with disabilities (including psychiatric disabilities) have opportunities equivalent to those provided to people without disabilities. Title II protects all justice system participants from discrimination: employees, witnesses, victims, and community members, as well as the accused and convicted people who are the focus of this text.

For people accused of and convicted of crimes, the ADA regulates how people are treated at all stages of the system (from arrest to reentry), including people who are imprisoned and have lost many of their other rights and liberties. As noted by our nation's newest Supreme Court justice, Ketanji Brown Jackson, when she was still a lower court judge in the District of Columbia: "Incarceration inherently involves the relinquishment of many privileges; however, prisoners still retain certain civil rights, including protections against disability discrimination" (*Pierce v. District of Columbia*, 2015, p. 1). In other words, people who have committed crimes and, as a result, may have forfeited freedoms, possessions, and important rights (such as the right to vote) are nevertheless entitled to be free from discrimination based on certain factors—including disability. Even in prison, people may not be treated inequitably due to a disability (figure 3.15).

Figure 3.15. This photograph of a prison dormitory in Oklahoma shows, in the background, a man who uses a wheelchair in custody. People with a variety of disabilities, visible and not, have always been in the prison system. The ADA reduces the barriers they face due to their disabilities.

Accommodation and Modification

Broadly, the ADA recognizes that everyone, including a person with disabilities, has the same right to participate in the justice system, whether that is making a report to police, attending court proceedings, or reentering the community after prison. On a practical level, the ADA means that day-to-day practices of criminal justice entities (such as police transport, court procedures, and prison dormitory arrangements) should be modified as necessary to allow people with disabilities to access them. Modifications can involve physical changes to an environment, but often they are changes to policies, procedures, and behavior. A good example is communication: everyone in the justice system must take steps to ensure effective communication with a person with a disability—whether the disability is deafness, autism, or schizophrenia (Americans with Disabilities Act, n.d.).

The ADA's protection for people with mental disorders and its application to the criminal justice system are of enormous significance for justice-involved people. As you have learned, disability, often in the form of mental disorders, is exceedingly common among those who become engaged in the criminal justice system—whether they are simply accused of an offense, proceeding through trial, or convicted of a crime. A psychiatric or behavioral health disability that involves mental illness, a developmental disorder like autism, or an intellectual disability will trigger ADA protection of the person's rights and prohibit disability-based discrimination against the person. Requiring nondiscriminatory treatment for this substantial population in the criminal justice system increases the effectiveness of the system, ensuring public safety and welfare while reducing improper or excessive criminal justice involvement for people with disabilities.

ADA protections may apply in many situations within the criminal justice system. People who are being arrested, tried, or confined are entitled to reasonable accommodations to ensure that they do not suffer discrimination due to disability. A **reasonable accommodation** is something that meets the needs of the disabled person but does not place an excessive burden on the government entity. As you might imagine, there is considerable discussion in the courts and elsewhere about what these terms mean (what is *reasonable*, and what is an *excessive* burden?), and there is room for interpretation. Courts considering these questions offer some basic guidelines, but new facts considered by various judges ensure the law is continually evolving (Thompson, 2021). A few illustrative examples are as follows:

- A reasonable accommodation for a person with hearing impairments who is being interrogated by the police would be to provide that person with a sign language interpreter so that they have the opportunity to ask questions and tell their side of the story.
- A wheelchair user being transported by police would be reasonably accommodated by transporters safely securing the person's chair in the transport vehicle, both to prevent injury to the person and to preserve their dignity.
- Prison treatment or education opportunities for a person with a mental disorder might require accommodation. For example, a person with schizophrenia might be eligible to join an educational program at the prison but be unable to engage in a full day of classes as required by the normal prison schedule. The ADA should require the prison to consider reasonable program modifications that would not change the essential nature of the program or threaten security to make the program accessible for the person with a disability (figure 3.16).

Figure 3.16. Women in custody participate in educational activities. While prison involves limitations on freedom, if an opportunity is available to inmates without a disability, the same opportunity should be available to inmates with a disability, if that can be reasonably accommodated.

In a real-life example from Minnesota in September 2022, the U.S. Department of Justice determined that Minnesota's Department of Corrections was violating the rights of disabled prisoners when it did not allow them to seek testing accommodations (such as extended testing time) to successfully complete General Educational Development (GED) testing. Minnesota is responding to that finding by making changes to comply with the ADA. These changes will benefit those individual prisoners who want to take and pass the GED, as well as communities that will house and employ these individuals upon community reentry (U.S. Department of Justice, Office of Public Affairs, 2022). The Minnesota case is a perfect example of how the ADA creates equity by making sure people with disabilities are situated similarly to those without disabilities—inside and outside of the criminal justice system.

ADA Protection for All: Victims, Witnesses, and Employees

It is important to reiterate that the ADA applies to *everyone* in the criminal justice system, not just accused or convicted offenders. Victims and witnesses in the criminal justice system benefit from prohibitions on disability discrimination. For example, the ADA must be considered in interviewing victims or witnesses, who may receive accommodations for physical or mental disabilities as necessary to ensure their participation in the justice process. Likewise, when testimony is taken in the courtroom or when parties receive

communication of schedules or proceedings, those things must comply with any required accommodations so no person is shut out of or compromised in their participation in the justice system because of a disability. Courtrooms are public spaces, and they must be accessible for wheelchairs or other mobility devices (figure 3.17). If accommodation for a mental disorder is needed, the accommodation might take the form of an altered schedule to allow the impacted person to participate. As another example, a person with a disorder like autism might benefit from accommodations such as access to communication support (Moss, 2022). Most jurisdictions have ADA coordinators to ensure these accommodations are provided. Take a look at the ADA page for the **Multnomah County Circuit Court [Website]** if you are interested in seeing how local Oregon accommodations might be requested and fulfilled.

Figure 3.17. The exterior of a federal courthouse in Colorado, which has been made physically accessible with ramps bypassing the stairs at the entrances.

Because of the ADA, people working in the justice system in all different roles (lawyers, judges, officers, and staff) also are protected from discrimination due to disability. A disability may not be used as a reason to refuse to hire or promote someone unless a particular ability (e.g., the ability to run, lift certain objects, or work in remote locations) is explicitly listed as an essential part of the job the person has or is seeking. Disability cannot be used to deny or reduce training, advancement opportunities, or payment at a person's job. The ADA does not offer anyone special access or privileges; it simply demands that opportunities be available to people with disabilities on the same terms as they are available to people without disabilities. If you are wondering whether the ADA seamlessly accomplishes its goals, you may be unsurprised to hear that it does not. Sometimes enforcement is needed.

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Figure 3.16. **Photograph of Female Inmate Education Class** by **CoreCivic** is licensed under **CC BY-ND 2.0**.

Figure 3.17. **"Front exterior detail. Wayne N. Aspinall Federal Building and U.S. Courthouse,**

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3.5 Government Enforcement of Disability Rights

The **U.S. Department of Justice (DOJ)** is the federal agency that enforces the laws of the United States. The DOJ is thus the primary protector of the rights of individuals under the ADA, as well as other federal laws and the Constitution. The DOJ's Civil Rights Division in particular is tasked with responding to discrimination and violations of individual rights. The DOJ may offer its input in private lawsuits, it may respond to and act on complaints brought to its attention by individuals, or it may bring its own legal actions. Investigations and lawsuits regarding disability rights that are brought or joined by the DOJ are intended to force change broadly. They may be directed at one police department or one prison, but they are intended to be observed and set a precedent for others to follow.

DOJ Enforcement Related to Mental Disorders

Over the past decade, a significant number of DOJ-involved enforcement cases have focused on people with mental disorders in the criminal justice system. These cases assert that the rights of people with disabilities have been violated under the ADA, other federal laws, or the Constitution. These disability lawsuits continue to push forward change, slowly but surely, for the people who are the subject of our text. Cases range in topic, but the general theme is that an individual or a group of people are situated differently from others in terms of their ability to succeed, not due to the *existence* of their disability but because of the system's failure to create a level playing field by properly *accommodating* it.

As a recent (and as of this writing, ongoing) example, the New York case *M.G. v. Cuomo* alleges that people with serious mental illness suffer from a lack of treatment and housing options upon release from prison. The gist of this lawsuit is that people with psychiatric disability are in a fundamentally different position than those without these diagnoses at the point of reentry into the community. This is because people with serious mental illness are much more likely to be confined in an institution, whether they are held in prison longer or whether they are released to institutional care. The lawsuit claims that the system needs to change to prevent that outcome. People shouldn't be more likely to be confined due to a disability than to disability-neutral factors, such as the nature of their crime. Whatever its outcome, *M.G. v. Cuomo* will impact operations in New York and elsewhere (figure 3.18). New York specifically may be required to make changes based on the court's decisions, but other states also will observe and learn (U.S. Department of Justice, Civil Rights Division, 2024).

Figure 3.18. A lawsuit in New York, or any state, can impact outcomes for people in the justice system everywhere, as other jurisdictions may follow these examples.

An Oregon example of DOJ enforcement of the rights of a group of people with mental disorders is the lawsuit that was brought by the DOJ and resolved by a settlement with the Portland Police Bureau in 2012. That case alleged that the Portland Police Bureau was engaged in a pattern of violations involving excessive force used against people with mental disorders. The killing of James Chasse, a Portland man with schizophrenia, was one among several events that gave rise to the case. This case resulted in the City of Portland agreeing to enact numerous changes and reforms. More information on that case, and about Chasse and his death, is provided in Chapter 5 of this text.

Civil Rights of Institutionalized Persons Act

The 1980 **Civil Rights of Institutionalized Persons Act (CRIPA)** provides an option for the federal government to specifically protect the civil rights of people who are in institutions. This law was created after the 1970s public outcry against conditions at institutions that were still routinely housing people with mental disorders throughout the United States. An infamous offender was Willowbrook State School, a New York facility where thousands of children with mental disorders and disabilities were kept in horrid conditions and subjected to deeply unethical medical experimentation. This reality was brought into the public view when then-Senator Robert Kennedy toured the facility, calling it "a snake pit," and a television documentary about the place, full of disturbing

images, was released (Nicols, 2022). If you are interested in learning more about Willowbrook and its history, you may want to watch **a recent Public Broadcasting Service video on the topic [Website]**.

The long-overdue legislation known as CRIPA does not focus specifically on people with disabilities; it applies to everyone who is in a facility (e.g., jail, prison, juvenile hall, or state hospital). However, numerous CRIPA cases do relate to people with mental disorders because this population is so heavily represented in institutions—and because they are so vulnerable to neglect and harm in these environments. In 2020, the DOJ concluded a CRIPA investigation of the Massachusetts Department of Corrections (MDOC), ultimately concluding that MDOC had violated the Eighth Amendment to the Constitution, which prohibits cruel and unusual punishment. MDOC had failed to properly supervise and care for prisoners who were in mental health crises, resulting in some of these prisoners hurting themselves, and even dying, while on supposed mental health watch (U.S. Department of Justice Office of Public Affairs, 2020).

The DOJ also recently (in 2022) concluded a 2-year CRIPA investigation of the Parchman State Penitentiary, located in the Mississippi Delta. The prison is the state's oldest, and it holds nearly 2,000 people. At Parchman, Black Mississippians make up 70% of the population, even though Black people make up only 37% of the state's general population. In its investigation, the DOJ found that the Mississippi Department of Corrections had violated the Constitution in several specific ways, including failing to provide adequate treatment to people with serious mental illness, failing to enact sufficient suicide prevention, failing to prevent violence between confined people, and subjecting people to prolonged solitary confinement in egregious and harmful conditions. These violations had resulted in at least 10 homicides and 12 suicides at Parchman since 2019, when weeks of prison riots drew national attention to the long-standing problems.

The DOJ recognized that its work in the Parchman case targeted the intersection of race, disability, and criminal system involvement: "The importance of the department's work in remedying unconstitutional conditions of confinement is significant and far-reaching. Over two million people currently reside in our nation's prisons and jails. People of color and those with mental illness are disproportionately represented among them" (Clarke, 2022).

A documentary intended to expose the history of and conditions at Parchman, and to inform the public about the various legal actions there, was produced by Roc Nation, the entertainment company founded by artist and entrepreneur Jay-Z, and aired on television in June 2023. Watch the clip from that program (linked in figure 3.19) if you are interested in learning more about Parchman.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=PG-DObKhRi8

Figure 3.19. This short clip from the longer documentary *Exposing Parchman* (2023) offers a glimpse of some of the horrible conditions existing at Parchman prison. **Transcript.**

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Figure 3.18. Photo of NYPD neon sign by Janne Simoes on Unsplash.

Figure 3.19. Exposing Parchman by Roc Nation is licensed under the Standard YouTube License.

3.6 Individual Enforcement of Civil Rights

While Department of Justice actions allow the federal government to bear the burden of identifying and investigating problems and then enforcing its own laws, more isolated or individual violations are unlikely to be federal government enforcement priorities. In those cases, individuals can and do initiate lawsuits. Impacted individuals might sue a government official or entity—such as a corrections official or a police department—to enforce their civil rights under the Constitution or statutes. These lawsuits take many forms, but they generally claim that a person's rights were violated and that they suffered some injury as a result of that violation. Lawsuits like this can be critically important to enforcing laws or constitutional provisions that—like so many civil rights provisions—are "on the books" but not being observed in reality.

ADA Enforcement Lawsuits

The ADA is one vehicle for individual civil rights claims. The ADA does not provide for monetary damages; lawsuits may demand change, but they will not compensate a plaintiff. However, attorney fees may be recovered, which can encourage legal service organizations to represent ADA plaintiffs and causes. Additionally, individual states have laws based on the ADA that do allow the collection of monetary damages. Those laws are beyond the scope of this text but are certainly worth investigating in your jurisdiction.

Federal ADA lawsuits claiming criminal justice-related violations of rights can be brought under several different legal "theories" or approaches, all of which essentially assert that a state or local government entity (e.g., a department of corrections) failed to do something that was required to create equity for people with disabilities. An ADA lawsuit might focus on the wrongful arrest of a person, the failure to accommodate a disability, or the failure to train relevant personnel, resulting in disability-related harm. These different theories have a good deal of overlap, and a single set of facts might allow arguments or claims based on different theories (Levin, 2017). Consider how each of the scenarios described below could be framed in different ways to challenge criminal justice professionals' conduct, preparation, or knowledge based on the ADA:

- **Wrongful arrest** might be alleged when a person suffering a mental health episode appeared intoxicated and was detained for that behavior. The arrest could be an innocent accident, or it could be a wrongful arrest due to the officer's unacceptable failure to appreciate information that reasonably would have informed them that the person was displaying

signs of a disability rather than voluntary intoxication.

- A reasonable accommodation in response to a mental health crisis call might involve law enforcement including mental health professionals to help avoid a dangerous escalation of events. A deliberate failure to take this safety measure might provide grounds for a complaint of **failure to accommodate**.
- Finally, **failure to train** could involve an assertion that a criminal justice professional was not provided with adequate necessary training to keep a person with a disability safe in a particular situation—perhaps a seriously depressed person in jail who was unrecognized and engaged in self-harm. When the failure to recognize the situation and keep the person safe is attributable to a failure to provide proper training, an ADA violation may exist.

The U.S. Department of Justice has published tips and suggestions for criminal justice entities, encouraging adequate training as well as other measures to comply with Title II of the ADA—and presumably avoid legal action (U.S. Department of Justice, Civil Rights Division, 2017). However, as discussed in the next sections, individual claims like those described here are both difficult to bring and challenging to win, even when plaintiffs have experienced serious harm.

Outcomes in Civil Rights Lawsuits

Whether brought pursuant to the ADA or on other legal grounds, civil rights lawsuits are typically complex, lengthy, and expensive. Sometimes these lawsuits can vindicate a particular individual's rights, and sometimes they promise broader change by establishing a new rule or precedent that applies beyond an individual case. However, these are hard-won victories, and often plaintiffs have a very challenging time even finding and paying skilled legal representatives to pursue these lawsuits. Nevertheless, there are notable examples when lawsuits have brought critical change to the treatment of people with mental disorders.

Advocacy organizations like the American Civil Liberties Union (ACLU) or disability rights groups may represent individuals in bringing these lawsuits, as they also further the organization's larger advocacy objectives. For example, the nonprofit Disability Rights Oregon has been engaged in on-and-off litigation for more than 20 years now, ensuring that people with mental disorders who are too impaired or sick to proceed in criminal cases do not languish in jail for weeks and months while awaiting admission to the Oregon State Hospital for evaluation and treatment. If you would like to learn more about this litigation, you can read about Disability Rights Oregon's mental-health-related work at **Disability Rights Oregon [Website]**.

The Atlanta Legal Aid Society brought a disability rights lawsuit on behalf of Lois Curtis (introduced at the beginning of this chapter) in 1995, resulting in what is usually viewed as the most important Supreme Court decision on the rights of people with mental disorders (figure 3.20). The case of *Olmstead v. L.C.* (1999) was based on the Americans with Disabilities Act and challenged the disability-based confinement of Curtis and her co-plaintiff. The *Olmstead* case established the important principle that people with disabilities should not be segregated without justification (Bazelon Center for Mental Health Law, n.d.). See the Spotlight in this chapter to learn more about the *Olmstead* plaintiffs and their case.

Figure 3.20. Decisions by the Supreme Court, like that in the *Olmstead* case, are critical interpretations of laws that then become the law of the land.

Although *Olmstead* was not a criminal justice case specifically, its principles have the potential to inform approaches to people with mental disorders in the criminal justice system. Criminal justice scenarios are a common place for separation to occur in the name of protecting people with mental disorders or protecting others from people with mental disorders. Under the law after *Olmstead*, less restrictive environments have to be considered for people with mental disorders who might otherwise be segregated in the name of providing care. *Olmstead* has been cited to encourage the diversion of people out of the criminal legal system (discussed in **Chapter 4**), protest the use of very restrictive or solitary placements in prison, challenge the institutionalization of people before and after criminal convictions, and object to jail-based treatment for accused people who are mentally ill (discussed in **Chapter 9**). Students and criminal justice professionals should consider how the rule against segregation expressed by *Olmstead*, which is contrary to the entire notion of imprisoning people with mental disorders, might be employed to reform and reduce incarceration more broadly (McDonough, 2021; Morgan, 2020).

Constitutional Claims: Right to Care and Treatment

Individuals in the criminal justice system can bring claims based on their rights under the Constitution. For example, one particular issue that frequently applies to people with mental disorders in custody is the right to receive adequate medical treatment—including mental health treatment—based on the Eight Amendment to the Constitution. Similarly, prisoners have a related

right to be protected from self-harm in the event they are suicidal. In lawsuits regarding these rights, failure to provide adequate care is framed as a violation of a person's Eighth Amendment right to be free of cruel and unusual punishment.

Constitutional cases are very difficult for plaintiffs to prove and win, as they typically require evidence that the offending jail or prison personnel *knew* of a serious problem or threat and *chose* not to provide the required help or treatment, a challenging standard called **deliberate indifference** (*Farmer v. Brennan*, 1994). Nevertheless, despite significant obstacles, people injured by lack of mental health care in custody do bring lawsuits, and occasionally they win. When lawsuits based on lack of treatment are successful, and even sometimes when they are not, they can bring attention to problems and help carve out the increasing expectation that the criminal justice system must meet the legitimate needs of people with mental disorders. See **Chapter 7** for additional discussion of deliberate indifference in the context of prison-based health care.

Although any number of cases could serve as an example of private litigation being used to enforce prisoners' rights to mental health care, an Arizona case that was partially resolved in the summer of 2022 is illustrative of both the importance of those cases and the difficulties they pose (figure 3.21). That case, *Jensen v. Shinn*, was filed by a group of prisoners represented by the ACLU and the Arizona Center for Disability Law in 2012.

Figure 3.21. An Arizona prison facility in a desert-like landscape with mountains behind it.

The *Jensen* prisoner plaintiffs were not asking for monetary damages; they were asking for the court to give them some relief from their oppressive living conditions. After twelve years of fighting Arizona prison officials—and producing mountains of evidence of pervasive failure to meet the medical and mental health needs of prisoners in numerous ways—the plaintiffs finally got the case to trial, and a judge ultimately found that the prisoners' rights had been violated (ACLU, 2024). The evidence showed, overwhelmingly, that health care in the prison was grossly inadequate and that hundreds of people were being kept in restrictive maximum custody for no legitimate reason. In the judge's 200-page order describing her findings, she characterized prison conditions as cruel and shocking, and she ordered many changes be made—changes that lawyers must now fight to put into effect (ACLU, 2024). If you are interested, you can read more about the ongoing *Jensen* case, now called *Jensen v. Thornell*, at the **Arizona Center for Disability Law [Website]**.

SPOTLIGHT: Integration of People with Mental Disorders: The Olmstead Case

In the 1990s, two women, Lois Curtis ("L.C.") and Elaine Wilson, both of whom had mental disorders, were confined to a Georgia hospital where they received care funded by the state. Curtis had been at the hospital since she was 11 years old; Wilson had been in and out of many institutions, eventually landing at the hospital. Over time, it became clear to Curtis and Wilson, and to their care providers, that the women were capable of living in less restrictive environments in the community. They both wanted to and were capable of living in home-like settings with proper support. Neither woman required or desired confinement or the care of a hospital. However, the State of Georgia, via its Department of Human Services, refused to fund more independent care, and so the women remained in the hospital—against their wishes and at taxpayer expense. Their hospitalization continued for years.

Curtis and Wilson, represented by an Atlanta Legal Aid lawyer, eventually sued Tommy Olmstead, the Georgia Department of Human Services commissioner. Olmstead's refusal to shift funding to a community setting had kept Curtis and Wilson segregated in a hospital, but his name was about to become synonymous with the idea that segregation of people with disabilities is wrong (Appelbaum, 2019).

Curtis and Wilson's lawsuit pointed out that Olmstead's actions violated Title II of the ADA, which regulates state and local governments. People without their particular disabilities would have had the opportunity to live in the community, and they should have the opportunity to do the same. The ADA, they contended, gave them the right to receive services they might need in the same way nondisabled people would, in a less restrictive, integrated, community-based setting. This right should not be overshadowed by Georgia's apparent preference for funding institutional care. The women argued that their segregation in a hospital was unnecessary and violated the ADA.

The case made its way to the U.S. Supreme Court, which agreed with Curtis and Wilson. The court ruled that segregation of these women in a hospital—not allowing them to live with others in the community—was not required by the women's disabilities, but rather was due to the unwillingness of authorities to reasonably modify their response. The perpetuation of unnecessary segregation of these women was discrimination based on disability, which violated the ADA.

Justice Ruth Bader Ginsburg (figure 3.22) wrote the court's 1999 opinion in *Olmstead*, emphasizing that this type of segregation imposed upon people with mental disorders "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life" and observed that institutional confinement "severely diminishes the everyday life activities of individuals." (*Olmstead v. L.C.*, 521 U.S. at 583).

Figure 3.22. Justice Ruth Bader Ginsburg, the first Jewish woman and the second woman ever to sit on the Supreme Court, in her 2016 portrait. Ginsburg, who was nominated to the Supreme Court in 1993, was well-known as a women's rights advocate but is less commonly recognized for her significant contribution to disability rights.

The *Olmstead* decision was transformational. For Curtis and Wilson, their desire to live in the community was vindicated. For people who experience mental disorders throughout the nation, in all manner of institutional settings and supervised by local governments, the implications of Curtis and Wilson's case were enormous. The Supreme Court had affirmed that people with disabilities cannot be kept in a limiting or confining environment based on government preference when that type of removal from the community is not justified by the real needs of the person's care. If people can be included in the community, they should be.

Elaine Wilson died just a few years after she was finally allowed to live in her own home with a caregiver. Like her co-plaintiff, Wilson had begun her life of segregation as a child, after a high fever left her with disabilities, and she was moved in and out of facilities (which she despised) dozens of times. Reportedly, once Wilson was finally living in the community, she experienced joy in her new life: "'We saw Elaine became very independent and very proud of her independence,' [a caregiver] said. 'She loved to shop at Walmart and Kmart and the grocery store. One of her hobbies was to clip grocery coupons in the Sunday paper. She spent hours picking out greeting cards. She loved to visit people and have people come visit her. She was a very social person'" (Henry, 2004).

Until her death in 2022, Lois Curtis also engaged in her community and worked as an artist, pursuits that were not out of reach despite her diagnoses of developmental disability and schizophrenia, once her environment had adjusted to her needs. If you would like, you can see some of **Curtis's artwork [Website]** online. Curtis gave one of her self-portraits to President Barack Obama in a ceremony (pictured in figure 3.23) celebrating her advocacy in the *Olmstead* case (Brandman, 2022).

Figure 3.23. Lois Curtis, along with a support person, shares a painting she created with President Barack Obama at the White House in 2011.

Lois Curtis was asked in an interview, years after her Supreme Court case, what she would wish for all the people she had helped to move out of institutions and live in their communities. Curtis responded: "I hope they live long lives and have their own place. I hope they make money. I hope they learn every day. I hope they meet new people, celebrate their birthdays, write letters, clean up, go to friends' houses and drink coffee. I hope they have a good breakfast every day, call people on the phone, feel safe" (Curtis & Sanders, n.d.).

Of course, the victory of Lois Curtis impacted all people with disabilities, but many also see particular meaning in a Black woman fighting for and establishing her right to choice and bodily autonomy. Watch the short video linked in figure 3.24 to hear that perspective from people who admire her legacy.

This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=owU8bmGyZ0g**

Figure 3.24. Lois Curtis is honored for her contributions to the freedom of all people with disabilities, especially people of color. **Transcript.**

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Figure 3.21. "Arizona prison facility" by Xugardust is licensed under CC BY-SA 2.0.

Figure 3.22. "Ruth Bader Ginsburg 2016 portrait" by Steve Petteway is in the public domain.

Figure 3.23. Photograph of Lois Curtis with President Barack Obama by Pete Souza is in the public domain.

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Figure 3.24. Lois Curtis Documentary Trailer – 2023 Anniversary of Olmstead v. L.C. (Lois Curtis) by Bazelon Center is licensed under the Standard YouTube License.

3.7 Chapter Summary

- The law, in the form of both statutes and case law (court decisions), has been critical in curbing discrimination based on disability and enabling disabled people to access opportunities that are equivalent to those available to nondisabled people. Since the 1960s, laws have ensured progressively more access to community opportunities for people with disabilities, ranging from education to housing to jobs and more.
- Section 504 of the Rehabilitation Act of 1973 was the first law that recognized the civil rights of people with disabilities. This law, and the laws that followed, were a product of the disability rights movement that began in the 1970s and continues into the present.
- The ADA, passed in 1990, created broader access for people with disabilities as it applied to many areas of life. The ADA has been amended to clarify its application to people with mental disorders, or psychiatric disabilities, whether or not a particular person's condition is medicated or otherwise managed at a given moment.
- The ADA applies in the criminal justice system, which is composed of government entities specifically regulated by Title II of the ADA. The ADA requires that the criminal justice system accommodate the reasonable needs of people with disabilities in the system.
- The legal rights of people with disabilities in the criminal justice system may be enforced by the federal government as well as individuals. Government investigations and lawsuits are intended to force change in state and local government agencies. Individual lawsuits can also vindicate rights. One of the most important private lawsuits impacting people with disabilities, inside and outside of the criminal justice system, was *Olmstead v. L.C.* The *Olmstead* case established the rule that people with disabilities cannot be unnecessarily segre-

gated from other members of their community due to their disabilities.

KEY TERM DEFINITIONS

- **Ableism:** Discrimination against, exclusion of, or devaluation of people with disabilities.
- **Americans with Disabilities Act (ADA):** A civil rights law that prohibits discrimination against people on the basis of disability.
- **Civil rights**: Personal rights guaranteed and protected by the Constitution and laws. Civil rights include the right to vote and the right to access public establishments, among many others, where different treatment or discrimination is prohibited.
- **Civil Rights of Institutionalized Persons Act (CRIPA)**: A federal law that allows the federal government to protect the civil rights of people who are in a facility such as a jail, prison, juvenile hall, or state hospital.
- **Deliberate indifference:** A legal standard of proof required in some civil rights cases involving the criminal justice system, meaning that an official was aware of a substantial risk of harm but chose not to take action to avoid that harm.
- **Discrimination:** Different or unfair treatment of a person based on their status, e.g., disability.
- **Failure to accommodate:** A legal claim based on discrimination that alleges a failure to provide a disabled person with reasonable accommodations to place them on equal footing with nondisabled people.
- **Failure to train**: A legal claim intended to hold an agency or supervisors liable for their employees' conduct by asserting that lack of training caused the employee to do the harmful act.
- **Individuals with Disabilities Education Act (IDEA):** A law that established "special education" services for children who experience disabilities that impact their ability to learn and function in school. The IDEA requires that all students be provided with an appropriate and inclusive education.
- **Medical model of disability**: An understanding of disability that attributes associated problems to the person's impairment. This model contrasts with the social model of disability, which recognizes that the environment creates barriers—not the disability
- **Reasonable accommodation:** An adjustment or modification that removes a barrier for a disabled person but does not place an excessive burden on the person providing the accommodation.
- **Section 504 of the Rehabilitation Act:** A federal law prohibiting discrimination against people with disabilities in certain federal government contexts.
- **Social model of disability:** An understanding of disability as an aspect of a person's identity rather than as a source of problems, recognizing that environments present barriers for people who experience disability.
- **U.S. Department of Justice:** The federal agency that enforces the laws of the United States.

- **Wrongful arrest:** A legal claim asserting that an arrest of a person is unlawful and unreasonable. In the disability context, wrongful arrest may involve an arrest based on disability-related conduct that is treated as criminal conduct.

DISCUSSION QUESTIONS

- Identify the different branches of government that are involved in protecting the civil rights of people with disabilities. How does activism play a role in our legal system?
- What is ableism, and how does it impact people with mental disorders? What examples of ableism have you seen in your community, your school or workplace, or the media?
- The *Olmstead* case described in the text was significant in clarifying the rights of people with mental disorders to be free of overly restrictive living environments. How might the principles of the *Olmstead* case apply to people with mental disorders in the criminal justice world?
- Is it important that people with mental disorders are considered part of the larger disability community? How might this perspective impact outcomes for this group?

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3.8 References

Accessibility.com. (n.d.). *Timeline of disability rights in the United States.* https://www.accessibility.com/resources/timeline-of-disability-rights

Americans with Disabilities Act. (n.d.). *The Americans with Disabilities Act (ADA) protects people with disabilities from discrimination.* https://www.ada.gov/

Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 (2008 [as amended]). https://www.ada.gov/law-and-regs/ada/

Americans with Disabilities Act National Network. (2018). *Mental health conditions in the workplace and the ADA*. https://adata.org/factsheet/health

American Civil Liberties Union. (2024, May 12). *Jensen v. Thornell*. https://www.aclu.org/cases/jensen-v-thornell

Appelbaum, L. (2019, March 15). *Lois Curtis: Woman with disabilities fights for freedom for all.* RespectAblity. https://www.respectability.org/2019/03/women-disabilities-lois-curtis/

Bazelon Center for Mental Health Law. (n.d.). *The Olmstead case*. https://www.bazelon.org/the-olmstead-case/

Brandman, M. (2022). *Lois Curtis*. National Women's History Museum. https://www.womenshistory.org/education-resources/biographies/lois-curtis

Burgdorf, R. (n.d.). *A dozen things to know about the ADA.* Burgdorf on Disability Rights. https://adachronicles.org/stories-essays/a-dozen-things-to-know-about-the-ada/

Cabrera, K., & Ybarra, G. (2022, August 1). 'Capitol Crawl' participant recounts defining moment in disability rights—and where ADA has fallen short. *Texas Standard.* https://www.texasstandard.org/stories/activist-maria-palacios-recounds-1990-capitol-crawl-americans-disabilities-act/

Clarke, K. (2022, April 20). *Assistant Attorney General Kristen Clarke delivers remarks on findings that conditions at Mississippi State Penitentiary violate the Constitution*. [Speech transcript]. U.S. Department of Justice, Office of Public Affairs. https://www.justice.gov/opa/speech/assistant-attorney-general-kristen-clarke-delivers-remarks-findings-conditions

Cone, K. (n.d.). *Short history of the 504 sit-in*. Disability Rights Education & Defense Fund. https://dredf.org/504-sit-in-20th-anniversary/short-history-of-the-504-sit-in/

Connelly, E. A. (2020, July 8). Overlooked no more: Brad Lomax, a bridge between civil rights movements. *The New York Times*. https://www.nytimes.com/2020/07/08/obituaries/brad-lomax-overlooked.html

Curtis, L., & Sanders, L. (n.d.). *Lois Curtis on life after Olmstead*. ICI Webpub System. https://publications.ici.umn.edu/impact/28-1/lois-curtis-on-life-after-olmstead

Disability Rights Education & Defense Fund. (n.d.). *Celebrating Kitty Cone: 1944–2015*. https://dredf.org/2015/03/25/celebrating-kitty-cone-1944-2015/

Farmer v. Brennan, 511 U.S. 825 (1994). https://supreme.justia.com/cases/federal/us/511/825/

Henry, D. (2004, December 10). Elaine Wilson obituary. *The Atlanta Journal-Constitution.* https://www.legacy.com/us/obituaries/atlanta/name/elaine-wilson-obituary?pid=2907375

Heumann, J. E. & Joiner, K. (2021). *Being Heumann: An unrepentant memoir of a disability rights activist*. Beacon Press.

Jackson, J.M. (2012). The Americans with Disabilities Act, mental illness, and medication: A historical perspective and hope for the future. *Marquette Elder's Advisor, 12*(1), 218-46. https://scholarship.law.marquette.edu/elders/vol12/iss1/10

Kaufman, S. (2015, March 12). *They abandoned their wheelchairs and crawled up the Capitol steps*. https://archive-share.america.gov/crawling-up-steps-demand-their-rights/

Kurtsikidze, M. (2017, June 14). *Disability is caused by the way society is organized and not by a person's impairment, UNICEF says*. [Press release]. https://www.unicef.org/georgia/press-releases/disability-caused-way-society-organized-and-not-persons-impairment-unicef-says

Leone, P.E., Christle, C.A., Nelson, M., Skiba, R., Frey, A., & Jolivette, K. (2003, October 15). *School failure, race, and disability: Promoting positive outcomes, decreasing vulnerability for involvement with the juvenile delinquency system.* The National Center on Education, Disability, and Juvenile Justice. https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=6544d2531b05e7198b53a49bad4c5ffe41afa17c

Levin, R. (2017, January). Responsiveness to difference: ADA accommodations in the course of an arrest. *Stanford Law Review, 69*. https://review.law.stanford.edu/wp-content/uploads/sites/3/2017/01/69-Stan-L-Rev-269.pdf

McDonough, L. (2021, April 13). Prison reform and Olmstead. *The Regulatory Review, A publication of the Penn Program on Regulation*. https://www.theregreview.org/2021/04/13/mcdonough-prison-reform-and-olmstead/

Morgan, J. N. (2020, Winter). The paradox of inclusion: Applying Olmstead's integration mandate in prisons. *Georgetown Journal on Poverty Law & Policy,27*(2). 305-17. https://www.law.georgetown.edu/poverty-journal/in-print/volume-27-issue-ii-winter-2020/the-paradox-of-

inclusion-applying-olmsteads-integration-mandate-in-prisons/

Moss, H. (2022, October 4). *Autism within the criminal justice system.* Organization for Autism Research. https://researchautism.org/oaracle-newsletter/autism-within-the-criminal-justice-system/

Nicols, C. (2022, May 20). Deinstitutionalization of mental healthcare in New York. *NYC Department of Records & Information Services.* https://www.archives.nyc/blog/2022/5/20/oq2ongk62te2ht5zrnlikfg0g6gv98

Olmstead v. L. C., 527 U.S. 581 (1999). https://supreme.justia.com/cases/federal/us/527/581/

Pierce v. District of Columbia, 1:2013-cv-00134 (D.D.C. 2015). https://law.justia.com/cases/federal/district-courts/district-of-columbia/dcdce/1:2013cv00134/158123/90/

Social Security Administration, Special Collections (n.d.). *Chronology 1600s – 1800s* [Archival or historical document]. https://www.ssa.gov/history/1950.html

Temple University. (n.d.). *Disability Rights Timeline*. College of Education and Human Development, Institute on Disabilities. https://disabilities.temple.edu/resources/disability-rights-timeline

Thompson, R.M. II. (2021, June 8). *The Americans with Disabilities Act (ADA) and on-the-street police encounters*. Congressional Research Service. https://crsreports.congress.gov/product/pdf/LSB/LSB10606

U.S. Department of Health and Human Services, Office for Civil Rights. (2006). Your rights under Section 504 of the Rehabilitation Act [Fact Sheet]. https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf

U.S. Department of Justice, Civil Rights Division. (n.d.). *Introduction to the American with Disabilities Act*. https://www.ada.gov/topics/intro-to-ada/

U.S. Department of Justice, Civil Rights Division. (2017). *Examples and resources to support criminal justice entities in compliance with Title II of the Americans with Disabilities Act* [Archive]. https://archive.ada.gov/cjta.html

U.S. Department of Justice, Civil Rights Division. (2024, January 16). *M.G. v. Cuomo*. https://www.justice.gov/crt/case/mg-v-cuomo

U.S. Department of Justice, Office of the Attorney General. (2016, October, 11). *Amendment of Americans with Disabilities Act Title II and Title III regulations to implement ADA Amendments Act of 2008*. https://archive.ada.gov/regs2016/final_rule_adaaa.html

U.S. Department of Justice, Office of Public Affairs. (2020, November 17). *Justice Department alleges conditions at Massachusetts Department of Corrections violate the Constitution* (Press Release No. 20-1247). https://www.justice.gov/opa/pr/justice-department-alleges-conditions-massachusetts-department-corrections-violate

U.S. Department of Justice, Office of Public Affairs. (2022, October 3). *Justice Department finds Minnesota Department of Corrections violates rights of incarcerated individuals with disabilities* (Press Release No. 22-1054). https://www.justice.gov/opa/pr/justice-department-finds-minnesota-department-corrections-violates-rights-incarcerated

CHAPTER

4

Reducing Criminalization of Mental Disorders

4.1 Chapter Learning Objectives and Overview

LEARNING OBJECTIVES

The following learning objectives tell you what is most important in this chapter. Use these statements as a guide to make sure you get the most out of this chapter.

1. Describe the problem of criminalization of mental disorders, particularly among multiply-marginalized populations.
2. Discuss the importance and impact of diverting people with mental disorders out of the criminal justice system.
3. Compare and contrast diversions that may be accomplished at different points in the criminal justice system.
4. Evaluate the role of specific interventions (e.g., mental health courts) in the effort to avoid criminalization of mental disorders.

KEY TERMS

Look for these important terms in the text in bold. Understanding these terms will help you meet the learning objectives of this chapter. You can find definitions for these terms at the end of the chapter.

- **Community corrections**
- **Criminalization of mental disorders**
- **Diversion**
- **Intercept**
- **Mental health court**
- **National Alliance on Mental Illness (NAMI)**
- **Pretrial services**
- **Problem-solving courts**
- **Reentry**
- **School-to-prison pipeline**
- **Substance Abuse and Mental Health Services Administration (SAMHSA)**
- **Sequential Intercept Model (SIM)**

Chapter Overview

Imagine a person who experiences multiple mental disorders; we can call them Jamie. Jamie is unhoused, has recently been unable to access prescribed medication, and has become increasingly mentally ill. Jamie lives in a makeshift shelter in the park and uses various substances. Jamie has created a pile of garbage and miscellaneous items near a playground structure in the park, blocking the sidewalk and limiting access for people who use the park (figure 4.1). Neighborhood residents and park users call for help from local authorities. Police respond and confront Jamie, who becomes belligerent and resists intervention. Police arrest and then hold Jamie for several hours due to perceived safety risks. While in custody, Jamie spits on the face of a deputy at the jail, incurring a more serious assault charge.

Figure 4.1. Garbage that might be found where an unhoused person is living is a result of a lack of housing and a legitimate safety issue. Criminalization is at risk of occurring when a community nuisance or safety threat exists primarily because of a person's mental disorder.

As we have learned in previous chapters, and as Jamie's story illustrates, communities may struggle to find appropriate (i.e., effective, ethical, and positive) responses to people who experience mental disorders. The challenge of responding appropriately increases when mental disorders are difficult to manage, as when they cause disruption or offending behavior. Although most people with mental disorders do not show this type of behavior, when it does happen, it may require some sort of community safety response. Because our modern community response to public disruption generally involves law enforcement, people with mental disorders have been introduced disproportionately into the criminal justice system via law enforcement encounters and everything that may follow, including arrest, detention, conviction, and incarceration. That outcome is generally identified as a problem—the criminalization of mental disorders.

This chapter discusses the problem of criminalization and the reasons that it exists. The chapter goes on to consider diversion, or redirection, opportunities for people who have been drawn into the criminal justice system due to mental disorders. Diversions can happen at numerous points along the criminal justice system pathway—from first police contact to post-prison or post-jail reentry into the community. In this chapter, you will learn about diversion opportunities throughout the criminal justice system and consider how these approaches may reduce the criminalization of mental disorders.

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Figure 4.1. Photo of bottles on soil by Jonathan Gonzalez on Unsplash.

4.2 Criminalization of Mental Disorders

Perhaps Jamie, described in the chapter overview, is soon released from custody—without resolution of housing issues, medical and psychological problems, or substance use; without increased access to healthcare and medications; and with a new legal barrier: criminal charges. Alternatively, perhaps Jamie is too mentally ill to even understand what has happened, so Jamie stays in jail a while longer, awaiting an evaluation and legal negotiations. At this point, Jamie still has not resolved any existing issues, likely has exacerbated mental health symptoms, and is sitting in custody. The criminal justice system has been employed to address real problems, but it has arguably made these problems worse. Most of us can also imagine far worse outcomes, for everyone involved, that might have occurred when police responded to Jamie in the community, especially if a weapon had been involved. Jamie's story is just one example of the problem of criminalization (figure 4.2).

Figure 4.2. Criminalization of mental disorders can exacerbate preexisting problems of isolation and mental illness for people who are arrested.

The **criminalization of mental disorders** refers to the use of the criminal justice system as the first-line response for people who come to the attention of authorities primarily due to their

mental disorders. This leads to people facing criminal justice consequences such as arrest, criminal charges, and incarceration. As in the chapter-opening scenario with Jamie, criminal justice consequences can escalate once they begin. And because the criminal justice system can be ill-equipped to manage serious mental disorders, people can remain "stuck" in the system for much longer than expected or intended. While stuck, a person with mental disorders may find that their original mental health condition deteriorates, making them subject to victimization or self-harm, or prompting the commission of new offenses.

Of course, people who have mental disorders—just like people without mental disorders—do commit offenses, of all levels of seriousness, that warrant criminal processing. However, the problem of criminalization addressed here arises when people are not primarily criminal in their conduct but are brought into the criminal justice system, which then worsens the situation. A person may have done something that is technically an offending behavior (as in Jamie's case), or community members may legitimately fear that a person will engage in increasingly offensive behavior due to obvious signs of a mental disorder. Police are enlisted to assist, usually as the only option available, and the person is then introduced (or reintroduced) into the criminal justice system. Often, this person is not dangerous and primarily needs help. They do not need or benefit from criminal processing. In fact, they and the larger community may be harmed by this response.

The Roots of Criminalization

As discussed in **Chapter 1** of this text, the deinstitutionalization movement—eliminating long-term hospitalizations in favor of community support for those with mental disorders—began in the early 1960s with high hopes, but more moderate accomplishments. The righteous intent of deinstitutionalization was to eliminate the incarceration and segregation of people with mental disorders, as well as to provide help and treatment to this population in their communities. The planned reduction of institutions became a reality; hundreds of thousands of people with mental disorders left hospitals to live in the community, as was their right (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). As we have learned, the next step in the deinstitutionalization movement—the creation of a robust community mental health infrastructure—did not fully materialize. Mental health care was simply not available at the level of need. Many of the people released from restrictive hospital settings properly reentered the community but were allowed no real chance of succeeding there.

The gap in support that grew as institutions subsided led to a newly voiced concern by observers beginning in the 1970s: the criminalization of those with mental disorders. And indeed, many of those who had been released from closing institutions fell into that gap in care. They ended up in jail or prison, with the criminal justice system providing the "care" that was unavailable elsewhere. To some, it appeared that people with mental disorders were simply going to be shifted from one institution to another, an idea termed *transinstitutionalization*, which was introduced in **Chapter 1**.

However, the increase in incarcerated people with mental disorders was not caused by the closure of institutions alone (Lurigio, 2013). Another enormous factor was the overall increase in incarceration generally and the increase in drug-related prison sentences particularly. The United States was getting "tough on crime," especially drug offenses. President Richard Nixon's "war on drugs" in 1971 gained speed and power in the 1980s and continued for decades—resulting in draconian prison sentences at both the state and

federal levels. In 1950, 175 out of every 100,000 United States residents were incarcerated. By 1985, the number was up to 312 per 100,000 and rising. By 2005, it was at 743 per 100,000 (Cullen, 2018).

Women were a significant part of the increase in incarceration, especially women of color (figure 4.3). From 1990 to 2010, the number of women in prison increased twice as fast as the number of men; of those, Black women were more than three times as likely as white women to be incarcerated. Most of the women in prison are mothers of young children, creating complicated family struggles (Lapidus, 2011). There was also an enormous impact on people with mental disorders, who often experience primary or co-occurring substance use disorders as part of their diagnosis. Drug use leads to an increase in criminal system engagement for most people—especially for people with serious mental illness (Lurigio, 2013).

Figure 4.3. Tutwiler Women's Prison, pictured here, is located in Alabama and has been notorious for abuse of its overcrowded inhabitants.

Criminalization Today

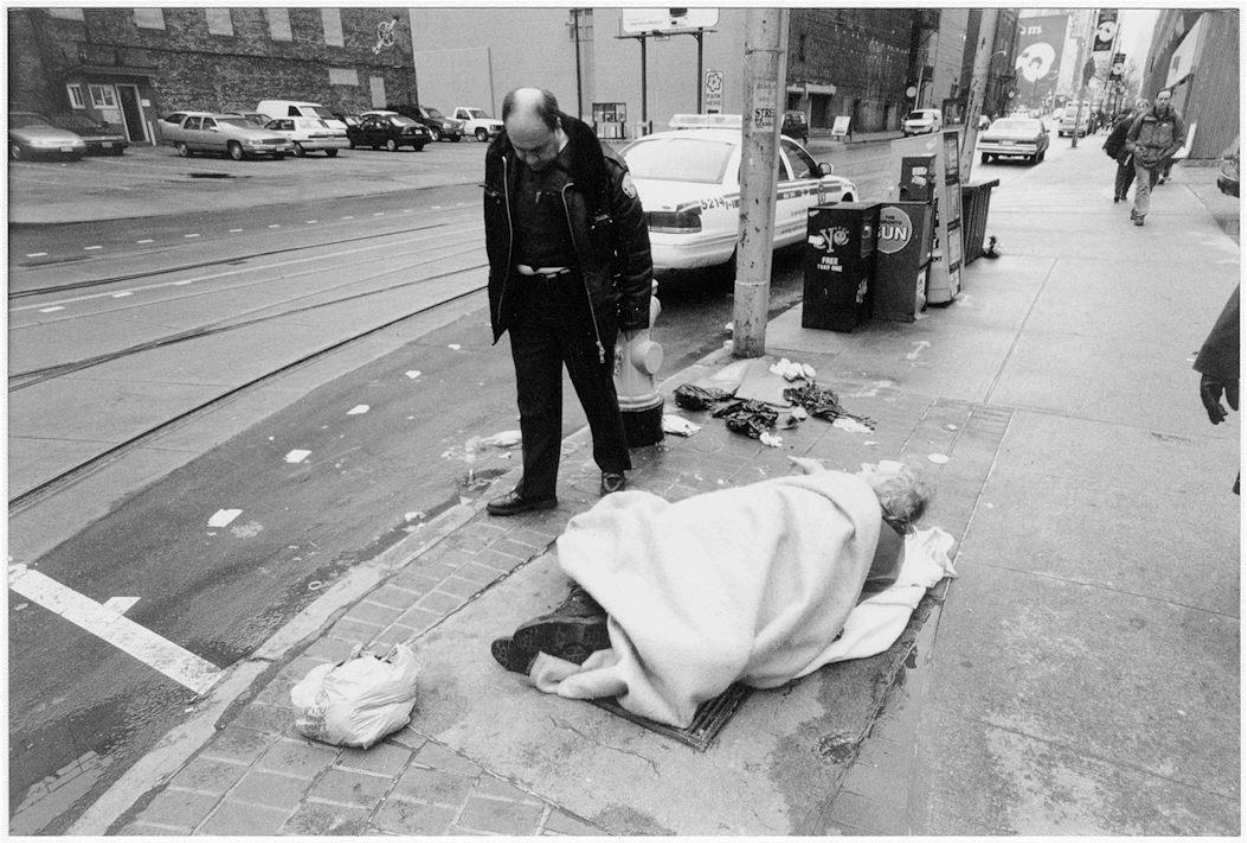
Some 50 years after concern about criminalization was first voiced, the problem has grown and persists. People who experience mental disorders are still vastly overrepresented in our nation's jails and prisons, especially among vulnerable populations, including youth, women, and veterans (National Alliance on Mental Illness, n.d.-b). Stigma around mental illness and disability and the inaccurate assumption that people who have mental disorders are very likely to engage in criminal activity continue to fuel the practice of treat-

ing mental disorders as a criminal justice issue (Pescosolido et al., 2019).

The rate of mental disorders among incarcerated people began to rise in the 1970s and kept going up. It now appears at a rate up to 12 times that found in the general population (Wolff, 2017). Nearly all states have more patients with mental disorders in their jails and prisons than they hold in state hospitals. According to the nonprofit Treatment Advocacy Center, people experiencing serious mental illnesses such as schizophrenia are 10 times more likely to be in jail or prison than in a hospital (Treatment Advocacy Center, n.d.). About half of the people incarcerated in Oregon prisons, for example, have diagnosed mental illnesses and/or developmental disabilities (Oregon Health Authority, n.d.). The Cook County Jail in Chicago, widely reported to be the largest mental health facility in America, is full of people who have mental illness and have committed so-called "crimes of survival," such as theft to get something to eat or breaking and entering to find a place to sleep (Ford, 2015).

People living in extreme poverty, namely the unhoused population, are at serious risk of experiencing criminalization due to mental disorders, including substance use disorders. Although Portland, Oregon, is not unique, statistics from this one city provide a snapshot of how these issues manifest. In 2017, more than half of Portland Police Bureau arrests involved people living on the street. The approximately 10,000 arrests of unhoused people that year were most often based on low-level crimes, such as theft or drug charges, with 86% of the arrests occurring for non-violent crimes and more than 1,200 of the arrests involving procedural offenses, such as missing court (Woolington & Lewis, 2018).

For many reasons, including a lack of adequate mental health care systems, there is not a clear accounting of exactly how many of Portland's unhoused arrestees have diagnosable mental disorders, but evidence suggests the numbers are high. The unhoused population overall is far more likely than others to be affected by mental disorders (figure 4.4). Almost half of Portland's unhoused residents overall self-report themselves as having mental illness; 38% report physical disabilities; and another 37.5% report substance use issues (Maui, 2019). Disability is more common than not among unhoused residents of Portland, with higher numbers in certain groups: 67% of unhoused women, for example, self-identify as disabled (The City of Portland, n.d.).



City of Toronto Archives, Series 1908, s1908_fl0440_it0001

Figure 4.4. This photo depicting police interaction with an unhoused community member shows a scene familiar in any large city in America in recent years.

In contrast to its prevalence among the unhoused population, about 20% of adults in the general population report having any mental illness, but only 5% report having serious mental illness (such as bipolar disorder or schizophrenia), and 6.7% report having both substance abuse issues and another mental illness (National Alliance on Mental Illness, n.d-c). Disability is likewise far less common in the overall population than among Portland's unhoused population, with about one-quarter of all Oregonians experiencing any sort of broadly-defined disability (Oregon Office on Disability and Health, 2010).

Licenses and Attributions for Criminalization of Mental Disorders

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Figure 4.4. "Toronto police officer and homeless man in 1995" by Ivaan Kotulsky, City of Toronto Archives, is licensed under CC BY 4.0.

4.3 The Costs of Criminalization

It is important to acknowledge that criminalization is not an unfortunate byproduct of a functioning system. Rather, it is incredibly costly, both in financial terms and human terms, and fails to solve problems effectively.

Financial Costs of Criminalization

The financial burdens of incarcerating people with mental disorders are large. For example, lengthy and unintended hospitalizations can become an expensive element of even a low-level arrest when a mental disorder is a factor. In this chapter's introductory scenario with "Jamie," it was imagined that this person with serious mental illness might be arrested and jailed for a minor criminal offense but be too mentally ill to understand their present circumstances. But Jamie has a constitutional right to understand the charges against them and to participate in their defense. If Jamie's ability to exercise these rights is excessively diminished due to a mental disorder, the case cannot be resolved until Jamie is stabilized, reevaluated, and declared mentally fit to proceed. This evaluative and treatment process may need to occur in a psychiatric hospital setting. These complex issues are discussed further in Chapter 6 and Chapter 9.

Rounds of incarceration and hospitalization are very expensive—and very slow. Financial costs include jail, lawyers, courts, psychological evaluators, and perhaps treatment at a state psychiatric hospital that can produce (in our Oregon example) a bill of around $250,000 per year (Disability Rights Oregon Mental Health Rights Project, n.d.). If the person continues on to prison, having gotten caught up in the criminal system, the average bill for a year in federal prison, based on 2020 figures, is around $40,000 (Annual Determination, 2021), and a year in a state prison may be even higher. In Oregon, the cost of a year in prison is estimated at closer to $45,000 (Mai & Subramanian, 2017). These expenses would be covered by taxpayers.

Human Costs of Criminalization

The costs associated with criminalization of mental illness are not, of course, limited to finances. There are enormous human costs borne by individuals and their communities. Criminalization has a continuing impact on individual mental health and ongoing community safety. In our jail-to-hospital scenario, the accused person is moved from one very restrictive environment to another, legally unable to resolve their case without achieving mental stability. A person may spend months jailed, hospitalized, and jailed again awaiting resolution of a case that, if they had no mental disorder, would have been resolved in short order and might not have even resulted in an arrest in the first place.

For a person with a mental disorder, any time spent in jail comes at a high cost. People with mental health disorders who are kept in jail or prison environments are less likely to get the treatment they need than they would in the community, even as they live in environments that are very likely to exacerbate mental disorder symptoms (Bryant,

2023). They may also be left to manage difficult and rule-dense prison environments with few or no accommodations for their disabilities. Failure to adhere to rules may result in additional trauma and harsh treatment, such as solitary confinement (Fellner, 2006). Young men of color, specifically, are more likely to be met with punishment for behavioral problems than to receive the treatment they need to meet expectations in prison, and they are more likely to spend time in solitary confinement (Kaba, et al., 2015). These issues are discussed in more detail in **Chapter 7** of this text.

As burdensome as the human costs of incarceration are, these situations represent some of the better outcomes for people with mental disorders who encounter the criminal justice system. People with mental disorders are far more likely than people without mental disorders to be killed by police in a law enforcement encounter. In Portland, Oregon, for the years 1975 to 2020, a total of 85 people were killed in police-involved shootings; 72% of those people were affected by mental disorders (Selsky & Willingham, 2022).

Awareness of Human Costs

Voices in opposition to criminalization cite the human costs when rallying against activities that tend to criminalize mental disorders. The **National Alliance on Mental Illness (NAMI)**, a nationwide advocacy organization for people experiencing mental illness and their families, has been a vocal advocate for reducing the criminalization of mental disorders. NAMI opposes laws that result in criminalization (such as zero-tolerance policing in the face of nuisance offenses) and seeks to educate for change through outreach.

Education should be impactful because the numbers are jarring. Among NAMI's gathered statistics:

- Nearly one in four people shot and killed by police officers between 2015 and 2020 had a mental disorder.
- About 2 million times each year, people with serious mental illness are booked into jails.
- Sixty-six percent of women in prison reported having a history of mental disorder (twice the number of men in prison).
- Among incarcerated people with a mental disorder, people of color are more likely to be held in solitary confinement, be injured, and stay longer in jail (National Alliance on Mental Illness, n.d.-b.).

NAMI's efforts to combat criminalization also include sharing powerful personal accounts from people with mental disorders who have experienced mental health crises—often resulting in interactions with law enforcement. If you would like, you can read firsthand experiences shared on **NAMI's website**. NAMI also encourages those with lived experience to share that information directly with law enforcement officers in their Sharing Your Story with Law Enforcement (SYSLE) program. The SYSLE program supports individuals in describing their life experiences to educate officers in law enforcement training programs. According to NAMI, these personal presentations are highly impactful for law enforcement officers, enabling them to bring understanding and empathy into future interactions with people experiencing mental disorders (National Alliance on Mental Illness, n.d.-a).

The short video in figure 4.5 describes NAMI's SYSLE program. As you watch it, consider the benefits to law enforcement officers, and to the larger community they serve, offered by these generous personal presentations.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=3HKBBzFifuU

Figure 4.5. This video provides officer perspectives on NAMI's Sharing Your Story with Law Enforcement program. You can learn more about the program, if you are interested, on **NAMI's web page about the program [Website]**. **Transcript.**

SPOTLIGHT: Homelessness and Criminalization of Mental Disorders

Homelessness and criminalization are issues throughout the United States, leading to crises and debates in the cities that wrestle with these problems. A 2019 video by Disability Rights Oregon (linked in figure 4.6) discusses the problem of criminalization and its connection to the homeless crisis in Oregon. Advocates for people with disabilities directly tie these issues together and highlight the moral quandary of the endless incarceration-to-street cycle created by criminalization.

This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=xfLfdU8Nu9s**

Figure 4.6. Disability rights advocates explain the criminalization cycle and its connection to the loss of or instability in housing. This video focuses on Oregon, but the issues discussed are more universal. **Transcript.**

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Figure 4.5. NAMI Sharing Your Story with Law Enforcement Program is licensed under the Standard YouTube License.

Figure 4.6. Decriminalize Mental Illness by Disability Rights Oregon is licensed under the Standard YouTube License.

4.4 Diversion from the Criminal Justice System

One response to the problem of criminalization is **diversion**, which is when a person is identified at some point (early or late) in the criminal justice system and provided with a pathway out of that system. Ideally, the person is shifted to an alternative form of supervision, support, or treatment. Referring back to the example of "Jamie," an early diversion might have involved a mobile mental health team (rather than police) responding to the park, connecting Jamie with mental health and housing resources—and perhaps food or some other comfort—and meeting Jamie's needs rather than making an arrest. Regardless of Jamie's responsiveness to help, the escalation might not have occurred, and Jamie would never have had the opportunity to assault a jail deputy. Jamie would have been diverted from the criminal justice system.

Diversions are not exactly an alternative to or rejection of the criminal justice system. Diversions, instead, are part of that system. Diversion usually requires a person to have at least a brush—and maybe full engagement—with the criminal justice system, whether that is as a subject of a 911 call from a community member, an arrest, or a conviction. Once a person is identified as a candidate for diversion out of the criminal justice system, the person is directed to a program or pathway suited to their needs. Thus, diversion relies upon the infrastructure of the criminal justice system to fulfill its purpose.

Most diversions seem imperfect, and that is at least in part because they are merely responses to the already unfolding problem of a person becoming justice-involved. The diversion recognizes that problem and ideally lessens its impact, but the underlying issue is not likely resolved. For example, "Jamie" may need help of some sort again in the future, and police are the most likely responders—setting everyone up for a repetition of events. Alternately, perhaps Jamie will respond to and benefit from resources, and there will not be a future call. In any case, an appropriate diversion ensures that Jamie will not spend months in jail or the hospital for a minor offense this time. Furthermore, the financial cost of diversion is relatively negligible, and an early diversion that takes place at the time of the first response (such as a response by someone other than police) reduces the chances of a violent confrontation in which Jamie or responding officers are injured.

Diversion can occur at different points during a person's involvement in the criminal justice system. Diversion may occur very early, allowing a person to fully avoid engagement in the system. In this case, the diversion might be as simple yet

powerful as outreach from a community mental health resource to a person who is experiencing a crisis, or the decision of a law enforcement officer to refer an unhoused community member to a shelter (figure 4.7).

Figure 4.7. Police officers have great discretion to offer resources and create an early diversion opportunity.

Diversion can also come later, such as when it takes place in alternative courts for those with mental disorders. In this case, a person has likely faced arrest and been referred to the district attorney for charges. A referral to a specialized court may give this person the opportunity to fulfill treatment or supervision requirements to avoid conviction on those charges. In other instances, a person may be deep in the criminal justice process, and diversion may present as planning that helps a person entering the community after incarceration find treatment and achieve stability.

Which moment is "best" diverting a person away from the criminal justice system is a point of much discussion and disagreement. Many contend that early diversion is crucial to avoid or minimize the risk, trauma, and stigma that can result from engagement in the criminal justice system. Others wonder whether accountability may increase the likelihood of successful diversion once a person has become engaged in the criminal justice system. Clearly, there are risks and benefits to various approaches to diversion, but it is safe to say that diversion at *any* point is likely an improvement over diversion at *no* point.

SPOTLIGHT: Solutions Not Suspensions

Disciplinary actions in K-12 schools are meant to curb bad behavior and hopefully deter future disruptive incidents. Unfortunately, some school disciplinary approaches push students down a path that sets them up for failure, sometimes feeding them directly into the justice system. This is referred to as the **school-to-prison pipeline**, and it is a source of anger and frustration for many communities (figure 4.8).

Figure 4.8. A community march in 2014 opposing school punishments that are part of the school-to-prison pipeline with the slogan "Solutions Not Suspensions."

For example, consider a young student who frequently loses his temper during class and becomes destructive. The rest of his classmates are ushered from the room while support staff are called in to handle the student's behavior. After too many incidents like this, the student is suspended for several days. Because of his suspension, he falls behind his classmates on his schoolwork and his academic progress. School failure increases his frustration, resulting in more outbursts and more disciplinary action. His classmates now perceive that something is "wrong" with the student, and he is further isolated from his peers, leading to even more behavioral problems. Eventually, the police get involved, and the student is now engaged with the juvenile (or criminal) justice system (figure 4.9).

Figure 4.9. A young woman holds a sign questioning why it takes the commission of a crime for a child to access mental health treatment.

Scenarios like this happen all too often, resulting in the punishment—rather than the treatment and support—of students with mental disorders. Students of color and those with a history of poverty, abuse, and neglect are particularly vulnerable to this mishandling. Meanwhile, involvement in the justice system does not resolve behavioral health issues; it exacerbates them.

Criminal justice involvement for youth is understood to be connected to adverse childhood experiences, or potentially traumatic events that occur in childhood (Graf et al., 2021). These adverse experiences can have lifelong impacts on young people; they have been linked to health complications, education problems, and work issues, in addition to mental disorders and criminal justice system contacts. Given the connections between trauma, mental disorders, and justice system involvement, the large number of justice-involved juveniles who meet the criteria for a mental disorder is less surprising. Some researchers estimate that as many as 70% to 95% of incarcerated youth have mental disorders (Ojukwu, 2022).

Certainly, there are better options for supporting students managing mental disorders and/or trauma, such as providing mental health services and other proactive social support for children in our K-12 schools instead of office referrals for punishment (Collins, 2015). While an

estimated 20% of all children have a diagnosable mental health disorder, less than a third of those children go on to receive any sort of mental health services.

Imagine the potential preventive impact of treatments that support our young people and help them avoid the myriad documented consequences of untreated mental disorders, which can include everything from lowered academic performance to increased dysfunctional relationships to higher rates of unemployment and incarceration. Then, consider the following questions:

- If schools focused on positively supporting students with mental disorders from an early age, do you think we would see fewer violent incidents at schools and in our communities?
- Could robust mental health and disability support in schools function as true "diversions" that steer children away from—rather than into—the juvenile or criminal justice systems?

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Figure 4.7. MPDC Officer in conversation with homeless man by Elvert Barnes is licensed under CC BY-SA 2.0.

Figure 4.8. February 2014 Moral March On Raleigh 36 by Stephen Melkisethian is licensed under CC BY-NC-ND 2.0.

Figure 4.9. Photograph of a young woman by National Juvenile Justice Network is licensed under CC BY-NC-SA 2.0.

4.5 Sequential Intercept Model

Diversion timing and opportunities are illustrated in the **Sequential Intercept Model (SIM)**. The SIM was developed within the federal **Substance Abuse and Mental Health Services Administration (SAMHSA)** as a project of its GAINS Center for Behavioral Health and Justice Transformation. SAMHSA is an agency created by Congress in 1992 to make information about substance use and mental disorders more accessible. The GAINS Center within SAMHSA is a government effort aimed at increasing community resources for justice-involved individuals via support and training for mental health professionals and organizations at all levels of government. The goal of SAMHSA/GAINS is to "transform the criminal justice and behavioral health systems" and recognize and seek to reduce the problem of criminalization of mental disorders (SAMHSA, 2022a). You will see many references in this chapter and throughout this text to SAMHSA resources.

In practice, the SIM is a valuable tool for discussing and assessing various diversion options that may be available in, or missing from, a community (figure 4.10).

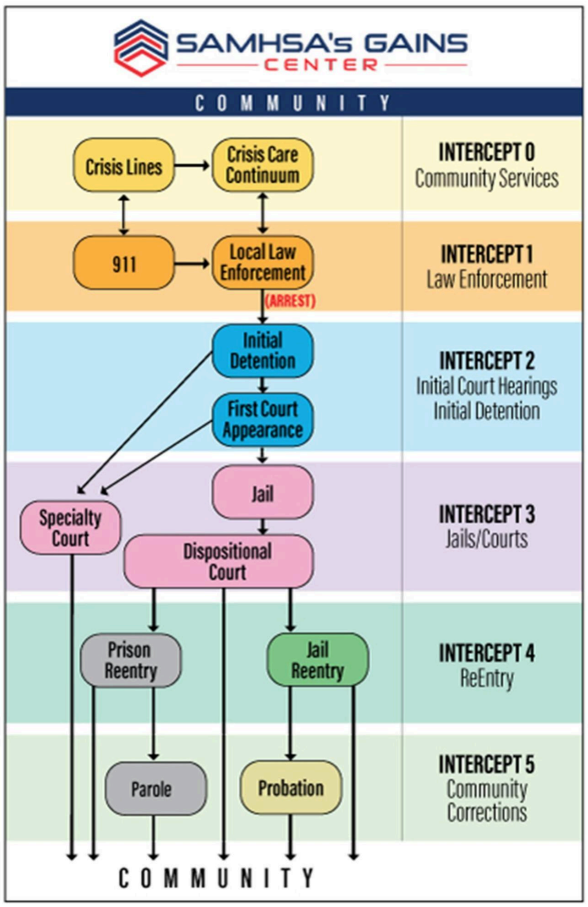

Figure 4.10. SAMHSA's diagram of the Sequential Intercept Model (SIM). **SAMHSA's website provides a detailed description of the SIM** and specifics about each intercept, numbered 0 to 5. Intercept 0 depicts community resources that precede entry into the criminal justice system, while intercepts 1 through 5 depict points in time that are progressively further along in the criminal justice progression.

The SIM illustrates how exit from the criminal justice system can occur at several points in time, from the beginning to the end of a typical pathway through that system. Each **intercept** within the SIM represents a window in time during a person's interaction with the criminal justice system when that person might be provided with direction or opportunity that can divert the person away from the justice system (SAMHSA, 2022b).

The SIM helps us visualize and consider each window in time when intervention and diversion might occur as a person proceeds through the criminal justice system. The specific diversion opportunities that may be available at each juncture are dependent upon the needs of the individual at that time, as well as the desires and resources of the community. Every community can look at the SIM and consider these important questions:

- Do we have diversion opportunities present at intercepts we consider most valuable?
- What opportunities or resources are missing?
- Where we lack diversion opportunities, can those be added or can others be shifted to maximize impact?

Because diversion involves cooperation from different agencies and groups who play roles in the process, creating diversion opportunities requires input and participation from an array of professionals, including first responders, mental health workers, and criminal justice professionals (Oregon Center on Behavioral Health and Justice Integration, 2023).

Each intercept in the SIM is briefly described in the following sections, with a link to the corresponding intercept discussion on the SAMHSA website. Please take a look at **SAMHSA's information on the SIM [Website]** generally. As you consider each intercept point discussed below, follow the specific link provided in that section to see examples of diversion programs at that intercept point.

Community Services (Intercept 0)

The very first intercept point, **Intercept 0, Community Services [Website]**, is the only opportunity in the SIM that allows for avoidance of the criminal justice system entirely. This intercept was added to the model in 2017, several years after the SIM was initially developed, and it focuses on the first recognized need for service, or the point where a crisis is identified (Pinals & Felthous, 2017). Intercept 0 suggests responses that fully eliminate the need for police presence, never opening the door to the criminal justice system or

the enormous risks that police encounters present for those with mental disorders. Community service responses such as hotlines or crisis lines (figure 4.11) are part of Intercept 0 (SAMHSA, 2022b).

Figure 4.11 A phone—one of the many everyday, non-criminal justice tools that are part of Intercept 0—may be used to access a crisis line or other community resource.

Peer-support programs, self-referral substance use programs, and respite homes that allow short stays for those in need of help would all fit into Intercept 0 as well (SAMHSA, 2022b). Yet another Intercept 0 option involves the various police alternatives that are increasingly being developed in cities throughout the country (Turner, 2022). Police alternatives are discussed further in **Chapter 5**. The key to Intercept 0 is an intervention that takes place and supports a person's access to treatment without the threat of an arrest.

Law Enforcement (Intercept 1)

Before Intercept 0 was added to the SIM, **Intercept 1, Law Enforcement [Website]**, was the first imagined opportunity for diversion out of the criminal justice system. (For more information and history, if you are interested, see **Using the Sequential Intercept Model to Guide Local Reform [Website]**.)

Intercept 1 focuses on policing as a tool that can be used for far more than just arresting people (figure 4.12). Intercept 1 imagines police serving as a filter of sorts: arresting people who need to be taken into criminal custody, while performing a protective or supportive role for others who may have been referred to or otherwise come to the attention of law enforcement but are not well-served by arrest. Of course, police have always had discretion to operate in this manner, but Intercept 1 emphasizes this opportunity and encourages skilled, informed, and community-supported approaches by law enforcement. Police use of discretion and resources to keep interactions non-coercive and non-violent increases safety for people who experience mental disorders, as well as for police themselves.

Figure 4.12. Although police response is part of Intercept 1, that response can involve an array of services that do not lead to arrest and entry into the larger criminal justice system.

One of the most prominent aspects of Intercept 1 is training law enforcement to de-escalate mental health crisis situations, without the use of force

when possible and with the goal of avoiding an arrest (SAMHSA, 2022b). Programs integrating crisis management training have been developed over the past several decades, and some police departments, such as the Portland Police Bureau, now require all officers to complete a 40-hour training specifically targeted to interactions with people with mental disorders. Co-response teams, in which law enforcement officers are paired with mental health professionals to respond to and manage calls involving mental disorders, are also an increasingly favored Intercept 1 approach (SAMHSA, 2022b). These options are discussed further in **Chapter 5**.

Initial Detention and Initial Court Hearings (Intercept 2)

Intercept 2, Initial Detention and Initial Court Hearings [Website], is focused on diversion opportunities for people who have been arrested and are facing initial criminal court appearances (figure 4.13). Here, the emphasis is on screenings or evaluations to identify the presence of mental disorders and substance use disorders, as well as on efforts to avoid or minimize time in custody.

Figure 4.13. At Intercept 2, a person has been arrested and formally entered the criminal justice system. At this intercept, there are still opportunities for a person to be diverted out of the system before they experience lengthy detention and conviction.

Pretrial services in both the federal and state court systems would be considered an Intercept 2 diversion, as these programs allow a person to be supervised in the community while awaiting resolution of criminal charges (SAMHSA, 2022b). If the person is suitable for community supervision (not likely to fail to show up in court or present a danger to the community), they would be released and required to follow certain conditions. This approach allows the person to avoid the negative impacts of jail while potentially benefitting from appropriate community-based treatment or services. A pretrial officer would be charged with supervising the person as they move through the court process. The person is not convicted of any offense at this stage, so it is still possible that charges could be dismissed in a resolution of the case.

Jails and Courts (Intercept 3)

As the focus shifts to **Intercept 3, Jails and Courts [Website]**, the SIM highlights diversion opportunities for people who are facing resolution of charges for offenses (figure 4.14). Examples would include jail-based treatment programs or treatment courts, such as drug courts, veterans' courts, or mental health courts, which are discussed in more detail in the Spotlight in this section (SAMHSA, 2022b).

A common criticism of diversion at this intercept, especially in treatment courts, is that defendants may be required to admit guilt and face conviction or punishment should the diversion not succeed. Here, the threat of criminal justice consequences is often used as leverage to ensure the participant's cooperation in the diversion process. In other words, a person who has been required to admit to wrongdoing to qualify for diversion may be motivated by fear of conviction or incarceration if they do not follow through with the diversion program. Is this a helpful tactic?

Some consider it an opportunity for defendants that also prioritizes public safety. Others argue that this type of leverage, or threat, is an inappropriate way to ensure treatment engagement.

Figure 4.14. The person at Intercept 3 is now being processed in the criminal justice system, past the arrest and initial detention stage. There remain numerous avenues and opportunities for diversion at this stage.

As noted at the beginning of this chapter, most diversions are imperfect, and most could be improved in some respects by simply happening earlier, thereby avoiding interactions with law enforcement, incarceration, and/or creation of a criminal record with the impact on life opportunities that entails. For an alternative visual model, consider taking a look at this **article from the Prison Policy Initiative [Website]**, which uses a non-SIM "highway" model to discuss diversion opportunities (conceived as "exits" off the highway) and develops the argument in favor of earlier diversion to maximize participant choice while minimizing criminal justice engagement.

SPOTLIGHT: Mental Health Courts

One Intercept 3 option is the mental health court. **Mental health courts**, modeled after other treatment or **problem-solving courts** (e.g., drug courts) focus on resolving an underlying problem rather than punishing an individual as a response to offending conduct. Like traditional criminal courts, mental health courts are overseen by a judge, the participant is represented by an attorney, and a prosecutor represents the state. The court's focus, however, is on case management and connecting the charged person with community support, job opportunities, and treatment—all supervised by the court.

These problem-solving courts follow the longtime example of juvenile courts in considering not just *what* a person did but also *why* a person behaved in a particular way, using the court system to support sustainable behavior changes with treatment and intervention rather than incarceration and an eventual return to offending. A person may be given the opportunity to participate in mental health court when they have an identified mental disorder and have been charged with a less serious offense that is appropriate for this more informal approach.

As noted earlier in this chapter, some advocates criticize later-stage diversions such as mental health courts, voicing concern that these criminal justice-involved efforts detract from more proactive community mental health initiatives (Bernstein & Seltzer, 2003). Like all diversions, mental health courts have flaws, and one concern around this diversion approach is that it may actually encourage arrest and justice system involvement by providing support in that context when support may be harder to access outside of the system.

Watch the 13-minute required video about a mental health court (linked in figure 4.15), and consider the pros and cons of these courts, as well as other later-stage diversions. Ask yourself these questions:

- Are the potential benefits to the person and their community worth the risk of deeper engagement in the criminal justice court system? Are there benefits to this level of criminal system involvement?
- Do you agree with the Minnesota judge in this video, who believes that mental health court offers an alternative to a "revolving door" to prison? How specifically do mental health courts accomplish this?

This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=jvufZsC7Yas**

Figure 4.15 This required video provides a view of a mental health court and allows you to hear from all participants. **Transcript.**

There are thirteen **mental health courts [Website]** in Oregon, including the **Multnomah County Mental Health Court [Website]** in Portland, which is overseen by Circuit Court Judge **Nan Waller [Website]** as of this writing (Multnomah County District Attorney, n.d.). If you are interested, you may follow the links to read more about these specific courts. You may also

contact your local court to arrange a visit. Courts are generally open to the public and welcome interested student observers.

Reentry (Intercept 4) and Community Corrections (Intercept 5)

The later intercepts modeled in the SIM, Intercept 4, Reentry [Website], and Intercept 5, Community Corrections [Website], are more focused on community success after a person has moved through the criminal justice system—issues that are addressed in more detail in Chapter 7 and Chapter 8 of this text (figure 4.16). In these final opportunities for diversion, a person is not so much avoiding criminal justice involvement and consequences (as those have already occurred) as they are seeking to lessen the problems associated with, and even benefit from, their justice system involvement. The focus at these intercepts is on reducing reoffending that will return the person to the criminal justice system. Diversion programs should be particularly aimed at preventing reoffending related to mental disorders. This is no small task as, overall, offenders released from state prisons typically reoffend at a rate of 83% within 9 years of release (Alper et al., 2018).

Figure 4.16. Interventions at Intercepts 4 and 5, which are both focused on people emerging from the criminal justice system into their communities, acknowledge the high risk of returning to the criminal justice system. Successful diversion efforts may prevent reoffending and increase community safety.

At Intercept 4, the SIM focuses on **reentry** preparation as a person is in the process of leaving jail or prison and reentering the community. Efforts to create success in reentry should begin during incarceration and continue in the community. Diversion efforts at Intercept 4 may involve planning to meet a person's mental health, medical, or other basic needs (SAMHSA, 2022b). Without needed medications or other treatment in the community, people with mental disorders are more likely to engage in new offending behavior and find themselves winding through the criminal justice system once again (Weatherburn et al., 2021).

Intercept 5 focuses on **community corrections**, which refers to a system of oversight outside of jail (probation) or after serving time in prison (post-prison or parole) in the community. A person under this type of supervision will have particular conditions they must fulfill to remain in the community, and they can be sanctioned by the court or a supervising agency, potentially landing the person right back in custody.

One important aspect of any diversion at Intercept 5 is ensuring that supervising authorities are well-trained and attuned to the needs associated with mental disorders. For example, probation officers may carry specialized caseloads of clients with identified mental health needs, allowing them to focus on collaboration with partner agencies and community organizations that can help their clients succeed (SAMHSA, 2022b).

As one Oregon example of an Intercept 5 effort, the Multnomah County Mental Health Unit provides community supervision services for people with serious mental disorders. The Mental Health Unit partners with other agencies and organizations that support and treat this population, including treatment providers, law enforcement, defense attorneys, courts, and advocacy groups like NAMI. The goal of the Mental Health Unit is to increase community safety while reducing criminal reoffending and mental health relapse.

Feel free to read more about the **Mental Health Unit [Website]** here.

Medication-based treatment for substance use disorders, in both jail and community settings, is a critical Intercept 4 and 5 intervention that has been shown to reduce the enormous risks of relapse and overdose in people dependent on opioids and alcohol (SAMHSA, 2022b). Interventions like this increase safety and may help reduce recidivism. Medication treatments for substance use are discussed in detail in **Chapter 8**.

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Figure 4.10. **https://www.samhsa.gov/criminal-juvenile-justice/sim-overview** by **SAMHSA** is in the **public domain**.

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Figure 4.15. **A Rare Look Inside a Mental Health Court, Blue Forest Films** is licensed under the **Standard YouTube License**.

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4.6 Chapter Summary

- When faced with people who need help managing mental disorders, communities have turned to the criminal justice system as a first-line response, adding to the problem of criminalization of mental disorders.
- Criminalization of mental disorders refers to the use of criminal justice tools to manage people with mental disorders who may not require or benefit from arrest or incarceration.
- Criminalization is a problem for criminal justice-involved people who may, as a result of their criminal-system involvement, incur significant harm from police interactions, incarceration, and criminal conviction. These harms may be intensified for otherwise marginalized groups. Criminalization of mental disorders presents legal problems, financial burdens, and poor outcomes that impact individuals, justice system participants, and the larger community.
- Diversion is a response to criminalization that offers opportunities for a person to exit the criminal justice system. Diversion can occur

at different points in the criminal justice system, spanning the time before first police contact to the post-incarceration period of supervision.

- The Sequential Intercept Model (SIM) is a tool to assist communities in visualizing various potential points of diversion, and it can be used to spur community development of diversion programs by identifying needs and opportunities. Intercepts 0 through 5 specifically highlight points in the criminal justice pathway where diversion can occur. Each intercept has strengths and potential weaknesses.

KEY TERM DEFINITIONS

- **Community corrections:** A system of oversight outside of jail (probation) or after serving time in prison (post-prison or parole) where the supervised person has conditions they must fulfill to remain in the community.
- **Criminalization of mental disorders:** Using the criminal justice system as a response to people who come to the attention of authorities primarily due to their mental disorders.
- **Diversion:** When a person is identified at some point (early or late) in the criminal justice system and provided with a pathway out of that system.
- **Intercept:** A window in time during a person's interaction with the criminal justice system when that person might be provided an opportunity for diversion out of the system.
- **Mental health court:** A diversion or "problem-solving" court that substitutes treatment and other interventions for traditional criminal punishments (jail or fines) for qualifying offenders.
- **National Alliance on Mental Illness (NAMI):** A nationwide advocacy organization for people experiencing mental illness and their families.
- **Pretrial services:** Programs that allow a person to be supervised in the community while awaiting resolution of criminal charges.
- **Problem-solving courts:** Courts that attempt to support sustainable behavior changes (and avoid incarceration) by responding to offending conduct with treatment and other interventions. Also called *treatment courts* or *specialty courts*. Examples are drug courts and mental health courts.
- **Reentry:** The process of leaving jail or prison, from preparation and planning during incarceration through release into the community.
- **School-to-prison pipeline:** Patterns of school discipline that push students toward entry into the juvenile or adult justice systems. This is a particular risk and concern for students of color, disabled students, and students living in poverty.
- **Substance Abuse and Mental Health Services Administration (SAMHSA):** An agency of the U.S. government that leads public health initiatives aimed at improving national mental health. SAMHSA offers extensive information and resources on mental disorders.
- **Sequential Intercept Model (SIM):** A tool for discussing and assessing various diversion options for people with mental disorders at progressive points, or intercepts, in the criminal justice system. The SIM may highlight options that are available or missing in a particular community or at a particular intercept point.

DISCUSSION QUESTIONS

- What factors led to the problem of criminalization of mental disorders? What solutions can you imagine that could reduce or solve this problem on a larger scale? Are there new problems created by your solution?
- How does the problem of criminalization of mental disorders differently impact groups of people who are marginalized in additional ways beyond their experience of mental disorders (e.g., by race, gender identity, poverty, or other factors)?
- Which particular intercept point, in your estimation, represents the best time to divert people out of the criminal justice system? What factors lead you to favor that intercept point?
- What are the pros and cons of mental health courts, as discussed in the text and portrayed in the linked video, as a diversion opportunity? What changes might you propose to improve the mental health court model?

Licenses and Attributions for Chapter Summary

4.7 References

Alper, M., Durose, M. R., & Markman, J. (2018, May). *2018 Update on prisoner recidivism: A 9-year follow-up period (2005-2014)* (NCJ 250975). US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. https://bjs.ojp.gov/content/pub/pdf/18upr9yfup0514.pdf

Annual determination of average cost of incarceration fee (COIF). 86 Fed. Reg. 49,060 (Sept. 1, 2021) https://www.federalregister.gov/documents/2021/09/01/2021-18800/annual-determination-of-average-cost-of-incarceration-fee-coif

Bernstein, R., & Seltzer, T. (2003). Criminalization of people with mental illnesses: The role of mental health courts in system reform. *University of the District of Columbia Law Review,* 7, 143–162.

Bryant, E. (2023, October 17). *The United States criminalizes people who need health care and housing*. Vera Institute of Justice. https://www.vera.org/news/the-united-states-criminalizes-people-who-need-health-care-and-housing

The City of Portland. (n.d.). *Homelessness Statistics*. https://www.portlandoregon.gov/toolkit/article/562207

Collins, S. P. K. (2015, April 24). Why mental health services could be the key to fixing the school-to-prison pipeline. *ThinkProgress.* https://archive.thinkprogress.org/why-mental-health-services-could-be-the-key-to-fixing-the-school-to-prison-pipeline-ffc47b66cfac/

Cullen, J. (2018, July 20). *The history of mass incarceration*. Brennan Center for Justice.

https://www.brennancenter.org/our-work/analysis-opinion/history-mass-incarceration

Disability Rights Oregon Mental Health Rights Project. (n.d.). *The criminalization of mental illness*. https://www.droregon.org/advocacy/stop-criminalizing-mental-illness-2

Fellner, J. (2006). A corrections quandary: Mental illness and prison rules. *Harvard Civil Rights-Civil Liberties Law Review*, *41*(2), 391–412.

Ford, M. (2015, June 8). America's largest mental hospital is a jail. *The Atlantic.* https://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/

Graf, G., Chihuri, S., Blow, M., & Li, G. (2021). Adverse Childhood Experiences and Justice System Contact: A Systematic Review. *Pediatrics*, *147*(1), e2020021030. https://publications.aap.org/pediatrics/article/147/1/e2020021030/77102/Adverse-Childhood-Experiences-and-Justice-System

Kaba, F., Solimo, A., Graves, J., Glowa-Kollisch, S., Vise, A., MacDonald, R., Waters, A., Rosner, Z., Dickey, N., Angell, S., & Venters, H. (2015). Disparities in mental health referral and diagnosis in the New York City Jail Mental Health Service. *American Journal of Public Health*, *105*(9), 1911–1916. https://doi.org/10.2105/AJPH.2015.302699

Lapidus, L. M. (2011, June 8). The war on drugs = A war on women and families. End the 40-year war on drugs. *American Civil Liberties Union News & Commentary.* https://www.aclu.org/news/smart-justice/war-drugs-war-women-and-families

Lurigio, A. J. (2013). Forty years after Abramson: Beliefs about the criminalization of people with serious mental illnesses. *International Journal of Offender Therapy and Comparative Criminology*, *57*(7), 763–765. https://doi.org/10.1177/0306624X13490142

Mai, C. & Subramanian, R., (2017, May). *The price of prisons: Examining state spending trends, 2010-2015.* Vera Institute of Justice. https://www.vera.org/downloads/publications/price-of-prisons-2015-state-spending-trends/legacy_downloads/the-price-of-prisons-2015-state-spending-trends_170523_195204.pdf

Maui, W. (2019, April 23). The numbers behind Oregon's homelessness crisis. *Portland Monthly.* https://www.pdxmonthly.com/news-and-city-life/2019/04/the-numbers-behind-oregons-homelessness-crisis

Multnomah County District Attorney. (n.d.). *Mental Health Court*. https://www.mcda.us/index.php/community-initiatives-special-programs/mental-health-court

National Alliance on Mental Illness. (n.d.-a). *NAMI Sharing your story with law enforcement*. https://www.nami.org/Support-Education/NAMI-Programs/NAMI-Sharing-Your-Story-with-Law-Enforcement

National Alliance on Mental Illness. (n.d.-b). *Mental illness and the criminal justice system*. https://www.nami.org/NAMI/media/NAMI-Media/Infographics/NAMI_CriminalJusticeSystem-v5.pdf

National Alliance on Mental Illness. (n.d.-c). *Mental health by the numbers*. https://www.nami.org/mhstats

Ojukwu, O. (2022, February 20). The mental health impacts of the school-to-prison pipeline [Substack newsletter]. *EQ Collective.* https://eqcollectivenews.substack.com/p/the-mental-health-impacts-of-the

Oregon Center on Behavioral Health and Justice Integration. (2023). *Sequential intercept mapping*. https://www.ocbhji.org/sim

Oregon Health Authority. (n.d.). *Oregon state population health indicators*. Oregon Public Health Division. https://www.oregon.gov/oha/PH/ABOUT/Documents/indicators/incarcerate.pdf

Oregon Office on Disability and Health. (2010). *Disability in Oregon: 2010 Annual report on the health of Oregonians with disabilities.* Oregon Health & Science University, Center on Community Accessibility. https://www.ohsu.edu/sites/default/files/2019-01/2010%20OODH%20Annual%20Report.pdf

Pescosolido, B. A., Manago, B., & Monahan, J. (2019). Evolving public views on the likelihood of violence from people with mental illness: Stigma and its consequences. *Health Affairs*, *38*(10), 1735–1743. https://doi.org/10.1377/hlthaff.2019.00702

Pinals, D. A., & Felthous, A. R. (2017, December 22). Introduction to this double issue: Jail diversion and collaboration across the justice continuum. *Behavioral Sciences & the Law*, *35*(5–6), 375–379. https://doi.org/10.1002/bsl.2322

Selsky, A., & Willingham, L. (2022, September 2). *How some encounters between police and people with mental illness can turn tragic*. PBS NewsHour. https://www.pbs.org/newshour/health/how-some-encounters-between-police-and-people-with-mental-illness-can-turn-tragic

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2019). *Civil commitment and the mental health care continuum: Historical trends and principles for law and practice*. https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2022a). *About GAINS Center*. https://www.samhsa.gov/gains-center/about

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2022b). *The Sequential Intercept Model (SIM)*. https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

Treatment Advocacy Center. (n.d.). *Criminalization of mental illness*. https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness

Turner, N. (2022, April 6). *We need to think beyond police in mental health crises.* Vera Institute of Justice. https://www.vera.org/news/we-need-to-think-beyond-police-in-mental-health-crises

Weatherburn, D., Albalawi, O., Chowdhury, N., Wand, H., Adily, A., Allnutt, S., & Butler, T. (2021, March 10). Does mental health treatment reduce recidivism among offenders with a psychotic illness? *Journal of Criminology*, *54*(2), 239–258. https://doi.org/10.1177/0004865821996426

Wolff, M. J. (2017, May 30). *Fact Sheet: Incarceration and mental health*. Weill Cornell Medicine. https://psychiatry.weill.cornell.edu/research-institutes/dewitt-wallace-institute-psychiatry/issues-mental-health-policy/fact-sheet-0

Woolington, R., & Lewis, M. (2018, June 27). *Portland homeless accounted for majority of police arrests in 2017, analysis finds*. Oregonlive. https://www.oregonlive.com/portland/2018/06/portland_homeless_accounted_fo.html

CHAPTER

5

Crisis Response and Law Enforcement: Safer Communities for People with Mental Disorders

5.1 Chapter Learning Objectives and Overview

LEARNING OBJECTIVES

The following learning objectives tell you what is most important in this chapter. Use these statements as a guide to make sure you get the most out of this chapter.

1. Recognize risks of police interactions with people experiencing crisis in the community.
2. Describe strategies to reduce and/or improve police interactions with people who have mental disorders.
3. Explain the role of a functioning crisis response system in reducing the criminalization of mental disorders.
4. Compare opportunities for police to respond to calls in ways that minimize harm and better meet the needs of the communities they serve, including people who experience mental disorders.

KEY TERMS

Look for these important terms in the text in bold. Understanding these terms will help you meet the learning objectives of this chapter. You can find definitions for these terms at the end of the chapter.

- **Assertive Community Treatment (ACT)**
- **Crisis Intervention Team (CIT) training**
- **Crisis line**
- **Crisis response system**
- **Crisis stabilization center**
- **De-escalation**
- **Forensic**
- **Forensic Assertive Community Treatment (FACT)**
- **Mobile crisis team**
- **Multidisciplinary team**
- **No-wrong-door approach**

Chapter Overview

In June of 2023, Melissa Perez, a 46-year-old Texan mother of four, was experiencing a mental health crisis (figure 5.1). She believed the FBI was listening to her via alarm wires connected to her apartment. Perez, who had a diagnosis of schizophrenia, began cutting the fire alarm wires to protect herself. The fire department and police responded to Perez's apartment complex. After speaking briefly with police officers—and informing them of her worries—Perez retreated into her San Antonio residence and locked the door (Edmonds, 2023).

Figure 5.1. A family photo shows Melissa Perez, second from right. After her mental health crisis resulted in police shooting and killing her, Melissa Perez's family filed a lawsuit demanding accountability. What can communities learn from stories like Perez's?

Perez's family members point out that it would have been obvious to police after speaking with Perez that she was in the midst of a mental health crisis. Perez told police she had schizophrenia, and she had a documented history of being taken into custody due to her mental illness. Furthermore, the officers weren't required to engage independently in a situation where they felt ill-equipped. San Antonio police has a 20-member mental health unit of officers specially trained to deal with precisely this sort of crisis—but no one called them to assist (Torres, 2023). Instead, the responding officers tried to enter Perez's home where she had retreated. Perez protested, pointing out that the officers had no warrant. She threw a candlestick at the officers from inside the home, hitting her own window (figure 5.2) (Edmonds, 2023).

Figure 5.2. An image from San Antonio police body-worn cameras, showing officers poised to shoot on Melissa Perez's porch. How could this encounter with police have progressed differently?

Eventually, Perez picked up a hammer, and three police officers watching Perez through her window opened fire on her, killing her. The officers' behavior was so clearly out of bounds that they were all promptly charged with crimes for shooting and killing Perez. Later, two of the officers' supervisors were disciplined for leaving work early on the night Perez was killed, making them both unavailable to consult on the Perez call (Collier & Hernandez, 2024).

Melissa Perez's family filed a lawsuit demanding accountability from the San Antonio police department and seeking to highlight the failures of the shooting officers as well as the dozen other responding officers who stood by without intervening while the crisis spiraled. In the words of Perez's family, their lawsuit is "about making sure police have proper training to handle people with mental illness, it's about making sure that when we trust a police officer to carry a deadly weapon, that they will only use it when it's absolutely necessary to protect the life of themselves or somebody else" (Torres, 2023).

How could the encounter between police and Melissa Perez have progressed differently and ended less tragically, or even positively? What can be learned from stories like Perez's? This chapter examines some of the options and approaches that may—if made available and used consistently—keep crisis interactions safer for people with mental disorders.

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Figure 5.1 "Melissa Perez and Family" Courtesy of the Perez Family, is included under fair use, permission request pending.

Figure 5.2 Body Worn Camera Footage by San Antonio Police Department is included under fair use, permission request pending.

5.2 Policing People with Mental Disorders

As stories from around the country attest, Melissa Perez's death was no isolated incident. People with mental disorders are up to 16 times more likely to be killed by police than people without those disorders (Fuller et al., 2015). For people of color, that elevated risk is more than doubled, and for people with other marginalizing factors (e.g., lower incomes), that risk continues to increase (Green & Peneff, 2021). While statistics are sometimes hard to find or fully grasp, individual stories of violence are easy to find, and here are just a few:

- Raul de la Cruz was one of more than 170,000 so-called "E.D.P." or "emotionally disturbed person" calls for New York City police in 2022. Officers shot de la Cruz repeatedly, less than 30 seconds after arriving on the scene in response to a call for medical help from his concerned father (Meko & Kriegstein, 2023).
- In the summer of 2021, Arcadio Castillo III was shot dead by police in his parents' home. Arcadio's mother, Misty (figure 5.3), had been trying unsuccessfully to get mental health treatment for her son. On this occasion, Misty called the police for assistance; she told them Arcadio was mentally ill, using substances, and had a knife. Five minutes later, an officer burst into the home and shot Arcadio: "[The officer] didn't try to calm him down. He just came in and immediately shot my son" (Selsky & Willingham, 2022).
- In October 2022, the family of Daniel Prude, a Black man experiencing an apparent drug-involved mental health crisis, was killed by police in an encounter where he was reportedly held, naked, in the street and placed in a "spit hood." Prude's family settled a multimillion-dollar lawsuit against the Rochester, New York, police department involved in Prude's death, but the police did not admit liability, and no officers were ever charged criminally (Clifford, 2022).
- Takar Smith, a father of 6, was killed by Los Angeles police in January 2023. Takar was at the home of his wife, Shameka, in violation of a restraining order. Shameka called the police to get help for Takar; she told dispatch that Takar was mentally ill. When police arrived, Takar grabbed a knife from the kitchen. He was on his knees on the kitchen floor, holding the knife over his head, when officers shot him. The officers never attempted to bring in the mental health support team that was available to them (KCAL News, 2023). Takar had schizophrenia and, like Daniel Prude, he was Black, placing him at a particularly dangerous intersection with respect to police. While people with mental disorders are at increased risk of being killed by police, Black people are already almost three times more likely than white people to be killed by police in any law enforcement encounter, even though they are less likely to be armed (Shadraven et al., 2021).

Figure 5.3. The police department in Salem, Oregon. Salem police killed Arcadio Castillo III in his family's home during a mental health crisis in 2021. What does the police department represent to you and your family?

Despite a universal desire to the contrary, violent encounters like these examples continue to happen when police are called to mental health crises. Police arrive armed with guns and sometimes without training or mental health backup. People in crisis are unpredictable, and sometimes they (like any other person) have access to weapons. A person in crisis may also be more likely to resist arrest, inviting the use of force by police (Green & Peneff, 2021). Typically, even where tragic outcomes occur, reviews of officer conduct typically conclude that police acted according to policy amid chaotic and dangerous circumstances. While these conclusions may reveal a reluctance to hold officers accountable, some also validate that these encounters are, in fact, very difficult to manage safely (Manfield, 2022).

Role of Untreated Mental Disorders

Police contact with people with mental disorders is not rare, and these instances seem to be increasing in frequency (Abramson, 2021). This is likely true in part because high-needs people, such as those with untreated or undertreated serious mental illness, are now more commonly part of our larger communities. This should be a cared-for group in our communities, but as we have learned, many people with mental disorders receive inadequate care, placing them at greater risk of problems that may draw police attention (Cruz Guevarra & Wilson, 2019).

Oregon is emblematic of these problems, reportedly ranking 48th among the states for access to care, but it is far from alone (Levinson, 2021). According to the U.S. government, over 14 million adults in this country experienced serious

mental illness in 2021, and more than half of them (51.5%) reported that their mental health care needs were not met (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021). Additionally, more than 46 million people over age 12 (about 17% of the population) met the applicable DSM-5 criteria for having a substance use disorder in 2021. Of these, nearly 30 million have an alcohol use disorder, and 24 million have a drug use disorder. An overwhelming 94% of these people struggling with substances received no treatment for their disorder in that year, and nearly all of them reported they did not believe they needed treatment (U.S. Department of Health and Human Services, 2023).

Impact of Substance Use Disorders and Homelessness

Along with huge numbers of people impacted by mental disorders, and a troubling lack of treatment, there is also a slow national retreat from drug-related incarcerations. This trend has kept more people with substance use disorders in the community rather than jailed. The turn away from mass incarceration is generally a welcome shift that reflects our growing distaste for jailing people with mental health disorders. However, this shift has often occurred without a corresponding uptick in community treatment options or engagement. One example is Oregon's Measure 110, decriminalizing possession and use of drugs, which was enthusiastically passed by voters in 2020 with the expectation that it would keep around 3,700 people out of jail or prison each year (Selsky, 2020). However, the systems and programs needed to adequately support those thousands of people with substance use disorders were slower to materialize. Alongside anecdotal reports of Measure 110 success was undeniable evidence of many people left untreated (figure 5.4) (Levinson, 2023). In 2024, the Oregon legislature partially reversed course, once again moving to criminalize small amounts of drugs.

Figure 5.4. Unhoused people manage substance use disorders in public spaces, which could draw a police response. When you see drug-related litter in a parking lot, do you see signs of an individual in crisis or a community in crisis?

When people's needs for resources or care are not met, they are increasingly likely to experience crises. Where housing availability is scarce, as it is in Oregon and elsewhere, people are at greater risk of being unhoused—one more factor that can exacerbate mental disorders. Moreover, where people are unhoused, the crises they experience are far more likely to happen in public spaces and draw police responses (Cruz Guevarra & Wilson, 2019).

Police as Crisis Responders

Everyone—from behavioral health providers to advocates to criminal justice professionals, including the police—seems to agree that police are not best suited to tend to people with mental disorders in crisis (Wesolowski, 2022). However, police remain on the front lines and are still most likely to respond to situations involving problems associated with mental disorders (USA Facts, 2023). The inevitable presence of weapons, threat of arrest, and availability of use of force that accompany a police response serve to escalate even situations that, prior to police arrival, may have been less volatile. Responding to these calls also takes up a significant portion of the average police officer's workday (figure 5.5). Nationally, it is estimated that up to 20% of police responses involve mental-health related calls (Westervelt, 2020).

Figure 5.5. Although police and community members may agree that law enforcement responses to mental health problems are a mismatch, police nevertheless are usually called to respond to crises.

In most cases, of course, police officers are able to resolve their calls safely, and those stories do not generally make the news. However, if police fail to do so, then the person they were called to help can become the person they harm or even kill. For communities and for the police officers dedicated to serving and protecting their communities, these outcomes are unacceptable. Efforts to avoid bad outcomes should include measures that, first, reduce the frequency of police encounters with people with mental disorders and, second, when encounters are required, ensure they are handled more effectively.

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Figure 5.4. Drug abuse at the Park and Ride apparently by G Witteveen is licensed under CC BY NC 2.0.

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Figure 5.3. Photo of the police department in Salem, Oregon by Max Rae on Flickr is licensed under CC BY-NC-ND 2.0.

Figure 5.5. Photo of policeman by Jacky Lam on Unsplash.

5.3 Reducing Police Encounters: Crisis Response Systems

One important way to improve crisis outcomes is to minimize or avoid police involvement in resolving crises. The primary way to accomplish this broad goal is to build and support a behavioral health **crisis response system** that is outside of the criminal justice system. A crisis response system is, simply, a way to respond to crises that includes three core elements: someone to call, people to respond, and a place to go (SAMHSA, 2023b). Where a functional behavioral health-focused crisis response system is in place, those elements are not satisfied by what many communities rely on now: 911, the police, and jail. Rather, these core elements are addressed by crisis lines or call centers, mobile crisis teams, and crisis stabilization centers (SAMHSA, 2023b). This section provides an overview of these approaches being explored nationally and locally in U.S. communities (figure 5.6).

As a reminder, the term *behavioral health* was introduced in Chapter 1 of this text as a very broad term that includes care for and responses to mental disorders as well as various other forms of support around emotions, behavior, and well-being. The approaches discussed in this chapter are described with this term because, while they meet the needs of the people with diagnosable mental disorders who are our focus, these approaches also are intended to apply more broadly to meet the needs of anyone in crisis.

This interactive content is not available in this version of the text. It can be accessed online here:
https://youtu.be/tjEZsIPv_nA

Figure 5.6. A short video produced by the mental health advocacy organization National Alliance on Mental Illness (NAMI) that explains the elements of a crisis response system. NAMI endorses these systems as options that are preferred to law enforcement for addressing community mental health crises. Watch this video as an introduction to the material in this chapter. Transcript.

Crisis Lines

The increased presence of **crisis lines** both locally and nationally is an important step in minimizing harm to people with mental disorders (SAMHSA, 2023a). Crisis lines or hotlines, other than 911, are precisely what was envisioned at the "Intercept 0" point of diversion discussed in Chapter 4 of this text. Crisis lines provide a connection between a person in need and services—someone to call—while bypassing police and criminal justice system involvement. Two examples of this type of diversion are the new federal Suicide and Crisis Lifeline (988) and, in Oregon and elsewhere, county-based hotlines.

Lifeline: 988

While Congress approved funding for a national suicide prevention hotline more than twenty years ago, the shift to nationwide use of the 988 "Suicide and Crisis Lifeline" did not occur until 2023. The 988 Lifeline was conceived as an easy-to-remember 911 alternative where people could seek help without calling the police (figure 5.7). Now, anyone throughout the country can dial or text 988 at any time to reach a trained counselor and get assistance in managing a crisis for themselves or someone else. People using the 988 Lifeline need not provide any payment or insurance information to receive support.

Figure 5.7. One of the many social media shareables produced by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to advertise the 988 Lifeline and create awareness of reasons to call, namely a wide array and different levels of behavioral health needs, including problems like anxiety. Just as 911 calls are stigma-free, 988 calls can be understood as a straightforward opportunity to seek assistance.

In the longer term, the vision for 988 is to build a robust crisis response system across the country that links people who call, text, or chat to community-based providers who can deliver a full range of crisis care services (mobile crisis teams or stabilization centers), in addition to connecting people to tools and resources that will help prevent future crisis situations. The 988 number currently accesses a network of over 200 locally operated and funded crisis centers around the country. The federal government is also making significant investments to "scale up" physical crisis centers that would support 988 users in a way that would transform crisis care in the United States. As 988 creators observe, this envisioned transformation relies on the willingness of states to step up with

investments of their own to strengthen crisis care at the local level.

One innovative idea being used in some states is the embedding of 988 call centers within 911 facilities. This eases the shift of emergency calls away from fire and law enforcement responses to behavioral health call-takers, resulting in improved responses to community members as well as savings for taxpayers. One Houston, Texas, county implementing this model reported savings of $6.5 million over four years just by diverting calls away from police and fire departments to behavioral health call takers (SAMHSA, 2023a; Neylon, 2021). The call takers in the Houston program are rigorously trained and are required to have a bachelor's degree in a relevant field, as well as expertise in crisis resolution, cultural awareness, and trauma-informed care, among other topics (SAMHSA, 2023a).

Oregonians have rapidly engaged with the 988 service. Reports from mid-2023 indicate that Oregon residents reached out to 988 about 53,000 times between July of 2022 and July of 2023, representing a 30% increase over calls to the previous national 10-digit suicide hotline. Nearly all of the Oregon calls are routed to a Portland-based nonprofit called Lines for Life, which handles the interactions (Terry, 2023). Oregon is following the directive of federal 988 administrators by investing in programs to support local callers—including more than $1.3 billion in state funds allocated to behavioral health programs overall in 2021 (Terry, 2023). For Oregon calls to 988, a very small number (about 3%) result in call takers contacting emergency services, generally non-police supports such as Project Respond or CAHOOTS, both of which are discussed later in this chapter. Some callers request follow-up with a counselor, and some others are referred to services such as food assistance or peer support (Terry, 2023).

Local Crisis Lines

While 988 has been very successful, local call centers also continue to serve people in most states. Where states already operated crisis call centers prior to the 988 rollout, those lines continue to operate using local 10-digit or three-digit numbers, such as 211 (SAMHSA, 2023a).

Multnomah County, which includes Portland, as well as other counties in Oregon, have long maintained mental health crisis lines locally (figure 5.8), and they continue to do so, encouraging people in crisis to use these resources as alternatives to 911 (KGW8, 2021).

Figure 5.8 Multnomah County advertises its local crisis line (Behavioral Health Crisis Services, n.d.). What words stand out to you from this message?

If you are interested in exploring available mental health resources in your state—including local hotlines—county websites are a good source of information. In Oregon, the largest of those is **Multnomah County Behavioral Health [Web-**

site]. NAMI also provides listings of crisis and helplines, many of which are targeted to particular marginalized populations based on race, gender, tribal affiliation, or specific needs, such as abuse survivors or veterans. Take a look at NAMI's Oregon listings if you are interested: **Get Help Now – NAMI Oregon [Website]**.

Mobile Crisis Response Teams

As noted, "someone to call" is only the first step in a crisis response system. The next step is providing people to respond. Preferred responses avoid overuse of law enforcement and seek to avoid unnecessary hospitalizations or other problems, such as impacts on housing. Mobile crisis response teams, or simply mobile crisis teams, have emerged as the preferred "person" to respond to mental health calls, replacing police response where possible.

Mobile crisis teams are teams that respond to behavioral health crises in the community. These teams take different forms, but mental health authorities have outlined best practices that are recommended for mobile crisis teams. Under these guidelines, team members typically include a mental health provider and a peer specialist. Two-person teams are preferred for safety reasons and to most effectively divert people away from hospital emergency departments and the criminal justice system. Emergency medical service (EMS) providers can also partner with crisis teams where needed. Mobile crisis teams, according to best practices, are intended to respond without law enforcement accompaniment unless their presence is necessary (figure 5.9). Ideally, the mobile crisis team can respond to people wherever they are located and at any time of day.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=PtW0qTXd_sY

Figure 5.9. Watch the short video linked here to hear about a mobile crisis team program in Clark County, Washington. The program was funded with a federal grant and was specifically intended to respond to behavioral health crises without police, for the benefit of both police and service recipients. **Transcript.**

Mobile crisis teams can offer an array of services: screenings and assessments, de-escalation of crises, and medical and behavioral health follow-up and planning. If a person needs to be relocated to receive mental health or other treatment, the team can support them through the transportation and handoff process. However, nearly 85% of people needing crisis team response receive an intervention other than being taken to the hospital (Wesolowski, 2022).

Mobile crisis teams save money by reducing hospitalization and incarceration of people with mental disorders. Additionally, there is evidence that people are truly helped in the long term. For example, people with mood or psychotic disorders who have disconnected from mental health services are more likely to ultimately re-engage with mental health services after contact with a crisis team (Wesolowski, 2022).

As of 2023, almost every state has functional mobile crisis teams or is in the process of establishing teams. However, these teams are far from universally available, and there continue to be many people who cannot be served by crisis teams. Many states struggle to staff full-time crisis teams or to staff any teams at all in rural or remote areas. Fortunately, Oregon has multiple examples of mobile crisis support services making a difference in our communities.

Project Respond

Project Respond is a mobile mental health crisis team run by long-standing Oregon non-profit Cascadia Health. The two-person team provides 24-hour services to people in Multnomah County, 7 days a week. In addition to gathering information at the scene, assessing risk, and safety planning, Project Respond teams provide follow-up services to help people recover and connect them with peer wellness services (Cascadia Health, n.d.-b). Project Respond emphasizes the agency and voice of people who are in crisis, recognizing that—even in crisis—people need to be consulted on what will help them and to be included in the creation of their own safety plans (Cascadia Health, n.d.-a).

Watch the video linked in figure 5.10 to see a short (4 minute) news clip featuring the director of crisis services at Cascadia Health sharing an overview of Project Respond.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.kgw.com/video/features/hello-rose-city/how-project-respond-helping-portlands-homeless-community/283-74a5c8d0-5426-4ab7-a00f-9dd744b539b3

Figure 5.10. A news clip from the fall of 2022 that introduces Cascadia and Project Respond. The director of crisis services at Cascadia speaks about the role of the crisis team and its relationship to other emergency services, as well as the stigma that surrounds accessing mental health support. **Transcript.**

Portland Street Response

Portland Street Response is a newer program that is operated by Portland Fire and Rescue and accessed through 911 calls (figure 5.11). Typical calls include situations where a person is visibly distressed or intoxicated in public or where a person is "down" on the street and needs to be checked. Portland Street Response teams do not respond to private homes, to suicide calls, or to scenes where weapons are involved. As of this writing, teams are available to respond to calls city-wide from 8 a.m. to 10 p.m., 7 days per week, with the hope that hours can be expanded in the future (Portland Street Response, 2023). Portland Street Response is not a mental-health staffed team like Cascadia's Project Respond, and it has more limits on its ability to respond and act than the Cascadia team does. For example, Portland Street Response workers do not have the authority to perform mental health "holds" when people are a danger to themselves or others (discussed in more detail in **Chapter 9** of this text). Some believe this limitation is a barrier to Street Response's ability to provide proper aid; others believe this limitation is beneficial (Peel, 2023). Nonetheless, Portland Street Response teams provide a police alternative that can meet the needs of many people in our community who are at risk of criminalization or other harm if they come in contact with police. Despite funding challenges and some struggles to find their proper lane in the array of 911 services, many people point to the reduced burden on police and fire departments and the increased availability of help for people on the streets as signs of success and reasons to expand the Portland Street Response program (KGW8, 2022; Zielinski, 2023).

Figure 5.11. Portland Street Response team members respond to an area of the city where unhoused people are living. How does their response compare to that of police?

Portland Street Response took some inspiration in its creation and approaches from the very successful police-alternative program CAHOOTS (an acronym for Crisis Assistance Helping Out on the Streets) which has been operating in Eugene, Oregon, for more than 30 years (Zielinski, 2023). See the Spotlight on CAHOOTS in this chapter for more details.

SPOTLIGHT: CAHOOTS

The CAHOOTS program in Eugene, Oregon, run by the non-profit White Bird Clinic, has been quietly succeeding as a police-alternative response team for about thirty-five years (figure 5.12). The White Bird Clinic, and later CAHOOTS, were created by self-described "hippies" in Eugene who were surprised to find themselves partnering with law enforcement but appreciate the unique elements of their program that fit well in its hometown (Parafiniuk-Talesnick, 2021). After George Floyd was killed by police officers in 2020, once again turning public focus to violent police encounters and their potentially horrific outcomes, the CAHOOTS program gained deserved attention and praise among people searching for approaches that could truly help make a difference in avoiding these encounters, particularly when they involve mental health crises (Parafiniuk-Talesnick, 2021).

Figure 5.12. A CAHOOTS-branded van in front of a mural of another Eugene-Springfield claim to fame, the Simpsons. CAHOOTS is known and appreciated in the Oregon community it serves.

On its website, CAHOOTS explains that its mobile crisis intervention services are offered 24 hours per day, 7 days per week throughout the Eugene metro area and in the neighboring city of Springfield. CAHOOTS teams, which include a nurse or EMT and crisis worker, are summoned and dispatched through the 911 emergency system or the police non-emergency number. These teams travel to the person in need with the ability to offer crisis counseling and conflict resolution, as well as more concrete support, such as first aid and transportation to services (White Bird Clinic, n.d.). CAHOOTS is funded by the City of Eugene, supplemented by donations.

What doesn't CAHOOTS do? They do not serve as law enforcement; they do not make arrests. They are unarmed and do not use lights or sirens. However, CAHOOTS is clear that they are in partnership with police and fire departments. They cannot respond to scenes of violence, where weapons are involved, or to "criminal or dangerous situations" (White Bird Clinic, n.d.). In a social media post linked on its website, CAHOOTS poses the question: "How does CAHOOTS both support Black Lives Matter and work with police?" Their answer: "Thoughtfully. . . . Police officers and the fire departments are our community partners in the public safety system. Our work is different, but it overlaps. We work together to respond to community needs" (White Bird Clinic, n.d.).

CAHOOTS reported that in 2020 they responded to around 24,000 calls and requested police backup about 250 times. This is an enormous money-saver, estimated to reduce yearly Eugene public safety expenditures by about $8.5 million, and ambulance and emergency room costs by about $14 million. The entire annual CAHOOTS budget is just over $2 million (White Bird Clinic, n.d.).

The CAHOOTS program attributes its success to several factors, including its longstanding position of trust in the community as well as the primary goal that underlies all of its actions: to help. A key to good outcomes is certainly the robust staff training. Compared to police officers who may have a few dozen hours of training on crisis response, CAHOOTS workers typically undergo several hundred hours of training and practice in crisis response, de-escalation, and other tools—in the classroom and the field—before operating independently in two-person teams. Notably, team members also participate in mentorship programs to process their crisis work and maintain their own mental health so that they can continue to productively serve others (Beck et al., 2020). The importance of these measures is discussed more in **Chapter 10** of this text.

Please watch the linked video clip in figure 5.13 to hear from former CAHOOTS crisis worker Ebony Morgan, who was interviewed about the program in 2020 in the aftermath of the George Floyd murder. Morgan shares her personal connection to the mission of the program (her own father was killed in a police encounter), as well as her professional insight on why and how CAHOOTS works so well.

This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=K-abSfki-IM**

Figure 5.13. A video clip from CNN featuring an interview with former CAHOOTS team member Ebony Morgan, who shares her insights into the successes and challenges of this model crisis response program. **Transcript.**

Crisis Stabilization Centers

The third core element in a functional crisis response system is a "place to go." Although the preference is for services to meet people where they are and serve them without the need for relocation, that is not always possible. Whoever responds to a crisis (including police) may need a place to transport a person to keep them safe. Without appropriate alternatives, that place tends to be either a hospital emergency department or a jail—both expensive and usually inappropriate options for a person experiencing a temporary mental health crisis. While the problems inherent in jailing people are obvious, many people may not realize that the chaotic and stressful environment of hospitals can also be very difficult and disruptive for people in crisis, not infrequently leading to escalating problems.

Places that best serve people in crisis are often known as **crisis stabilization centers** or receiving centers. Regardless of the precise name, these are facilities that typically focus on less than 24-hour care (i.e., they are temporary and non-residential) for behavioral health crises, and they follow what is called a **no-wrong-door approach**. The no-wrong-door idea is meant to convey that anyone can receive services there, whether they walk in or are brought by a crisis team or law enforcement, and once there, they will be assessed for whatever care they need at whatever level, large or small. No one is turned away or treated as if they came in a "wrong door."

Many factors contribute to the creation of a no-wrong-door facility. For example, chairs and recliners, rather than beds, may be offered to ensure that physical space is not a barrier to admission. Stabilization centers must also make the commitment that when a person needs additional treatment, the facility will make that determination and any necessary arrangements. Specifically, law enforcement should never be put in the position of assessing a person's needs and navigating the crisis system. With the understanding that no one will be rejected and a smooth handoff will be possible, first responders will (in theory) not hesitate to use this option as a "place to go" rather than jails or hospitals.

The majority of states have at least some crisis stabilization programs in place, and many have facilities in the works, if not yet fully operational. However, as with mobile crisis services, assuring these programs are available statewide and 24/7 is a major challenge for nearly all states. Hiring and training a workforce to staff these facilities is the biggest challenge.

Watch the short video linked in figure 5.14 to learn about the Stabilization Center in Deschutes County, which provides many services, including a 23-hour respite center.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=i5RG4zdcb14

Figure 5.14. A two-minute video introducing the stabilization center located in Deschutes County. While facilities will vary in appearance and services, most will follow the best-practice guidelines discussed in this section and explained in this video. **Transcript.**

Crisis stabilization centers can be supported by facilities that provide slightly different levels or types of service. Examples are short-term residential facilities, which are home-like facilities that can serve as an alternative to hospitalization for people who need more continuous monitoring. Peer-operated respite programs are also short-term care facilities but run by peers. Some facilities offer the valuable services of a stabilization facility but must limit those to certain needs or certain days and hours. In Hillsboro, Oregon, for example, the Hawthorn Walk-In Center is highly

praised but only available during part of the day, 6 days per week (Washington County, n.d.). Oregon, like many states, needs far more stabilization and support programs than it has available, and there is not always agreement on where funding should be directed (e.g., longer-term facilities versus "no wrong door" crisis facilities that take all comers) (Bernstein, 2023).

Licenses and Attributions for Reducing Police Encounters: Crisis Response

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Figure 5.7. "There is Hope. Text or Call 988" by SAMHSA, which is in the Public Domain.

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Figure 5.9. Mobile crisis team hits the streets in Clark County by KGW News is licensed under the Standard YouTube License.

Figure 5.10. How Project Respond supports our community with crisis mental health care by KGW8 is licensed under the KGW8 Terms of Service.

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Figure 5.14. Stabilization Center Tour by Deschutes County is licensed under the Standard YouTube License.

5.4 Crisis Prevention: Help and Treatment

As the creators of the 988 Lifeline acknowledge, a crisis line is a valuable tool, but it cannot stand alone as a crisis resolution system. Rather, hotlines need to ultimately connect people to services, and more intensive levels of service need to be available and provided to people who are at high risk of engagement with the criminal justice system. Where supportive services are in place, crises involving police may be reduced, and where they fall short, crises will continue to occur and involve police contact. It is not unusual for people who end up in violent confrontations with police to later be seen as having fallen in a large "gap" between those well enough to succeed in the community with minimal support and those impaired enough to need care in a hospital (Levinson, 2021).

Earlier chapters of this text have touched on available treatment modalities and systems. Treatment in custody and via involuntary hospitalization are discussed later, in **Chapter 7** and **Chapter 9**. What if there were more intensive and supportive forms of treatment to reach those who fall into the "gap" between more casual care and institutional care? Could this variety of treatment be part of a larger system of crisis management?

Assertive Community Treatment (ACT)

Intensive community-based treatment approaches exist, and they are proven to work. One such model, known as **Assertive Community Treatment (ACT)**, is a model of care that has been used and studied for decades. The ACT approach allows people with serious mental disorders (such as schizophrenia) to access treatment and services in an intense model while living in their communities, thus decreasing the need for hospitalization for this population (figure 5.15). ACT is intended to be both non-restrictive and accessible. The ACT model provides a person with continuous services from a team of providers with different specialties, called a **multidisciplinary team**, and treatment is offered in the person's own home (or shelter or gathering place) instead of in a clinic or office (Cunic, 2020).

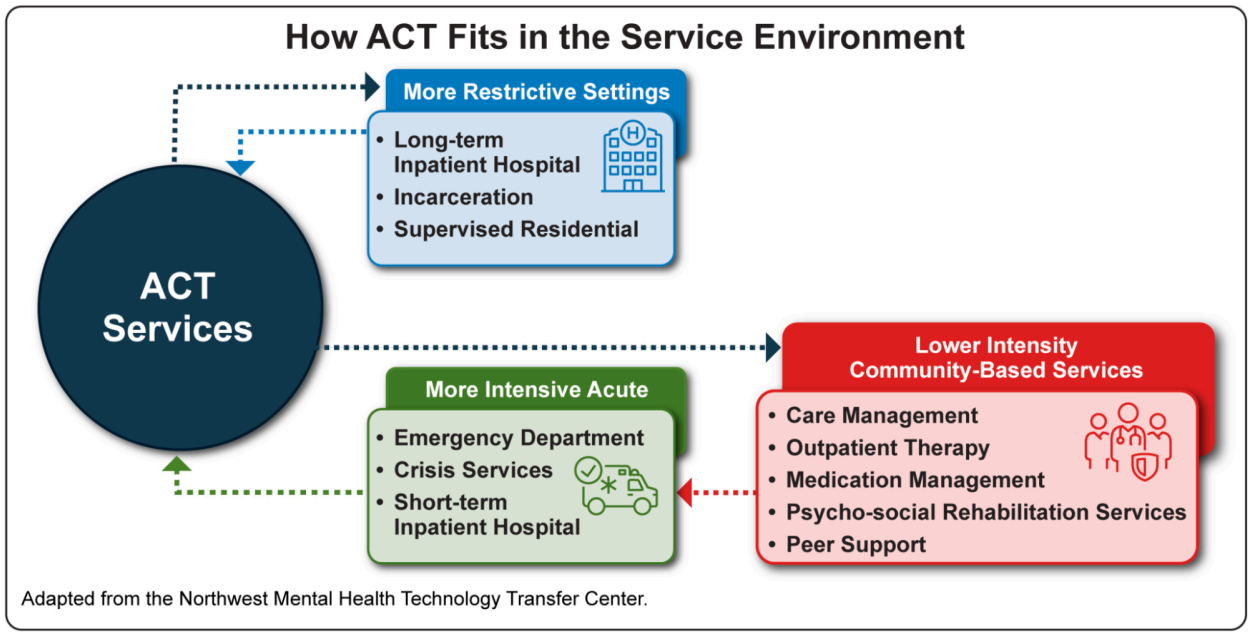

Figure 5.15. This diagram shows how Assertive Community Treatment (ACT) services, the intensive treatment approach described in this section, fits into the larger picture of proactively addressing issues presented by mental disorders. ACT services can transition people away from care in restrictive settings (like hospitals and prisons), while helping them bypass crisis services (and law enforcement engagement) with a supported transition to community-based services (SAMHSA, 2023b). Image description available. **Image description.**

ACT treatment is intended to prevent people from having to be in a hospital and also prevent them from becoming unhoused or otherwise going into acute crisis (Cunic, 2020). The ACT team provides everything to a participating person, from assessments to psychiatric and substance abuse treatment to daily life support, including going to appointments, managing medications, and seeking or maintaining employment. ACT team members include a prescriber such as a psychiatrist or nurse practitioner, a therapist, a substance abuse specialist, a case manager, and a peer support person (The Oregon Center of Excellence for Assertive Community Treatment [OCEACT], n.d.-a). The team typically engages with a person under the ACT model around four times per week. According to the Oregon Center of Excellence for ACT, a significant number of people who engage in ACT programs eventually become ready to step down to lower levels of support (OCEACT, n.d.-b ; OCEACT, n.d.-a). If you are interested in learning more about ACT, watch the linked video produced by SAMHSA in Figure 5.16, which introduces the model.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=o6NtKACjwps

Figure 5.16. This optional video introduces the ACT model, including the ACT treatment team and typical clients. As you watch, consider the myriad challenges associated with experiencing serious mental illness and navigating daily life challenges. Also, consider the importance the ACT model places on providing services in a person's community to foster independence. **Transcript.**

Forensic Assertive Community Treatment (FACT)

An extension of ACT is known as FACT, or **Forensic Assertive Community Treatment**. FACT (like ACT) provides community-based, continuous services via a multidisciplinary team. The **forensic,** or court-related, aspect of the FACT team is directed specifically toward people who have been involved in the criminal justice system—clients with serious mental illness who have been arrested/incarcerated and who have significant criminal risk. To this end, the FACT team adds criminal justice specialists, including a peer specialist with lived experience in the criminal justice system. FACT is an intervention that bridges the behavioral health and criminal justice systems (SAMHSA, n.d.).

In Multnomah County, Oregon, Cascadia Health provides FACT services. Cascadia aims FACT services at people with serious mental illness who need intensive support (e.g., a history of hospitalizations or being unhoused) and who also have repeated criminal justice involvement (e.g., frequent arrests) with "moderate to high risk to reoffend." Cascadia's program can serve a maximum of 45 clients drawn from a very-high needs group (Cascadia Health, n.d.-b). The qualifying level of need, in addition to capacity limits, obviously restricts the number of people who can be served in a FACT program.

While ACT and FACT are highly supportive options, these are not approaches that are available to all who might benefit. In Oregon, for example, most counties have one ACT provider, but at least six counties have none (OCEACT, n.d.-c). ACT and other intensive service models require referrals, often from hospitals or other crisis care programs.

Licenses and Attributions for Crisis Prevention: Help and Treatment

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5.5 Crisis Services for Special Populations

An important focus for states trying to improve their crisis response systems is ensuring those services meet the needs of diverse groups. To be effective, crisis response must be available to anyone, anytime, anywhere. This includes availability to populations that are traditionally overlooked in planning, yet who we understand to be especially vulnerable to harm. The federal agency SAMHSA surveys states' progress toward meeting these goals, helping to identify areas of improvement as well as shortfalls and areas for growth.

In SAMHSA's 2023 summary report on behavioral health crisis systems nationwide, 21 states reported that their crisis systems "recognized" racially and ethnically diverse communities and acknowledged their overrepresentation in the mental health and correctional systems. However, disappointingly few states were able to "describe

how crisis services systems will be tailored to address the unique needs of diverse racial and ethnic communities" (SAMHSA, 2023c). Oregon is one state that has articulated some plans in this area, including the development of a workgroup focused on improving crisis services for Black, Indigenous, and people of color (BIPOC) communities. Likewise, Wisconsin is implementing a peer-run "warmline" to support diverse populations across the state; peers will identify as Latinx, Black, or Hmong. Virginia also reports efforts to improve relationships between the various organizations in the crisis response system to ensure BIPOC leadership and participation in services and research.

The city of Minneapolis has launched efforts to provide mobile crisis teams ready to respond to underserved populations and people of color, with particular recognition of the stigma that may be associated with their services in certain communities. Watch the short video link in figure 5.17 to hear from one Minneapolis crisis responder.

This interactive content is not available in this version of the text. It can be accessed online here:
https://youtu.be/AH_d3fwOBHs

Figure 5.17. This video introduces mobile crisis services in Minneapolis, Minnesota, that exhibit awareness of cultural and language barriers to care. **Transcript.**

Eighteen states claim engagement in activities related to improving crisis services for Native Americans and/or Alaska Natives. Most of these states are collaborating with tribal communities and governments to ensure that services are culturally relevant and meet the unique needs of tribal populations. Alaska reported a need to address access challenges where roads are lacking and travel is limited to air or water. Access is key to making sure people in these communities who need services do not have to be transported hundreds of miles away from their homes, families, and cultural traditions (figure 5.18).

Figure 5.18. According to the Centers for Disease Control, American Indian and Alaska Native people are at significantly higher risk of dying by suicide compared with other Americans. How could this information shape crisis response?

A minority of states (16, including Oregon and Washington) provide crisis services specifically targeted to individuals in the LGBTQIA+ community. More states reported efforts to address crisis needs in elderly populations, and almost all states currently have specific crisis services in place for children. For children, states have been seeking to expand crisis services in schools and to grow the crisis workforce (including peers) for children and youth. One National Suicide Prevention Lifeline site in Oregon provides youth- and young-adult-specific text services through the Youthline. Mobile Crisis Response is also available for children and youth in Oregon.

Additional special populations that many states consider specifically in crisis planning include veterans, people living in remote or rural areas, and people with co-occuring mental health disorders (e.g., gambling or substance use disorders in addition to mental health needs). Targeting these populations, and all of those discussed in this section, to better understand and meet their needs is critical to an effective crisis response system that avoids the overuse of police responses and criminalization of mental disorders.

Licenses and Attributions for Crisis Services for Special Populations

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Figure 5.18. **American Indian and Alaska Native People** by **Centers for Disease Control and Prevention** is in the **Public Domain**.

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Figure 5.17. **Mobile Crisis Services in Minneapolis** by **cityofminneapolis** is licensed under the **Standard YouTube License**.

5.6 Improving Police Encounters

Sometimes, police encounters with people with mental disorders or who are in crisis need to happen. There are limits on crisis response systems, and when those limits are reached, the responsibility of dealing with crises will fall to law enforcement. Additionally, some people who experience mental disorders are contacted by police due to conduct or presentation of risks that legitimately require their arrest. In these cases, the focus needs to be on making police encounters as safe and as productive as possible.

Many resources address specific policing techniques and scenarios. This textbook is not one of them. However, this section offers some general information to increase awareness of the risks associated with police encounters involving mental disorders and some ideas to reduce those risks. Two important approaches that may improve police interactions with people with mental disorders are, first, use of targeted training programs, and, second, use of specialized police teams or units to take those calls that are known to involve mental disorders. Officers who are well-prepared and experienced tend to be more willing, even eager, to resolve encounters constructively. Fortunately, there are plenty of law enforcement officers (including some of those highlighted in this section) who offer positive examples and insight for criminal justice students.

Use of Force in Crisis Encounters

The information in the introduction to this chapter and in the upcoming Spotlight about Portland's James Chasse makes clear the most dire risks associated with excessive use of force against people with mental disorders. Police also use force in many situations that draw less attention but remain quite harmful. NAMI takes the position that police should seek to avoid the use of force entirely against people experiencing problems due to mental disorders, arguing that the use of any force is especially harmful to this vulnerable group. NAMI urges law enforcement leaders and policymakers to "prioritize policies that prevent use of force when law enforcement is responding to a person in a mental health crisis to reduce trauma and tragedy" (NAMI, 2024).

Use of force by police officers, in any case, must occur only when necessary; this is a demand of our Constitution and laws. Should police, as

NAMI asserts, go a step further and seek to avoid all use of force against those experiencing mental disorders? Policy enacted by the Portland Police Bureau (PPB) seems to endorse this position, urging restraint in the use of force with this particular group. PPB's general use of force policy states:

> The Bureau recognizes that members may need to use force in the performance of their duties. In these circumstances, the community expects and the Bureau requires that members use only the objectively reasonable force necessary based on the totality of the circumstances (City of Portland, 2023).

However, PPB policy goes on to specifically recognize mental disorders as a moderating consideration weighing against the use of force:

> Members shall attempt to avoid or minimize the use of force against individuals in actual or perceived mental health crisis or those with mental illness and direct such individuals to the appropriate services, where possible (City of Portland, 2023).

Unfortunately, despite positions and policies to the contrary, people with mental disorders nationwide are not spared the use of force more often than others—rather, they are at higher risk of experiencing police use of force than other groups. People with serious mental illnesses (such as schizophrenia) are more than ten times as likely as others to experience the use of force in law enforcement interactions as people without those diagnoses (NAMI, 2024). NAMI attributes this disparity to a number of underlying problems, including officer misinterpretation of unusual behavior and unexpected responses to commands that may be demonstrated by people with mental disorders. Accordingly, it is vital that police engage in training that teaches them about mental disorders and emphasizes **de-escalation**—the use of skills to slow events and decrease the risk of physical confrontation. Also critical is the development of police department culture that seeks to minimize the use of force, as communicated by its leaders and its policies, and demonstrated by officers in performing their duties (NAMI, 2024).

Crisis Intervention Team Training

For police to respond appropriately to people with mental disorders, they require appropriate training. The most well-known of these training approaches, **Crisis Intervention Team (CIT) training**, is also known as the "Memphis Model" after the city where it was created. CIT training is intended to help criminal justice professionals safely and effectively respond to individuals in crisis by emphasizing de-escalation techniques and referrals to mental health and social services.

Development of the CIT Approach

Citizens in Memphis raised a public outcry after Memphis police officers killed a young Black man, Joseph DeWayne Robinson, in 1987. Details are scarce regarding Robinson's story, but it was clear after his death that his only weapon was a knife, that he was suicidal, and likely his only intent was to hurt himself. Robinson was shot by police, and the outraged city demanded action. This action came in the form of a new type of training known as Crisis Intervention Team, or CIT, training (figure 5.19) (University of Memphis, n.d.).

The CIT Center in Memphis, Tennessee, now holds itself out as a resource for police departments across the country seeking to avoid outcomes like that in the Joseph DeWayne Robinson case and so many others since then. The CIT Center touts the CIT training model as a best practice recognized by organizations such as NAMI, the Department of Justice, and SAMHSA (University of Memphis, n.d.). In addition to its benefits for

community members interacting with police, CIT training has been credited with reducing officer injuries in mental health crisis calls by 80% (NAMI, n.d.).

Figure 5.19. Officers engaged in classroom training. Many officers offer positive examples and insight into improving crisis services. What training objectives would you want them to meet?

Crisis Training Objectives

CIT training teaches law enforcement officers how to work as a team to meet the immediate needs of people with mental disorders and how to divert these individuals away from incarceration (at the Intercept 1 point discussed in **Chapter 4**). The objectives of CIT training are admirable and in line with the goals addressed throughout this text:

- To decrease the risk of harm to individuals in crisis;
- To promote decriminalizing individuals with a mental illness;
- To lessen the stigma associated with mental illness; and
- To reduce injuries to law enforcement officers.

Specific elements of CIT training may vary by location, but 40-hour programs typically include at least these elements: active listening, specific mental health diagnoses and suicidality (including officer suicide), legal information, and de-escalation techniques (University of Memphis, n.d.; Why Crisis Intervention, 2019).

Originally envisioned and used as special training for certain officers, CIT is gradually becoming more of a standard practice. Some believe it should be a mandatory element of all police training. Many police departments (including the Portland Police Bureau) have shifted towards requiring basic CIT training, along with regular updates, for

all of its officers. As a state, Montana includes CIT training as part of its law enforcement academy and makes the training available throughout an officer's career. Montana has found that incorporating CIT has helped to shift the culture in the state surrounding law enforcement's response to mental illness. The training in Montana has evolved over time to incorporate peer-to-peer training, in which officers train other officers on how to best address mental health issues (Ezekiel, et al. 2021 as cited in SAMHSA, 2023c).

Training should always be updated as our knowledge evolves. A variation on CIT training, called CRIT (Crisis Response and Intervention Training) has recently been piloted in a few cities around the country, including Corvallis, Oregon. CRIT is described as an "extension" of CIT training, with some added emphases—including a much-needed focus on police interactions with people who experience developmental disorders and intellectual disabilities (Davis, 2023). It remains to be seen whether CRIT is a variation that will exist alongside CIT or whether its innovations represent a shift that will be made on a larger scale in the future. If you are interested in learning more about the CRIT pilot program, take a look at the **Corvallis Police website** for more information.

Focus on De-Escalation

De-escalation relates closely to avoiding the use of force and, therefore, it is a way to keep people safe. The Department of Justice defines de-escalation as:

> [T]he range of verbal and nonverbal skills used to slow down the sequence of events, enhance situational awareness, conduct proper threat assessments, and allow for better decision-making to reduce the likelihood that a situation will escalate into a physical confrontation or injury and to ensure the safest possible outcomes (U.S. Department of Justice, n.d.-a).

In other words, effective and useful de-escalation is a complex concept that includes communication and physical action, as well as other elements, such as awareness of implicit bias that can impact actions and decisions (U.S. Department of Justice, n.d.-a).

Effective de-escalation techniques may vary depending on the identities of the officer(s) using them, as well as those of the person being engaged by police. This is one of many opportunities to consider how policing and our communities might benefit from a more diverse police force (figure 5.20). For example, most de-escalation training is taught by and for men, who still make up the vast majority of law enforcement professionals. Women make up less than 15% of full-time law enforcement officers in the United States (Van Ness, 2021).

Figure 5.20. Gender diversification of police departments brings benefits, including the reduction of excessive force.

Commenters have observed that women may more naturally tend to de-escalate situations, perhaps stemming from the physical reality that most women cannot actually "muscle" their way out of confrontations and may be socialized throughout their lives to work as peacemakers. Female officers

more readily rely on their voices, their reason, and their empathy to de-escalate situations. Some advocates suggest that a substantial increase in women on police forces might be critical to truly changing the culture of policing: female officers are statistically less likely to use excessive and deadly force than male officers, and so are male officers who work alongside female officers (Naili, 2015). However, adding more women does not solve all policing problems: even where police departments increase their female employees, racial disparities in arrests have not notably improved (Corley, 2022).

Direct training and practice of individual de-escalation techniques are basics of police training and a focus of CIT training. Watch the short (3 minute) video in figure 5.21 sharing the experience of officers engaged in CIT de-escalation training, noting the methods used to build empathy among the officers. Do you believe these are effective approaches?

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=QQ01xCL6B0Y

Figure 5.21. This news report shows New Jersey police training on de-escalation techniques, which can be as simple as talking to a person to establish common ground. **Transcript.**

SPOTLIGHT: A Death in Portland

In September of 2006, Portland, Oregon, experienced a tragedy that involved a police encounter with a person with mental illness. Though not an isolated incident, it shook the city and continues to be part of conversations about these issues now, almost twenty years later.

James Chasse, a slender 42-year-old man, had a diagnosis of schizophrenia. Chasse lived in an apartment near downtown Portland, and he had at some point before his death stopped taking his psychiatric medications. His mental health had deteriorated (Slovic, 2014). On the day of his death, September 17, Chasse was violently arrested by several officers on the streets of Portland's Pearl District. There was, as it turned out, no real reason for the arrest, and during it, a terrified Chasse was brutally injured—not by a gunshot but by the hands, bodies, and taser of police and a sheriff's deputy. Later, medical examiners would reveal that among Chasse's many injuries were 26 breaks on 16 of his ribs (Slovic, 2014). A photograph, taken by a man working in a nearby restaurant, shows officers and medical personnel standing around a bloody and hog-tied Chasse as he suffers (figure 5.22). In and out of consciousness, Chasse did not stop breathing until later, when he was taken to the jail instead of a hospital at the direction of officers on-scene. Chasse's death occurred 106 minutes after the initial police contact (Slovic, 2014).

Figure 5.22. James Chasse lies on the sidewalk in Portland, surrounded by police.

Portlanders were overwhelmingly horrified and outraged by this brutality in broad daylight on the then-clean streets of early 2000s Portland. Hundreds of people attended Chasse's memorial (figure 5.22). Seeking answers, the City of Portland commissioned an investigation and eventually released a report of the details around Chasse's death, including a number of recommendations for change. If you are interested, that report is available here: **Report to the City of Portland Concerning the In-Custody Death of James Chasse [Website]**.

Figure 5.23. Items at James Chasse's memorial service, including a portrait of Chasse.

No officers were charged or, ultimately, disciplined for the events that caused Chasse's death. However, some changes have occurred over time. In 2011, for example, the city opened a 16-bed Crisis Assessment and Treatment Center in Multnomah County. Additionally, in 2012, after a federal investigation into the Portland Police Bureau, the U.S. Department of Justice found that the bureau had a pattern of using excessive force against people with mental disorders (including Chasse), and better training and other measures were required by that settlement (Slovic, 2014). Those efforts are still a work in progress, but now every Portland Police officer receives CIT training to better prepare them to serve people with mental disorders in the community.

One of the officers involved in Chasse's death left the sheriff's office and joined PPB as part of its unit that specializes in mental health responses. "'It's definitely something that's changed my life,' [the officer stated in an interview regarding] Chasse's death, 'and changed the way we do police work here in the city'" (Slovic, 2014). There is little question, however, that Portland can do even more, both in terms of concrete change and building trust among community members. It is not unthinkable to many people that a similar set of events could happen today.

Filmmaker Brian Lindstrom made a documentary about the life and death of James Chasse, and it is fascinating and heartbreaking to watch and hear from so many people who were involved in Chasse's life, as well as in his death. A 2-minute trailer for that film is linked in Figure 5.24; you may want to watch the full film online if you are interested. If you do watch the film,

consider whether the attitudes, actions, and outcomes of any of the participants would be different if these events occurred in Portland today.

This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=hllAMAA01b4**

Figure 5.24. This video provides a glimpse of **Brian Lindstrom's documentary film** about James Chasse, *Alien Boy*. **Transcript.**

Specialty Units and Co-Responder Teams

In addition to individual officer training, police departments seek to improve their handling of behavioral health calls through the use of specialty units and teams. Designated units allow police bureaus to respond to these calls with officers who have enhanced training and are aware of the resources available to them. Officers in these specialty behavioral health units generally have not only additional training but also a desire to take on this particular role.

Some specialized police units pair trained officers with mental health practitioners who can bring their skills into police encounters, to the benefit of all (U.S. Department of Justice, n.d.-b). These collaborations are referred to as co-responder teams. The U.S. Department of Justice encourages the development of specialized mental health and co-responder programs in police bureaus, and it offers funding opportunities, as well as information support, for bureaus pursuing this option (U.S. Department of Justice n.d.-b). While models, practices, and outcomes vary from department to department, researchers have observed several advantages of this model: better crisis de-escalation, increased connection of individuals to services, reduced pressure on the criminal justice system (e.g., fewer arrests and less time spent by officers on calls), and reduced pressure on the health care system (e.g., fewer emergency department visits and psychiatric hospitalizations) (University of Cincinnati, n.d.).

Watch the short video clip in figure 5.25 to hear from a police chief discussing his experience with CIT training and co-responder teams in his department in Portland, Maine. The chief emphasizes the safety improvements that come along with these advancements and discusses the need to shift police culture in favor of these improvements.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=nAUF99P7U0s

Figure 5.25. A video clip of a Portland, Maine, police chief discussing CIT training and police collaboration with mental health professionals. **Transcript.**

Leadership in Portland, Maine, is not alone in appreciating the importance of police "culture" change. A *New York Times* report on the leadership of Portland, Oregon, in using CIT training (figure 5.26) highlighted the resulting changes in officer approaches as contributing to safety, but also noted that effective CIT-based approaches need "the full backing of a police department's leadership, continual checks on . . . effectiveness, and collaboration with the mental health community" (Goode, 2016).

Figure 5.26. All Portland police officers have CIT training that has allowed them to increase the safety of their interactions with people with mental disorders.

As noted, police specialty units, including co-responder units, employ different approaches with varying levels of success in different communities. Consider the following two videos of programs in Bellingham, Washington, and Portland, Oregon, where police use specialized training and resources to address challenging calls related to mental disorders.

Behavioral Health Officer

As an example of officers using behavioral health training and experience, watch the 10-minute video in figure 5.27 that was produced by the Bellingham, Washington, police department. The video depicts, and narrates from the law enforcement perspective, an encounter with a person in crisis. Body camera footage is shown to portray the real situation. Consider as you watch: what things went right here? What were the officers' concerns? What did, or could have, gone wrong? Which elements of this response were required because this was a law enforcement event, and which were optional? And what, if anything, might you have done differently?

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=szbTcECOQ7c

Figure 5.27. A video showing an interaction between police officers and a person in crisis. The primary officer is part of the Belling-

ham Police Department's specialized Behavioral Health Unit. Transcript.

Co-Response Team

In Oregon, the Portland Police Bureau (PPB) also has a Behavioral Health Unit, which responds to assist people in the community in crisis or struggling with mental disorders, including substance use disorders. While all Portland police receive CIT training, certain Behavioral Health Unit officers have "enhanced" training on mental disorders and de-escalation tactics beyond that provided to other officers. These officers with enhanced training serve in a voluntary capacity on teams that can be dispatched to situations requiring these particular skills and techniques. PPB reports a very low incidence of use of force by these officers: force (of any level) is employed in only one in 500 calls where officers with enhanced CIT training respond (Behavioral Health Unit, n.d.).

A co-response team called the Behavioral Health Response Team is one tier of service employed by PPB's Behavioral Health Unit (Behavioral Health Unit, n.d.). Watch the video in figure 5.28 to get an inside view of PPB's co-responder team in action. Both members of the team share their perspectives on the work they do. As you watch this video, consider the benefits of having behavioral health providers and specially trained police officers working together as a team to meet the needs of community members. What are the positives and negatives of this arrangement? If you were the person in need, is this a team that you would want to respond?

This interactive content is not available in this version of the text. It can be accessed online here:
https://youtu.be/X537AK7wvYA

Figure 5.28. An officer in PPB's Behavioral Health Response team and his partner, a mental health clinician, share their thoughts about their work in the community. The PPB officer describes his role on the team as his "dream job." Transcript.

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Figure 5.19. **Photo of officers in training** by Eric Wheeler at **Metro Transit** on **Flickr**.

Figure 5.20. **Photo of Denver police at a protest** by **Colin Lloyd** on **Unsplash**.

Figure 5.21. **Police officers take course teaching de-escalation techniques** by **NJ Spotlight News** is licensed under the **Standard YouTube License**.

Figure 5.22. **Photograph of James Chasse** by Jamie Marquez, *Portland Mercury*, is included under fair use.

Figure 5.23. **Photograph of James Chasse at his memorial** by **Compassionpdx** is licensed under **CC BY-SA 3.0**.

Figure 5.24. **James Chasse Documentary Trailer** by **Mental Health Association of Portland** is licensed under the **Mental Health Association of Portland** terms of service.

Figure 5.25. **Learning About Police-Mental Health Collaboration Programs** is licensed under the **Standard YouTube License**.

Figure 5.26. **Photo of Portland police** by **Wesley Mc Lachlan** on **Unsplash**

Figure 5.27. **Bellingham Police Perspective Project / 20E5: Responding to a Behavioral Health Crisis**by **Office of Justice Programs** is licensed under the **Standard YouTube License**.

Figure 5.28. **Behavioral Health Unit: Ride along with a Behavioral Health Response Team** by **Portland Police** is licensed under the **Standard YouTube License**.

5.7 Chapter Summary

- Policing people with mental disorders who are in crisis comes with numerous risks. There are countless examples of police encounters with people in crisis that have gone terribly wrong, ending in serious harm or death to the person in need of help.
- Reducing police-involved harm to people with mental disorders can include both measures to avoid these encounters by providing proper alternatives and efforts to improve police encounters when they are required.
- Robust community behavioral health crisis response systems can serve to reduce the number of encounters between police and people with mental disorders by avoiding the need for law enforcement response to crises and replacing law enforcement with crisis services.
- Core elements of a robust community crisis response system include crisis lines (someone to call), mobile crisis teams (someone to respond), and crisis stabilization units (somewhere to go). Intensive community-based treatment can help prevent crisis situations for people who are most at risk of police encounters.
- Some police engagement with people who experience mental disorders is inevitable. Police must have knowledge of risks, training in crisis response, and awareness of and access to appropriate resources to best serve their communities and avoid tragic outcomes. Police focus should be on de-escalation of encounters and avoiding use of force where safe and feasible. Specialty police units with additional training and personnel can be an effective policing approach to people in crisis and people with mental disorders generally.

KEY TERM DEFINITIONS

- **Assertive community treatment (ACT):** A community-based model of care where mental health services are provided by a team in a person's home or in a community location. ACT has the goal of keeping people with serious mental disorders in the community and decreasing hospital admittance.
- **Crisis Intervention Team (CIT) training:** A program aimed at training criminal justice professionals to safely and effectively respond to individuals experiencing mental health crises. CIT training emphasizes de-escalation techniques and referrals to mental health and social services.
- **Crisis line:** A telephone line or hotline, other than 911, that provides a connection between a person in need and services. The federal Suicide and Crisis Lifeline (988) is an example.
- **Crisis response system:** A network of community supports (including someone to call, people to respond, and a place to go) for people experiencing behavioral health crises. A functioning crisis response system avoids criminal justice involvement in response to crises.
- **Crisis stabilization center:** The element in a crisis response system that provides a person in crisis with a place to go for help, if needed, other than jail or a hospital. Crisis stabilization centers can take different forms, but 23-hour respite centers are an example.
- **De-escalation:** Use of skills to slow events, decrease risk of physical confrontation, and increase opportunity for improvement of outcomes.
- **Forensic:** Relating to investigatory or court proceedings.
- **Forensic Assertive Community Treatment (FACT)**: An extension of ACT, which provides community-based, continuous services via a multidisciplinary team, that is directed specifically toward people who have been involved in the criminal justice system.
- **Mobile crisis team:** A team, often consisting of a mental health worker and a peer support provider, that responds to mental health crises in the community. Team members vary, and some operating under this name may include different types of professionals including law enforcement professionals.
- **Multidisciplinary team:** A team of providers with members from different professions or specialities. ACT and mobile crisis teams, for example, are multidisciplinary.
- **No-wrong-door approach**: The idea that anyone can receive services at a provider, whether they walk in or are brought by a crisis team or law enforcement, and once there, they will be assessed for whatever care they need at whatever level, large or small.

DISCUSSION QUESTIONS

1. Best practice guidelines dictate that mobile crisis teams should operate without law enforcement. Do you agree with that approach, and why?

2. What are the benefits of crisis stabilization centers? Are there negatives to using these facilities as a "place to go" in a crisis? What is the importance of the "no wrong door" approach?
3. Mental health advocates urge police to avoid the use of force to the maximum extent possible when working with people who experience mental disorders. Why? How can police accomplish this goal?
4. If you or a family member were experiencing a mental health crisis, what type of community response would you want to receive?

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5.8 References

Abramson, A. (2021, July 1). Building mental health into emergency responses. *American Psychological Association.* https://www.apa.org/monitor/2021/07/emergency-responses

Beck, J., Reuland, M., & Pope, L. (2020, November). *Case study: CAHOOTS, Eugene, Oregon*. Vera Institute of Justice, Behavioral Health Crisis Alternatives. https://www.vera.org/behavioral-health-crisis-alternatives/cahoots

Behavioral health crisis services. (n.d.). Multnomah County. https://www.multco.us/behavioral-health/mental-health-crisis-intervention

Behavioral health unit. (n.d.). City of Portland. https://www.portland.gov/police/divisions/behavioral-health-unit

Bernstein, M. (2023, September 26). Multnomah County chair pursues stabilization services over drop-off triage center to combat drug, mental health crisis. *The Oregonian.* https://www.oregonlive.com/portland/2023/09/multnomah-county-chair-pursues-stabilization-services-over-drop-off-triage-center-to-combat-drug-mental-health-crisis.html

Cascadia Health. (n.d.-a). *Crisis Intervention, Project Respond*. https://cascadiahealth.org/services/crisis-intervention/

Cascadia Health. (n.d.-b). *Mental health treatment, We all need help sometimes.* https://cascadiahealth.org/services/mental-health-treatment/#:~:text=Cascadia%27s%20Forensic%20Assertive%20Community%20Treatment,and%20physical%20health%20and%20wellness

City of Portland. (2023, December 15). *1010.00 Use of Force*. https://www.portland.gov/policies/police-directives/weapons-ammunition-equipment-1000/101000-use-force

Clifford, T. (2022, October 6). Family of man who died in police custody settles lawsuit with City of Rochester. https://www.reuters.com/legal/family-man-who-died-police-custody-settles-lawsuit-with-rochester-ny-2022-10-06/

Collier, D. & Hernandez, E. & Herrera, I. (2024, January 12). SAPD lieutenant fired, suspended for leaving shifts early the night Melissa Perez was shot, killed. *KSAT News*. https://www.ksat.com/news/ksat-investigates/2024/01/12/sapd-lieutenant-fired-sergeant-sus-

pended-for-leaving-shifts-early-the-night-melissa-perez-was-shot-killed/#:~:text=Three%20San%20Antonio%20Police%20Department,assault%20with%20a%20deadly%20weapon

Corley, C. (2022, July 31). Increasing women police recruits to 30% could help change departments' culture. *NPR*. https://www.npr.org/2022/07/31/1111714807/increasing-women-police-recruits-to-30-could-help-change-departments-culture

Cruz Guevarra, E. & Wilson, C. (2019, January 28). The safety net is broken: How police became mental health first responders. *Oregon Public Broadcasting*. https://www.opb.org/news/article/mental-health-first-responders-police-oregon/

Cunic, A. (2020, April 07). *The basics of Assertive Community Treatment*. https://www.verywellmind.com/assertive-community-treatment-4587610

Davis, H. (2023, April 12). *Crisis response and intervention training (CRIT)*. Policy Research Associates. https://www.prainc.com/crisis-response-intervention-training-toolkit-available/

Edmonds, C. (2023, July 22). A mental health crisis. An officer's gun. A too-common tragedy. *New York Times.* https://www.nytimes.com/2023/07/22/us/melissa-perez-police-shooting-san-antonio.html

Ezekiel, N., Malik, C., Neylon, K., Gordon, S., Lutterman, T., & Sims, B. (2021, August). *Improving behavioral health services for individuals with SMI in rural and remote communities*. SMIAdviser, SAMHSA & The American Psychiatric Association. https://smiadviser.org/wp-content/uploads/2021/09/Improving-Behavioral-Health-Services-for-Individuals-with-SMI-in-Rural-and-Remote-Communities-Full-Report-September-2021.pdf

Fuller, D., Lamb, H. R., Biasotti, M., & Snook, J. (2015, December). *Overlooked in the Undercounted*. https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted

Gennaco, M., Miller, R. & Ruhlin, J. (2010). Report to the City of Portland concerning the in-custody death of James Chasse. https://www.portlandoregon.gov/ipr/article/478816

Goode, E. (2016, April 25). For police, a playbook for conflicts involving mental illness. *The New York Times*. https://www.nytimes.com/2016/04/26/health/police-mental-illness-crisis-intervention.html

Green, E., & Peneff, O. (2021). *An overview of police use of force policies and research.* Illinois Criminal Justice Information Authority. https://icjia.illinois.gov/researchhub/articles/an-overview-of-police-use-of-force-policies-and-research

KCAL News. (2023, November 29). LA police commission says officers violated policies when they killed a mentally ill man. *KCAL News.* https://www.cbsnews.com/losangeles/news/la-police-commission-says-officers-violated-policies-when-they-killed-a-mentally-ill-man/#

KGW8. (2021, August 9). If 911 isn't the best choice, who do you call when you see someone in distress in Portland? https://www.kgw.com/article/news/local/homeless/portland-mental-health-crisis-response/283-e87bf87c-e3f0-430e-9ac0-dce2b37426ec

KGW8. (2022, April 26). Portland Street Response 'demonstrated success' in first year, PSU report finds. https://www.wweek.com/news/2https://www.kgw.com/article/news/local/homeless/portland-street-response-success-psu-report-expansion/

Levinson, J. (2021, July 28). Portland police killed 2 people this year. Both sought mental health care before their deaths. *Oregon Public Broadcasting.* https://www.opb.org/article/2021/07/28/portland-police-killed-2-people-this-year-both-sought-mental-health-care-before-their-deaths/

Levinson, J. (2023, June 27). Measure 110 forced Oregon to build a new drug addiction services model. Here's how that's going. *Oregon Public Broadcasting.* https://apnews.com/article/oregon-first-decriminalizing-hard-drugs-01edca37c776c9ea8bfd4afdd7a7a33e

Manfield, L. (2022, December 28). Police bureau explains why it did not discipline officers who killed two mentally ill men last year. *Willamette Week.* https://www.wweek.com/news/courts/2022/12/28/police-bureau-explains-why-it-did-not-discipline-officers-who-killed-two-mentally-ill-men-last-year/

Meko, H. & Kriegstein, B. (2023, March 30). He was mentally ill and armed. The police shot him within 28 seconds. *New York Times.* https://www.nytimes.com/2023/03/30/nyregion/nypd-shooting-mental-health.html

Naili, H. (2015, January 28). *More female officers defuse violent policing style*. Women's eNews. https://womensenews.org/2015/01/more-female-officers-defuse-violent-policing-style/

National Alliance on Mental Illness [NAMI]. (n.d.). Crisis Intervention Team (CIT) Programs. https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs

National Alliance on Mental Illness [NAMI]. (2024). *Police Use of Force*. https://www.nami.org/Advocacy/Policy-Priorities/Stopping-Harmful-Practices/Police-Use-of-Force#

Neylon, K. (2021, December 14). Embedding crisis response in Harris County's 911 dispatch center. *#CrisisTalk, CrisisNow*. https://talk.crisisnow.com/embedding-crisis-response-in-harris-countys-911-dispatch-center/

The Oregon Center of Excellence for Assertive Community Treatment [OCEACT]. (n.d.-a). Assertive community treatment. https://oceact.org/assertive-community-treatment/

The Oregon Center of Excellence for Assertive Community Treatment [OCEACT]. (n.d.-b). Oregon ACT research & outcomes. https://oceact.org/outcomes/

The Oregon Center of Excellence for Assertive Community Treatment [OCEACT]. (n.d.-c). ACT Programs in Oregon by Provider. https://oceact.org/programs/

Parafiniuk-Talesnick, T. (2021, December 10). In CAHOOTS: How the unlikely pairing of cops and hippies became a national model. *The Register-Guard.* https://www.registerguard.com/story/news/2021/12/10/cahoots-eugene-oregon-unlikely-pairing-cops-and-hippies-became-national-model-crisis-response/6472369001/

Peel, S. (2023, June 21). Portland Street Response futilely sought authority to hold distressed people against their will. *Willamette Week*. https://www.wweek.com/news/2023/06/21/portland-street-response-futilely-sought-authority-to-hold-distressed-people-against-their-will/

Portland Street Response frequently asked questions. (2023). City of Portland. https://www.portland.gov/fire/streetresponse/psr-faq

Selsky, A. (2020, November 4). Oregon leads the way in decriminalizing hard drugs. https://apnews.com/article/oregon-first-decriminalizing-hard-drugs-01edca37c776c9ea8bfd4afdd7a7a33e

Selsky, A. & Willingham, L. (2022, September 1). 'Tragic outcomes': Mentally ill face fatal risk with police. https://apnews.com/article/health-police-oregon-mental-salem-a5a933c76760a8d3929595f846876bb0

Shadraven, S. M., Edwards, M. D. & Vinson, S. Y. (2021, June 10). Dying at the intersections: Police-Involved killings of black people with mental illness. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000942

Slovic, B. (2014, November 4). Sept. 17, 2006: Police beat James Chasse to death...*Willamette Week*. https://www.wweek.com/portland/article-23444-sept-17-2006-police-beat-james-chasse-to-death.html

Substance Abuse and Mental Health Services Administration. (n.d.). *Forensic Assertive Community Treatment (FACT)*. https://store.samhsa.gov/sites/default/files/d7/priv/pep19-fact-br.pdf

Substance Abuse and Mental Health Services Administration. (2021). *Highlights for the 2021 national survey on drug use and health.* https://www.samhsa.gov/data/sites/default/

files/2022-12/2021NSDUHFFRHighlights092722.pdf

Substance Abuse and Mental Health Services Administration. (2023a). *988 Key Messages*. https://www.samhsa.gov/find-help/988/key-messages

Substance Abuse and Mental Health Services Administration. (2023b). *Maintaining fidelity to ACT: Current issues and innovations in implementation*. https://store.samhsa.gov/sites/default/files/pep23-06-05-003.pdf

Substance Abuse and Mental Health Services Administration. (2023c). *Snapshot of behavioral health crisis services and related technical assistance needs across the U.S.* https://www.samhsa.gov/sites/default/files/behavioral-health-crisis-services-snapshot.pdf

Terry, L. (2023, July 14). *Oregon's 988 suicide prevention hotline sees jump in demand*. Oregon Capital Chronicle. https://oregoncapitalchronicle.com/2023/07/14/oregons-988-suicide-hotline-sees-jump-in-demand/

Torres, R. (2023, July7). Family of Melissa Perez, who was shot and killed by 3 SAPD officers, sues City of San Antonio. *San Antonio Report.* https://sanantonioreport.org/family-of-melissa-perez-who-was-shot-and-killed-by-3-apd-officers-sues-city-of-san-antonio-for-wrongful-death/

University of Cincinnati. (n.d.). *Assessing the impact of co-responder team programs: A review of research*. International Association of Chiefs of Police, UC Center for Police Research and Policy. https://www.theiacp.org/sites/default/files/IDD/Review%20of%20Co-Responder%20Team%20Evaluations.pdf

University of Memphis. (n.d.). *The CIT Center, A resource for CIT programs across the nation*. Department of Criminology and Criminal Justice. http://www.cit.memphis.edu/overview.php?page=1

USA Facts. (2023). *How do crisis teams handle mental health calls differently from police?* https://usafacts.org/articles/how-do-crisis-teams-handle-mental-health-calls-differently-from-police/

U.S. Department of Health and Human Services. (2023). *SAMHSA announces national survey on drug use and health (NSDUH) results detailing mental illness and substance use levels in 2021.* https://www.hhs.gov/about/news/2023/01/04/samhsa-announces-national-survey-drug-use-health-results-detailing-mental-illness-substance-use-levels-2021.html

U.S. Department of Justice. (n.d.-a). Community policing development: De-escalation training solicitation. https://cops.usdoj.gov/de-escalation

U.S. Department of Justice. (n.d.-b). *Learning, Police-Mental Health Collaboration (PMHC) Toolkit*. https://bja.ojp.gov/program/pmhc/learning

Van Ness, L. (2021, October, 20). *Percentage of women in state policing has stalled since 2000*. States Newsroom. https://stateline.org/2021/10/20/percentage-of-women-in-state-policing-has-stalled-since-2000/

Washington County. (n.d.). Hawthorne Walk-In Center. https://www.washingtoncountyor.gov/behavioral-health/hawthorn-walk-center

Wesolowski, H. (2022, July 13). *Mobile crisis teams: Providing an alternative to law enforcement for mental health crises*. National Alliance on Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/July-2022/Mobile-Crisis-Teams-Providing-an-Alternative-to-Law-Enforcement-for-Mental-Health-Crises

Westervelt, E. (2020, September 18). Mental health and police violence: How crisis intervention teams are failing. *NPR.* https://www.npr.org/2020/09/18/913229469/mental-health-and-police-violence-how-crisis-intervention-teams-are-failing

White Bird Clinic. (n.d.). *CAHOOTS: Crisis assistance helping out on the streets*. https://whitebirdclinic.org/cahoots/

Why crisis intervention team training should be the standard. (2019, December 13). National Alliance on Mental Ill-

ness. https://www.nami.org/criminal-justice-and-legal/why-crisis-intervention-team-training-should-be-the-standard/

Zielinski, A. (2023, June 27). Portland Street Response, despite success, faces an uncertain future. *Oregon Public Broadcasting.* https://www.opb.org/article/2023/06/27/portland-street-response-citywide-one-year-later-future/

CHAPTER

6

Mental Disorders in the Criminal Courts: Competence and Insanity

6.1 Chapter Learning Objectives and Overview

LEARNING OBJECTIVES

The following learning objectives tell you what is most important in this chapter. Use these statements as a guide to make sure you get the most out of this chapter.

1. Explain the competence requirement and the insanity defense, describing the differences between the two.
2. Describe the conditions and standards that must be met for a person who is criminally accused to be competent to stand trial.
3. Analyze the insanity defense, considering variations of the defense and limitations on its use and success.
4. Discuss the role of mental disorders in sentencing criminal offenders.

KEY TERMS

Look for these important terms in the text in bold. Understanding these terms will help you meet the learning objectives of this chapter. You can find definitions for these terms at the end of the chapter.

- **Affirmative defense**
- **Aid and assist**
- **Competency evaluation**
- **Competence**
- **Due process**
- **Durham rule**
- **Dusky standard**
- **Excuse defense**
- **Guilty except for insanity (GEI)**
- **Insanity defense**
- **Irresistible impulse test**
- **Justification defense**
- **Legal standard**
- **Mitigation**
- **Model Penal Code (MPC)**
- **M'Naghten rule**
- **Non-qualifying mental disorder**
- **Qualifying mental disorder**
- **Restoration of competence**

Chapter Overview

When a person is accused of a serious criminal offense, they will likely face charges within the criminal courts, regardless of the presence of a mental disorder. However, an accused person's path through the criminal court system may become more complex if they have—or previously had—an active mental disorder that impacts their behavior or decision-making capacity.

The forward movement and eventual outcome of the person's criminal case will depend on the degree and the timing of their mental impairment. For example, if the accused person was very impacted by a mental disorder (perhaps experiencing severe paranoia) at the time the crime occurred, that may provide the accused with a defense to the crime. Or if the person is seriously impaired by a mental disorder at the start of court proceedings, they may be unable to properly participate in their own defense, preventing the case from proceeding. A particular case can involve one or both of these complications.

On the other hand, if the person simply has a diagnosis of a mental disorder, even a serious one, but the impacts are not significant enough or do not coincide with critical times in the criminal case, the existence of that mental disorder may not change the outcome of the case at all. Indeed, most people with mental disorders do *not* commit

crimes, and most people who commit crimes do not do so *because* of mental disorders. In this chapter, you will learn how and why a person's mental disorder may impact the operation of the criminal courts and the experience of that person within the court system.

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6.2 Competence to Stand Trial

Jose Veguilla, an elderly father of five grown children, was already in his 80s when he developed severe dementia after sustaining a brain injury in a fall. Veguilla was placed in a care home, where he displayed aggression and experienced other problems before he eventually and devastatingly killed his facility roommate by bludgeoning him with a walker. Veguilla's violent act was the first event in the story of his murder case. However, it was only later that Veguilla's mental state became an issue that impacted the court. When Veguilla first appeared in court to hear the judge read the charges against him, he clearly had no understanding of the information being provided to him (figure 6.1). His dementia prevented him from knowing even what day or year it was. He had no memory of what he had done. "'You could tell he had no clue what was going on,' said his son, Henry Veguilla. 'He was smiling for the cameras like he was at a birthday party'" (Thompson, 2023).

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=yP-BIJ8H3pc

Figure 6.1. This optional news clip reports the charges against Jose Veguilla. Although the focus is already on who is responsible for his murderous acts, given his severe dementia, the first barrier to resolving this case would be Veguilla's competence to proceed. **Transcript.**

As in the Veguilla case, early events in a criminal case typically include an appearance before a judge and a meeting with a defense attorney. If, like Jose Veguilla, the accused person has significant impairment at this point in time, the question will arise: is this person mentally able, or competent, to engage in the criminal court process? Note that this question of competence is entirely separate from the issue (which we will discuss later) of whether or not a mental disorder played any role at the time of the crime. In other words, the only issue at this point in Veguilla's case (or any similar case) is whether the defendant's mental disorder prevents him from adequately participating in the court proceedings—not whether his mental disorder caused him to kill the victim.

The issue of whether an accused person is mentally able to engage in the criminal court process is referred to by varying terms, depending on the legal language of a particular jurisdiction. Many relevant statutes use the terms "fitness" or "competence" to stand trial. **Competence** (or whatever alternative term a state uses) means that a person is able to understand what is happening and to participate in their own defense. In Oregon, competence is often referred to as the ability to **aid and assist**, a phrase that focuses on the person's

ability to work with their defense attorney as a key element of competence.

Requirement of Competence

Competence, or ability to aid and assist, looks at the accused person's mental state and abilities at the time they are engaging with their attorney or with the court—not at the time of the offending conduct. Mental state or impairment at the time of the offending conduct may be considered later, possibly in defense of the person's actions. First, however, the person must be competent to work with their attorney and the court. If a person is not competent, the criminal proceedings against them must stop. The proceedings usually just pause until the person is judged competent to move forward, but sometimes proceedings may pause repeatedly or even stop completely.

The requirement that a person be competent is an ongoing demand throughout the time a person is involved with the courts. Often, questions about competence arise early, when the person first appears in court or confers with an attorney, as in the example of Jose Veguilla. A newly appointed defense attorney who suspects their client may not be competent faces a decision: defense attorneys are supposed to zealously advocate as their client directs, not reveal their secrets. However, if there is a clear lack of competence, the attorney is probably ethically obliged to report this concern to the court. Whether raised by an attorney or the court itself, this early recognition of a competency question is often the first step in the procedures described in this chapter. Sometimes, however, competence issues can become apparent later, even in the midst of a trial. Regardless, the accused person needs to be competent to participate *throughout* their court proceedings.

Figure 6.2. It is often in the early stages of a case, when the court first becomes involved, that questions of a defendant's competence are raised.

Competence as a Constitutional Issue

Why is competence so important? And why does a lack of competence demand that a criminal proceeding be halted? The protection of individual rights is central to our ideas of fairness in the criminal justice system. We presume a person is innocent, for example, until they have been proven guilty beyond a reasonable doubt. We ensure that a person knows the charges against them, we protect them against self-incrimination, and we provide them with an attorney. These rights are guaranteed by the U.S. Constitution (specifically the Fifth and Sixth Amendments as applied to the states by the Fourteenth Amendment). These constitutional amendments are intended to ensure that every single person in the criminal justice system is governed by the same fair rules and pro-

cedures—including (and perhaps most especially) marginalized individuals, such as those who experience mental illness or disability. The idea of fairness based on established procedures is what is meant by **due process**. If you are unfamiliar with the language of the **Fifth [Website]**, **Sixth [Website]**, and **Fourteenth Amendments [Website]** to the Constitution, you may use these links to familiarize yourself.

When a person is not competent or "fit" to proceed with trial, their constitutional rights may not be protected, and the fairness of the proceeding is endangered. The conviction of a person who does not understand the charges against them, cannot appreciate the gravity of their predicament as an accused person, or cannot work with a defense attorney thus violates the Constitution—specifically the constitutional guarantee of due process.

> The Fourteenth Amendment to the Constitution, Section 1, Due Process Clause: "[N]or shall any State deprive any person of life, liberty, or property, without due process of law."

Although some criminal procedures can occasionally be bypassed or violated without significant consequence, the competence of the defendant is not one of those; it always matters whether a defendant is fit to proceed. In 1966, the U.S. Supreme Court clarified this point in the case of Theodore Robinson, who had killed his wife. Robinson had a lifelong history of mental disorders after sustaining a serious head injury as a small child. However, despite serious questions about Robinson's mental capacity, no hearing was held to determine his competence during the criminal proceedings. Robinson was tried and convicted of murder in the Illinois court system. The U.S. Supreme Court overturned Robinson's conviction, ruling that competence had to be considered at the time competency questions were raised and prior to proceeding with the case—even if the defendant was not asking for such a hearing (*Pate v. Robinson*, 1966). Based on *Pate v. Robinson*, competence is a constitutional issue that cannot be bypassed—even by the accused person.

Although a court must avoid proceeding against a mentally incompetent person, there are also competing concerns, including the prompt resolution of criminal cases. The Sixth Amendment to the Constitution guarantees, for the sake of the accused, that a criminal trial must occur without unnecessary delay. This is often called the accused's right to a "speedy" trial. While criminal trials in the United States are rarely "speedy" in our common understanding of that word, the system should not tolerate unnecessary delays.

> The Sixth Amendment to the Constitution, Speedy Trial and Assistance of Counsel: "In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury . . . and to have the Assistance of Counsel for his defence."

Legal Standard for Competence

Competence to proceed as a defendant in a criminal case is a very particular requirement that is not necessarily the same as having the competence to do other things. A person who is charged with murder may have a diagnosis of a serious mental disorder and be impaired in certain areas but still be reasonably fit to proceed in court. For the parties in a case to question competence and for the court to decide whether a person is competent, there must be a shared understanding of what that term means in this context. This shared understanding is called a **legal standard**—a guidance or definition that the courts follow, so every judge is

not making up their own definition of what makes a defendant competent.

The Supreme Court provided a legal standard as to the meaning of competence in *Dusky v. United States* (1960) (figure 6.3). In *Dusky*, the Supreme Court ruled that it is not enough for a defendant simply to know where they are and what happened—what the *Dusky* court called "oriented to time and place" with "some recollection of events." Rather, the accused person must have a more meaningful understanding of their situation. Specifically, the **Dusky standard** requires that the defendant should (1) be able to consult with their lawyer "with a reasonable degree of rational understanding" and (2) have a "rational as well as factual understanding of the proceedings" against them (*Dusky v. United States*, 362 U.S. at 402).

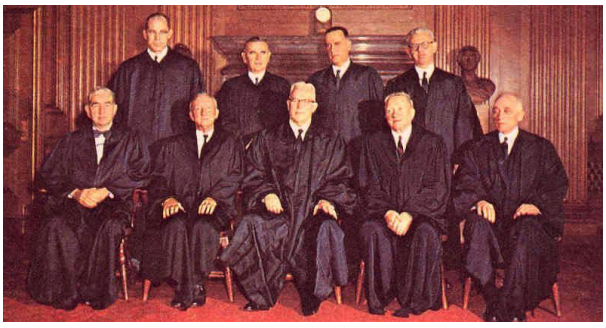

Figure 6.3. The Supreme Court in 1960, led by Chief Justice Earl Warren (center), that decided the *Dusky* case. The Supreme Court remained all white until 1967, when Justice Thurgood Marshall was appointed to the court, and all male until 1981, when Justice Sandra Day O'Connor joined the court.

There have been many legal discussions about the meaning and significance of the repeated word "rational" in the Dusky standard (figure 6.4). A common-sense understanding is that the Supreme Court intended defendants to be the opposite of "irrational," meaning that they have a clear and unconfused grip on the situation, with the ability to consider options and make reasoned decisions based on the facts (Felthous, 2011; Maroney, 2006). Returning to our example of Jose Veguilla, he would be expected to be found competent under *Dusky* if he understood and could discuss the basic landscape of his case: that he was charged with killing his roommate with his walker, that the prosecution had witnesses to his conduct, and that he was facing severe punishment if convicted. Veguilla (or any other defendant) would need to further understand that he might receive a lighter sentence for admitting the crime in a plea bargain, but that he has the right to go to trial to contest the charges. A competent defendant would be able to weigh the pros and cons of alternative courses of action in discussion with an attorney.

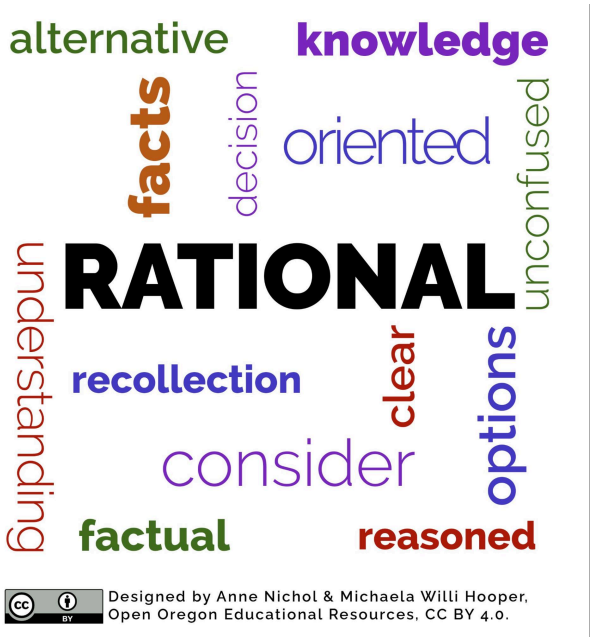

Figure 6.4. This graphic shows various terms associated with the subjective standard of "rationality" encompassed in the Dusky standard for competence.

All state and federal criminal courts use a version of the Dusky standard to define competence. Although jurisdictions may use varying language, they must follow a standard that at a minimum complies with the Constitution as interpreted by the Supreme Court. In Oregon, for example, competence is defined by statute that largely mirrors the Dusky standard language: a defendant is incompetent ("incapacitated") for purposes of a criminal trial if, due to a mental disorder, the defendant cannot understand the proceedings, cannot "assist and cooperate with" their attorney, or cannot "participate in" their defense (Or. Rev. Stat. § 161.360). When Oregon courts apply or

interpret this language, they must do so in accordance with Oregon law and the federal constitutional standard set by *Dusky*.

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Figure 6.4. "Rational word cloud" by Anne Nichol and Michaela Willi Hooper is licensed under CC BY-NC 4.0.

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Figure 6.1. Prosecutors: 83-Year-Old Used Walker To Kill Nursing Home Roommate In Haverhill by CBS Boston is licensed under the Standard YouTube License.

Figure 6.3. Dusky v. United States via Juvenile Competency Attainment Research and Development Center, UVA, is included under fair use.

6.3 Establishing Competence

Competence is not just a legal principle; it is something that must be ensured for each individual in the criminal courts. If a serious question is raised about a defendant's competence, the defendant must be evaluated by a mental health professional to determine their ability to proceed and advise the court on the required next steps (Pinals & Callahan, 2019). In our example case, Jose Veguilla's new defense attorney, at that very first hearing, recognized that Veguilla was likely not competent. The attorney objected to the case moving forward at all. The judge did complete the hearing, advising Veguilla of his charges, and then ordered Veguilla to be sent to a psychiatric hospital for a formal evaluation of his competence to stand trial (Thompson, 2023).

The flowchart in figure 6.5 illustrates the progression of the "aid and assist" or competence to stand trial (CST) process. The chart shows the key points in the competence process as (1) the point where the issue of competence is raised; (2) the competency evaluation; (3) the attempted competency restoration(s), if necessary; and (4) eventual resumption of the criminal process, where possible. Each of these steps is discussed in the text of this chapter. In the flowchart, icons indicating the roles of participants are included in each step of the competence process, showing that after the issue of competence is raised in court, multiple stakeholders must engage and cooperate at every step to resolve competence issues.

The flowchart also shows, with arrows, that a person can be diverted out of the criminal system at any point in the competency process. The corresponding intercepts in the Sequential Intercept Model (SIM), discussed in detail in Chapter 4, are indicated at the top of the figure 6.5 flowchart. Exploration of competence often occurs during SIM Intercept 2, where there are opportunities for dismissal of charges, while cases that move for-

ward in the competence process also move more deeply into the criminal justice system, into SIM Intercept 3 or beyond. Less serious cases may be considered for alternative handling rather than pursuit of competence, while more serious cases may demand significant effort to complete the criminal process.

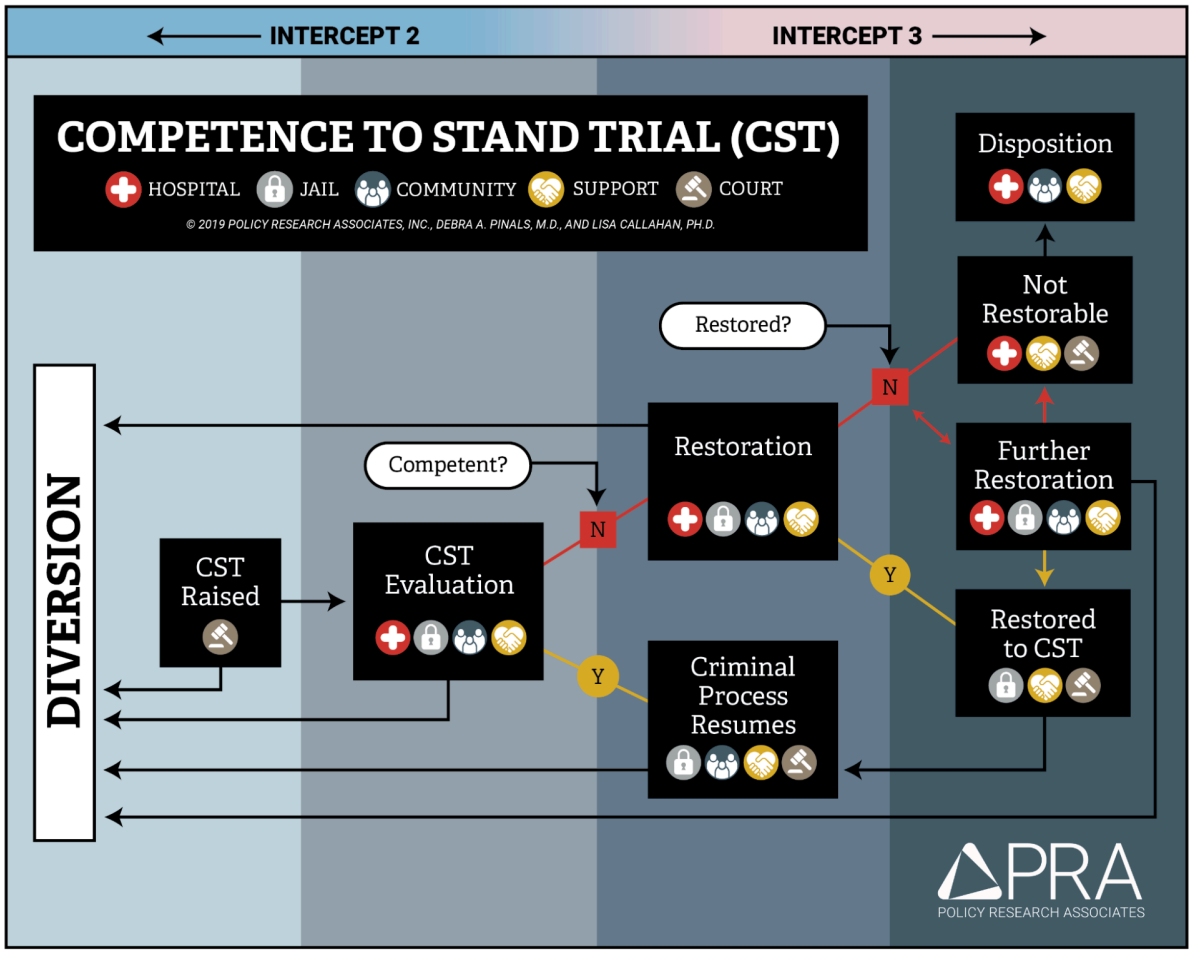

Figure 6.5. This flowchart illustrates the progression of the "aid and assist" or competence to stand trial (CST) process. Each of the steps illustrated here is discussed in the text of this chapter. Image description available. **Image description.**

Assessing Competence

When an accused person is clearly very mentally ill or disabled and wholly unable to comprehend the reality of their situation, it may seem obvious that they are not competent to proceed with their case in court. This would seem the situation for Jose Veguilla, who suffered from severe dementia. It would likewise seem true for any defendant who is extremely impaired by a mental disorder—for example, a defendant operating on delusional beliefs, such as insisting that they are an undercover operative in a military action rather than a defendant on trial. Nonetheless, a determination about competence has an enormous legal impact, with the power to halt a murder trial, and so it must be made with care and based on the evidence and the law.

The key piece of evidence in a competency determination is an evaluation of the defendant. A typical competency evaluation is performed by a licensed mental health professional, generally a

psychologist or psychiatrist. The evaluator considers the person's mental capability in light of the legal standard for competence in the relevant jurisdiction and then offers a professional opinion as to whether the person is legally competent. A competency evaluation contains information that supports the evaluator's conclusion as to competence and allows a judge to use the evaluation as the basis for a legal decision. Specifics would include:

- a mental status examination that looks at whether the person has basic orienting facts, such as who and where they are;
- a description of psychiatric symptoms the person is experiencing, such as loss of memory, hearing voices, or having delusional beliefs; and
- an assessment of the person's understanding of the criminal proceedings, including their knowledge of the charges against them, possible outcomes in court, and perhaps the pros and cons of engaging in a plea agreement.

It is also important for a competency evaluation to explicitly address whether the evaluator believes that the person is making up or exaggerating symptoms for some benefit, such as avoiding criminal processing, which is known as *malingering* (discussed in **Chapter 2**; Or. Admin R. 309-090-0025).

To think about how a competency evaluation process looks in practice, imagine a defendant who has bipolar disorder and is symptomatic in the midst of a manic episode (see the discussion of bipolar disorder in **Chapter 2**). The defendant might meet the requirement of factually understanding the proceedings against them, but their racing thoughts, delusional beliefs, and overall uncontrolled emotions might prevent them from working effectively with their defense attorney. The defendant might be unable to track discussions about their case or be constantly trying to fire their attorney. The defendant's active mental illness may prevent them from behaving in an orderly way that would allow them to attend their courtroom proceeding. In this case, the evaluator may state their opinion that the person is not competent to proceed and needs treatment to gain competence.

Each state's practices vary in terms of requirements for determining competence, and the federal system has its own separate set of rules. Regardless of specifics, these procedures must, at a minimum, protect a defendant's due process rights. Procedures also should consider the safety of the public, concern for victims, and the integrity of the criminal justice system. Oregon examples are provided here for purposes of illustration.

In Oregon, the law governing competency determinations is **Oregon Revised Statute 161.370 [Website]**, and the process is formally called a "Determination of Fitness to Proceed." You can click the link provided if you are interested in seeing the statutory language. The competency evaluation performed as part of an Oregon court's determination is typically called either an "aid and assist evaluation" or a "370 evaluation" based on the local statute number. Consideration of malingering (or "faking" to manipulate outcomes, an issue discussed in **Chapter 2**) is specifically required by Oregon law governing these evaluations (Or. Admin R. 309-090-0025). If the defendant is evaluated and found competent to proceed, they will be allowed to proceed with their criminal case.

If an Oregon criminal defendant lacks competence, the parties have several options for going forward. Among the available options listed in the Oregon statutory scheme are:

- pausing to "restore" the accused person's competence, anticipating a resumption of the criminal case (discussed later in this chapter);

- dismissing the charges against the person; and/or
- beginning the process of hospitalizing the person for involuntary mental health treatment, or civil commitment, which is discussed in Chapter 9 of this text.

Which of these options is appropriate will depend on the nature of the underlying charges and the specific condition of the defendant.

Restoration of Competence

You have learned that the mere presence of a mental disorder does not prevent a person from being arrested or charged with a crime, though diversion opportunities (discussed in Chapter 4) may offer police or prosecutors an alternative to criminal proceedings in some cases. However, if a person is headed to criminal court, lack of competence is a complete bar to continuing the legal case; an accused person cannot go forward to trial or any other resolution (e.g., a guilty plea) unless or until they are competent to do so. The process of treating a person with the objective of making them competent, or able to aid and assist, is referred to as **restoration of competence** (figure 6.6).

Figure 6.6. A provider offers therapeutic services to a small group. Restoration can involve an array of services aimed at making a person competent to resolve their legal case.

Restoration involves targeted treatment to take an accused person from an irrational or confused state to one of adequate understanding of the criminal process and their particular situation.

Some people are not good candidates for restoration. The elderly dementia patient Jose Veguilla, who we have discussed throughout this chapter, cannot be made competent, as several professionals have opined; rather, his memory and ability to aid and assist in his defense worsen over time as his dementia progresses. This presents a particular problem that is discussed further in **Chapter 9** of this text: the defendant who is not restorable, or never able to proceed (Thompson, 2023).

However, most defendants are better suited to competency restoration. For example, the competency evaluation of a person experiencing a manic episode, such as that imagined in the previous section, involves a mental health professional finding that a defendant lacks the ability to aid and assist their attorney. In this type of case, restoration should strive to address areas of deficit identified by the evaluator (e.g., racing thoughts, delusional beliefs, and limited attention span). Restoration is specifically meant to help the person meet competency requirements so that they can resolve their case. Restoration treatment is not focused on the overall mental health of the person, although it often requires psychiatrically stabilizing the person with medication and therapy. If psychiatric symptoms such as voices, delusions, or mania are preventing a person from meeting the standard of competence, those symptoms need to be targeted in restoration treatment. If the person refuses medication that is necessary for restoration, medication may be given on an involuntary basis under some limited circumstances (*Sell v. United States*, 2003).

Another part of competency restoration treatment is the teaching of legal terms and concepts. For example, a person may be instructed about the role of their lawyer, what confidentiality means, what a judge and jury do, and other general information about the criminal justice system. In its fact sheet on the topic, the Oregon State Hospital (figure 6.7) describes restoration as potentially including other therapeutic services, such as occupational therapy to work on daily living skills (cooking and managing personal finances), educational services, and medical and dental services (Oregon Health Authority, 2019).

Figure 6.7. The Oregon State Hospital in Salem is one place where evaluation and treatment for restoration of competence can occur for criminal defendants in Oregon.

Restoration can take place in a variety of settings, including in state psychiatric hospitals, such as the Oregon State Hospital, where this process is generally referred to as treatment under a "370 order," again referring to Oregon's particular competency statute. Commitment to a psychiatric facility for restoration of competence is discussed more in **Chapter 9** of this text, along with other types of civil commitments.

In Oregon, as well as other jurisdictions, people with serious mental disorders who are accused of crimes can face significant delays in resolving their charges when there are questions about their competence and hospital transfers are involved. For example, a person may wait in jail for potential

resolution of their case, which becomes impossible due to competence questions; they then await admission to a hospital for a competency evaluation, only to return to jail and then wait *again* for restoration treatment, if ordered. Defendants such as Jose Veguilla exemplify an extreme version of this issue, where restoration to competence is impossible, but the case involves very serious crimes that no victim or prosecutor is likely to want to dismiss or set aside.

In Oregon, as in most other states, the law provides for restoration in the community under the supervision of mental health providers, rather than in a hospital setting, if that can be done safely (Or. Rev. Stat. § 161.370). Usually, either the competency evaluator or another designated evaluator will offer an opinion as to whether the defendant needs to remain in the hospital or whether treatment can occur in the community. Often, a person may be incompetent to proceed to trial, but they can be safe in the community while receiving care.

A number of states have jail-based restoration programs, avoiding transfers to a state hospital or other facility for restoration, and bypassing the risks of community placement (figure 6.8). Providing restoration services in jail is controversial, with proponents emphasizing the immediacy of treatment available and opponents noting the lack of a therapeutic environment, among other problems. Of significant concern is the potential for prolonging the incarceration of a person because of a mental disorder (Ash et al., 2020).

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=duX_28uaOKE

Figure 6.8. This short video produced by the San Diego County Sheriff's Department introduces the county's jail-based restoration program. Watch the video and consider the pros and cons of restoration services provided in jail versus other options. **Transcript.**

Alternatives to Restoration

As noted previously, restoration is only one of the options available to the parties when an accused person is not competent to proceed with their case. Other options (outright dismissal of charges or pursuit of a civil commitment, described in **Chapter 9**) would remove the case from the criminal courts more permanently, possibly to the detriment of victims, as well as the larger community. Victims deserve resolution in cases where they have been harmed, and important goals of the criminal justice system are not met if offenders are released into the community without accountability and supervision.

However, outright dismissal of criminal charges may be a reasonable or preferred option in some cases. For non-violent or lower-level charges, the lengthy process of evaluation, restoration, and resumption of court proceedings might take far longer than the person would ever have been jailed for an underlying charge of theft or trespass. Thus, insisting on continuing a minor case—with all of the delays involved—arguably places an unfair burden on people with mental disorders. In these cases, dismissal can be a just resolution, especially if support can be offered to avoid reoffense.

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Figure 6.7. Photograph of Oregon State Hospital Sign by Ocsdog is used under CC BY-SA 4.0 via Wikimedia Commons.

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Figure 6.5. Competence to Stand Trial (CST) Flowchart by D.A. Pinals and L. Callahan, Policy Research Associates, is all rights reserved and included with permission.

Figure 6.8. Jail Based Competency Treatment Program by the San Diego Sheriff's Department is licensed under the Standard YouTube License.

6.4 Insanity as a Criminal Defense

The first section of this chapter discussed scenarios in which an accused person's mental disorder impacts their ability to navigate the court process. Backing up in time, the person's mental state *when they committed the offense* (often months or years before the resolution of the case) can be an important factor in how the case is ultimately resolved. The lack of mental capacity to commit a crime is a rare but important defense to criminal conduct. When a person asserts the **insanity defense**, they typically admit that they did the accused act, but they assert (and must prove) that they are not guilty of a crime due to the influence of their mental disorder on their conduct.

The mere presence of a mental disorder diagnosis does not make a person legally "insane" for purposes of the insanity defense. A mental disorder is a medical diagnosis (e.g., schizophrenia, bipolar disorder, intellectual disability). People who have these diagnoses live productive and prosocial lives in our communities, *and* people with these diagnoses sometimes engage in criminal behavior for which they should be held accountable. But occasionally—rarely—certain mental disorders can render a person legally insane under the law in their jurisdiction, and that can provide a defense to otherwise criminal conduct.

When a person is found *not guilty by reason of insanity*, as it is termed in many states, or **guilty except for insanity (GEI)**, as it is called in Oregon, the result of this verdict is generally that the person is committed by the judge to the care of the state for services and supervision. For more serious offenders, care is generally provided in a restrictive hospital setting. Some state laws allow care to be ordered for an indeterminate period until the person can be adjudged safe to be unsupervised. Other states require care for a designated period, such that the person may be, and often is, committed for the maximum time that they would have been sentenced to prison had they been criminally convicted of that particular offense. Oregon is one of the latter states, which uses specific periods of commitment. So, if a person in Oregon is found GEI for the burglary of a residence, they may be committed to the state hospital for up to 20 years—the maximum prison time for a burglary conviction—but commitment can end early should the person no longer meet the legal standard (of dangerousness due to a mental disorder) to remain under supervision. Although these "criminal" commitments, discussed in more detail in Chapter 9, may feel or look like a punishment, a commitment order is not a criminal sentence, as the person has not been convicted of a criminal offense. Rather, the basis for the court order and the objective of a commitment is to provide care for the person and to

minimize the person's danger to others as well as themselves.

Excuse Versus Justification Defense

Certain criminal defenses involve a defendant admitting they did a particular act but claiming that circumstances surrounding the act remove criminal responsibility or guilt for the act. The two groups of defenses in this category are justification defenses and excuse defenses:

- **Justification defense: I killed that person because I actually needed to, so I am not criminally responsible.**

The accused person has committed no crime because their behavior was warranted, or justified, by the circumstances. The behavior is not wrong, but right, in this case. The classic example of justification is self-defense, where the defendant was being attacked and in response killed the alleged victim (the attacker) to save their own life. The accused has not committed a crime; they were justified in defending themselves.

- **Excuse defense: I killed that person, but I didn't intend to do something wrong, so I am not criminally responsible.**

The accused person has done something wrong, but due to the circumstances or their understanding of that act, it is not in the interest of justice to find them guilty of a crime. Perhaps the person was forced at gunpoint to rob a bank (the defense of duress) or perhaps they chose to commit a burglary to feed a starving child (the defense of choice of evils). Criminal law should hold people accountable for doing bad things—but not necessarily punish people who didn't want to do bad things.

Insanity is an excuse defense because the act the person is charged with was wrong, but the person did not know, understand, or intend that wrong, depending on the facts of the case. For example, an insanity defense case might involve a defendant who killed a person they truly believed (incorrectly, due to a mental disorder) was attacking them with intent to kill, while the victim was (actually) an innocent bystander on the sidewalk. We might say the defendant has committed no crime, or we might say that they have committed a crime, but we excuse it in this situation. Either way, the defense operates to prevent the criminal conviction.

Formulations of the Insanity Defense

The idea of the insanity defense has long existed in the criminal common law, stemming from the notion that people should not be held criminally responsible for unintended actions or events that they could not control. The Constitution demands that a person be competent to stand trial (under *Dusky*), and that right is carefully guarded. However, there is no similarly protected "right" to assert an insanity defense. A few states have largely rejected the use of an insanity defense, and this has been found not to violate the U.S. Constitution (*Kahler v. Kansas*, 2020). Most states, however, do recognize the insanity defense in one or a combination of four basic formulations described in this section and pictured in figure 6.9.

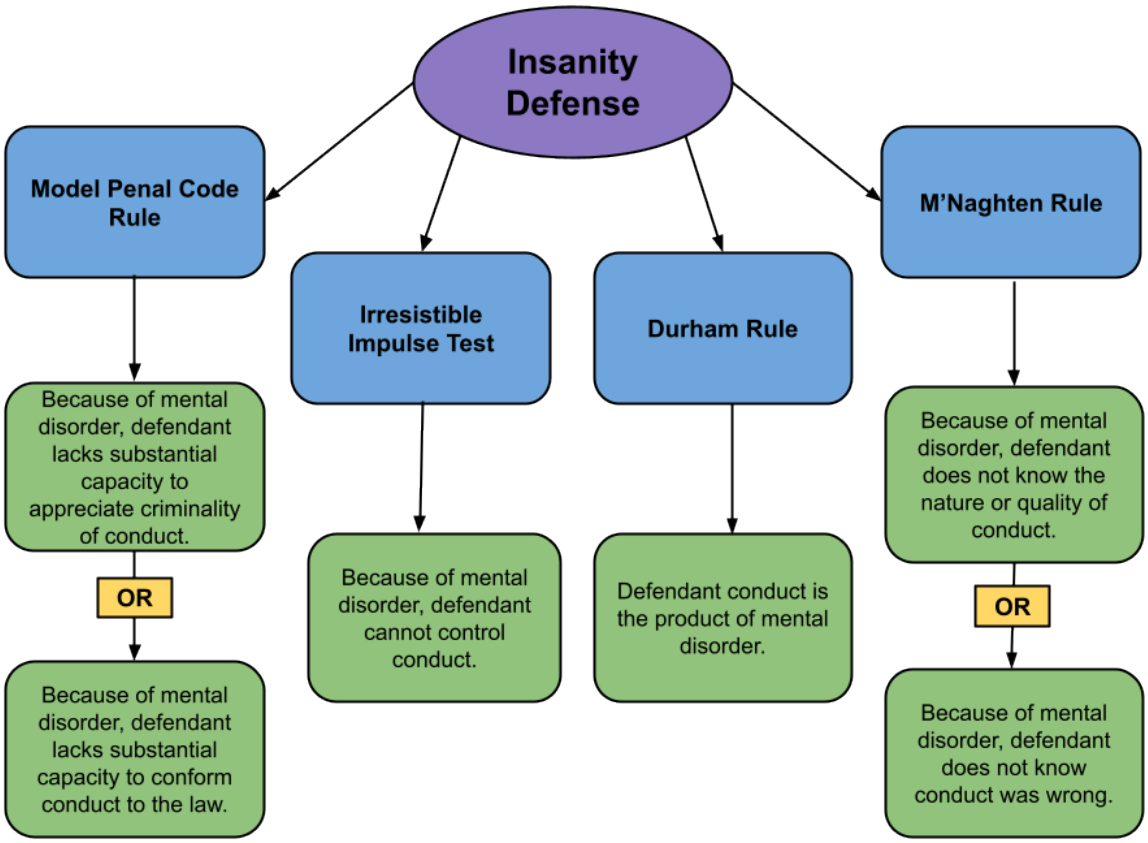

Figure 6.9. This chart summarizes four versions of the insanity defense: the Model Penal Code rule, the Irresistible Impulse Test, the Durham Rule, and the M'Naghten Rule. Whether certain facts qualify for the defense will depend on which version is applied. Image description available. **Image description.**

The M'Naghten Rule

The first enduring version of the insanity defense originated in the mid-1800s in England. This version of the defense was a reaction to a high-profile case involving a man named Daniel M'Naghten. M'Naghten had murdered Edward Drummond, secretary to the prime minister of England, thinking that Drummond was actually the prime minister. M'Naghten wanted to kill the prime minister because he believed, under the influence of a paranoid delusion, that the prime minister was out to kill M'Naghten. M'Naghten was found not guilty of murder due to his mental illness and sent to a hospital under the common law approach to insanity at the time. However, many were upset by his acquittal, and as a result, a stricter rule was demanded and created: the M'Naghten rule (Cornell Law School, Legal Information Institute, 2021).

The insanity defense, and with it the M'Naghten rule, came to America just a few years later, in 1847, as part of the case of a Black and Indigenous man named William Freeman (figure 6.10).

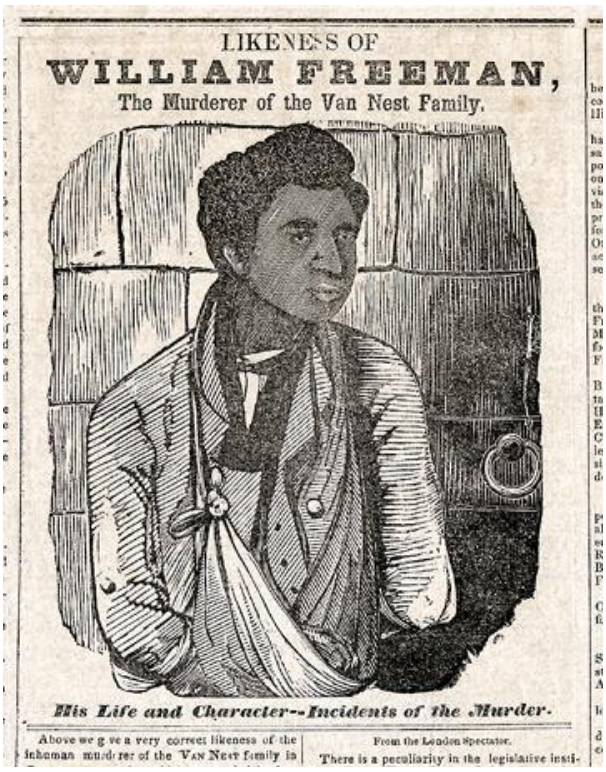
LIKENESS OF
WILLIAM FREEMAN,
The Murderer of the Van Nest Family.
His Life and Character--Incidents of the Murder.
Above we give a very correct likeness of the inhuman murderer of the Van Nest family in
From the London Spectator.
There is a peculiarity in the legislative insti-

Figure 6.10. An image of William Freeman in his jail cell in 1847.

Freeman had lived a difficult life, with signs of mental illness and a stint in prison, during which he sustained a serious head injury from beatings. After his release from prison, Freeman brutally murdered a family—both parents and a toddler. When his case went to trial, Freeman was defended in court by William Seward, former governor of New York and future senator and secretary of state under President Lincoln. Despite public hostility toward him for taking on this case, Seward was committed to seeking justice for Freeman. Seward attempted to defend his client based on insanity. However, the trial court declined to entertain the evidence and found Freeman guilty. Seward appealed Freeman's case, and with arguments based in part on the recent English M'Naghten case, Seward won Freeman a new trial with the right to present evidence of insanity. Freeman died before his new trial, but the M'Naghten rule survived and became the American legal standard for insanity (Cornell Law School, Legal Information Institute, 2021).

Under the **M'Naghten rule**, a defendant is presumed to be sane until they prove to the court or jury that, due to a mental disorder at the time of the act, they fit one or both of these criteria: (1) they did not know the "nature and quality of the act" they were doing, or (2) if they did know what they were doing, they did not know it was wrong. More simply, the M'Naghten rule is often described as requiring that a person did not know "right from wrong."

For example, a person with a significant intellectual developmental disability kills someone by poisoning, but due to the influence of their mental disorder, they believe they have helpfully assisted the victim go to sleep by administering the poison. This scenario might support an insanity defense under the first M'Naghten prong: they did not understand the nature of their act. Alternatively, the defendant has knowingly killed the victim with poison, but they thought (due to a delusional disorder) they had to kill the victim to protect a child from certain death at the hands of the (actually innocent) victim. This second scenario might warrant a defense under M'Naghten's second prong: they did not know what they were doing was wrong.

The M'Naghten rule is not perfect, and some of the later-developed versions of the insanity defense attempt to improve upon it. However, the M'Naghten rule became the standard definition of insanity in the United States, and it remains so in about half of the states and the federal courts (Cornell Law School, Legal Information Institute, 2021).

The Irresistible Impulse Test

Under the **irresistible impulse test**, an accused person argues that a mental disorder prevented them from controlling their behavior or compelled them to do the bad act: they were unable to stop themselves. Therefore, they lack criminal

responsibility for what is essentially an event outside their control. While the M'Naghten rule focuses on the accused person's mental state, the irresistible impulse approach considers the person's volition, or choice. Even when a person does *understand* their wrongful conduct, which would make them ineligible under M'Naghten, the irresistible impulse test asks whether the person was *capable of controlling* their conduct, given the impact of their mental disorder.

The irresistible impulse test is not so much a stand-alone legal standard as it is an addition to the M'Naghten rule, seeking to fill a perceived gap in coverage by M'Naghten. Many consider this test to be too broad, risking that a person with mere low self-control (rather than, say, a person with severe mania who is *unable* to control their conduct) could use the defense and avoid accountability (Cornell Law School, Legal Information Institute, 2021). Indeed, much criminal conduct is committed on "impulse," so the difficult question is whether that impulse was truly "irresistible" to the point that an insanity defense is appropriate.

Given its limitations, the irresistible impulse test is infrequently used. However, one sensational example of the irresistible impulse defense was the infamous case of Lorena Bobbitt. In 1993, Lorena Bobbitt cut off the penis of her then-husband John Wayne Bobbitt and disposed of it alongside a road, resulting in a dramatic trial and riveting multiyear international news cycle. At trial, Ms. Bobbitt's defense argued that she was weakened by years of abuse and trauma at her husband's hands, then became psychotic when he raped her that night. Her impulse to cut off his penis was "irresistible." While prosecutors argued otherwise, Ms. Bobbitt's team convinced the jury that she had acted under the force of an irresistible impulse—a theory that was permitted in her state—and she was found not guilty by reason of insanity (figure 6.11) (Sorrentino & Musselman, 2019).

Figure 6.11. In the Bobbitt case, the use of a household item as a weapon may have made the defendant's assertion of "irresistible impulse" more credible.

The Durham Rule

Under the **Durham rule** of insanity, an accused person is not criminally responsible if their act was the "product" of a mental disorder. This "product" approach has been followed in New Hampshire since the late 1800s, but it got its name from a 1954 federal court case that used the same idea: *Durham v. United States*. The rule seems appealing in its simplicity, but it is not widely used and currently remains the law only in New Hampshire.

The Durham rule is so broad that it would seem to cover everything under the two previously discussed rules—M'Naghten and irresistible impulse—and more. It does not sit well with many observers that under the Durham rule, a person might *understand* what they are doing, *know* it is wrong, and be able to *control* their actions—yet still be excused from criminal responsibility upon the conclusion of a mental health provider that the person's actions were otherwise a "product" of a mental disorder (Cornell Law School, Legal Information Institute, 2021). According to critics, the Durham rule is also too dependent on the conclusions of mental health professionals—which can vary greatly from person to person (Sanabria, 2023).

The Model Penal Code Rule

Most states, including Oregon, have adopted portions of their criminal law from the **Model Penal Code (MPC)**. The MPC is a criminal code created by the American Law Institute (ALI), a group of legal experts, in 1962. The MPC was developed to provide state lawmakers with standard language

on which to base their statutes (figure 6.12). The MPC included a version of the insanity defense that is similar to the M'Naghten rule, with a touch of the irresistible impulse rule. This MPC version (MPC Section 4.01) provides that a person is not responsible for criminal conduct when, as a result of a "mental disease or defect," they lack "substantial capacity" to either:

1. "appreciate" the criminality of the conduct, or
2. "conform" their conduct to the requirements of the law.

The MPC thus allows the insanity defense to be used where a person did not understand what they were doing, did not know that it was wrong, or was unable to stop their wrongful behavior (Cornell Law School, Legal Information Institute, 2021).

Figure 6.12. Every state has its own unique set of laws. The Model Penal Code (MPC) was created in an effort to bring some uniformity to state criminal laws, and the MPC version of the insanity defense is used in many states.

About 20 states use an MPC version of the insanity defense—just a few short of the number that use a variation on the M'Naghten rule (Strom, 2023). The federal courts initially adopted the MPC version as well. However, federal law was amended to restrict the use of the insanity defense in the 1980s. Public outcry demanded the defense be more restrictive after the acquittal of John Hinckley Jr., who shot then-President Ronald Reagan in an attempt to impress actress Jodie Foster. The Hinckley case is discussed in more detail in the Spotlight in this chapter.

Each state that uses the MPC version of the insanity defense has codified its own variation that can be used in the courts of that state. As an example, Oregon's insanity defense tracks the language of the MPC but is alternatively titled "*guilty*

except for insanity (GEI)," rather than the more typical "*not guilty* by reason of insanity" (Or. Rev. Stat. § 161.295). Additionally, in recent years Oregon rejected the outdated MPC language of "mental disease or defect" and substituted the term "qualifying mental disorder" as the precedent for a GEI verdict (Or. Rev. Stat. § 161.295).

Licenses and Attributions for Insanity as a Criminal Defense

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Figure 6.9. Insanity Defense Diagram by C. Courtney and Anne Nichol is licensed under **CC BY-NC 4.0**.

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Figure 6.10. **Image of William Freeman in his jail cell in 1847**, originally from the *Rochester Daily Advertiser*, is in the **public domain**.

Figure 6.11. **Photo of kitchen knives** by **DDP** on **Unsplash**.

Figure 6.12. **Photo of law books** by **Nasser Eledroos** on **Unsplash**.

6.5 Use of the Insanity Defense

The insanity defense is rarely presented in court, despite its intriguing nature, which brings it into media coverage as well as dinner-table discussions. The defense is even more rarely successful in excusing a person from criminal conduct. Any concern that offenders can easily "get away with" criminal conduct via the insanity defense is not well-founded. In fact, people who criminally offend are overwhelmingly convicted of those crimes and punished—and this is true even when mental disorders are part of the picture. In the federal criminal system, for example, more than 90% of charged defendants are convicted, almost all of them through guilty pleas without trial (Gramlich, 2019).

Only about one out of every 100 people being tried for felonies in U.S. courts asserts the insanity defense, and the defense is successful only about 25% of the time. In other words, in about 75% of the 1-in-100 cases where the defense is presented, the defense is rejected and the person is convicted (Justia, 2023). Even in the unusual event of having conduct excused due to insanity, rarely does that person walk away free. Long hospital stays and periods of supervision are the norm for those "excused" due to insanity.

As discussed earlier in this text, jails and prisons in the United States are filled with people experiencing mental illness and disability. While it is impossible to say how many were potentially eligible for an insanity defense, it seems reasonable to assume many were. For example, Oregon (which is certainly not alone in its mental health numbers) reports that in 2022 almost 30% of its adults in custody had serious mental disorders that needed high levels of care. At the same time, about 10% of Oregon adults in custody were rated to have "highest [mental health] treatment need," and another 18.4% were classified with "severe mental health problems" (Oregon Department of Corrections, 2022). Where the issues were not raised at the time of conviction, it is impossible to know whether or how much of the conduct that landed

these people in prison was a result of a mental disorder.

Prerequisites and Barriers to Defense of Insanity

The insanity defense is rarely successful because there are many barriers to its use, some of which are inherent to the system and others that are specific to certain defendants. A significant burden of proof is required of defendants who assert the defense, and that proof is both difficult to obtain and difficult to use successfully.

Proof of Insanity

The insanity defense is hard to prove. A successful insanity defense requires intricate proof on difficult issues of medicine and law. The insanity defense is generally an **affirmative defense**, meaning that it is a defense based on facts produced by the defendant, not by the state. Instead of the prosecutor having to prove that the person was "sane," the accused person must offer proof that they were "insane," or not mentally capable of committing a crime, according to rules in their jurisdiction.

The proof presented by the defense must include an evaluation by a mental health professional who can offer a diagnosis and explanation as to how a mental disorder impacted the conduct at issue. An evaluator would also consider whether the person is malingering, or "faking" a mental disorder to gain some benefit (discussed in Chapter 2). Remember that a diagnosis of a mental disorder is not the same thing as legal insanity. Many defendants who do have mental disorders, even significant ones, may be evaluated only to be advised that the evaluating expert does *not* believe that a mental disorder impacted their conduct sufficiently to warrant the use of the defense.

Additionally, not every diagnosed and impactful mental disorder can legally form the basis for an insanity defense. **Non-qualifying mental disorders** are diagnoses that, while potentially very impactful, do not make a person eligible for the insanity defense; if criminal conduct arises from a non-qualifying disorder, it will not be excused. Non-qualifying mental disorders usually include personality disorders, substance use disorders, and conditions such as pedophilia, which are generally excluded from the insanity defense by statute.

Diagnoses that are permitted to form the basis for an insanity defense are known as **qualifying mental disorders**. Qualifying mental disorders include psychotic disorders such as schizophrenia, mood disorders such as bipolar disorder, trauma-related disorders, and cognitive disorders. Developmental disabilities can also underlie an insanity defense. Each of these disorders is discussed in detail in Chapter 2 of this text. In any case, the impact of a qualifying mental disorder must be so severe as to overcome a person's ability to be criminally responsible for their behavior.

Defense Barriers

Another reason the insanity defense is not commonly used is that it is not necessarily the good "deal" some may imagine. Daniel M'Naghten, whose case inspired a tough new rule in his name, spent the rest of his life in a hospital, and John Hinckley Jr., who shot President Reagan in 1981 and inspired restrictive changes in the federal insanity defense, spent about 30 years in a state hospital and another decade on supervised release before being granted his freedom more than 40 years later in 2022 (Asokan, 2007; Johnson, 2021).

These cases are the rule, not the exception. A person who successfully asserts the insanity defense is almost certain to be committed to psychiatric care, often in a very restrictive setting

such as a state hospital (figure 6.13). Furthermore, this commitment can be quite lengthy. Some states routinely commit patients to a state hospital for the maximum length of time they could be imprisoned if they had been found guilty (Oregon's practice). Other states order commitment to care for an indeterminate period, with release nowhere in sight (McClelland, 2017). While early discharge is possible, it is not a certainty. This result may not appeal to every person to whom the defense is available.

Figure 6.13. Judges typically order lengthy commitments in restrictive settings for people who are excused from criminal conduct due to insanity.

Defendants may also hesitate to assert the insanity defense due to the stigma around mental health in our society generally or in their community specifically. Even if they do assert the defense, they may lack the prior diagnoses, history of treatment, and access to culturally competent assessments needed to gather the required proof. This is especially a problem for defendants who are Black, Indigenous, or people of color (BIPOC). It has become ever more apparent that the deck is fully stacked against BIPOC defendants with mental disorders, who suffer disproportionately from lack of access to care, lack of appropriate providers, and rampant misdiagnoses that may make mounting a compelling insanity defense near impossible (Perzichilli, 2020).

Prosecution Barriers

Even when a motivated, well-prepared, and racially/financially/medically privileged defendant does pursue an insanity defense, the prosecution will, in our adversarial system, appropriately challenge the defense, perhaps with a competing evaluation or other evidence. Elected prosecutors,

who are overwhelmingly white (95%) and male (73%), are also undoubtedly impacted by their own biases—in addition to the directives of their role—when deciding when and to what extent they will challenge an insanity defense (Reflective Democracy Campaign, 2019). A prosecutor's job, after all, is to convict offenders and protect communities, and supporting the use of an excuse defense like insanity can seem at odds with these concerns.

Excusing guilt due to the presence of a mental disorder meets the demand for fairness in the criminal justice system—that is, not convicting a person of a crime they did not intend to commit. However, it can also be very difficult and unsatisfying for victims. The insanity defense may be offered to excuse horrific and frightening offenses, including sexual assaults or brutal murders. Victims may feel justice is not served when no sentence or punishment is imposed—and these valid feelings may persist strongly even while they appreciate the injustice of punishing a person excused under the defense. The observing (and voting) public is likely to align with victims in their attitudes toward the insanity defense, which tend to be heavily negative. The overwhelming public perception is that the insanity defense is overused (it is not), and there is a general belief that verdicts based upon it fail to keep the public safe, though there is little evidence to support that belief (Hans, 1986).

Systemic Bias

Doubtless, the racism, sexism, and other improper biases inherent in all of our government systems, particularly in the criminal justice system, play a repeating role in the outcome of insanity defense cases. In some cases, statistics are available to illuminate this problem. For example, while juries and judges may be reluctant to excuse defendants who have done something harmful, studies suggest juries are *more* reluctant in the case of Black defendants (Maeder et al., 2020). It is reasonable to conclude that similar bias exists amongst prosecutors, judges, and other decision-makers in the criminal justice system. Bias likely impacts many mental health professionals conducting evaluations, defense attorneys who seek them, and every other cog in the wheel of the justice system. Because their behind-the-scenes work is less measurable than that of jury decisions, it is harder to produce supporting statistics as to some of these elements.

The result is that the insanity defense is far more likely to impact the verdicts of white men than other defendants. In Oregon, for example, of the approximately 600 people being supervised under GEI verdicts as of 2021, 82% were white and 83% were male. Only about 6% were Black, another 6% were Hispanic, and less than 3% were Native American (State of Oregon, 2021). This contrasts with Oregon's jail and prison population, which around the same time was about 9% Black, 13% Latinx, and only 74% white (Vera Institute of Justice, 2019). The disparity in these numbers raises the question of why Black and Latinx defendants do not, apparently, assert or succeed in using the insanity defense at the same rate as white defendants. Although the barriers to the use of the defense are substantial for all, they appear to be more substantial for people of color.

SPOTLIGHT: John Hinckley Jr. and the Insanity Defense

John Hinckley Jr. was raised in a home not unlike that of many conservative American families. His father worked full time, and his mother stayed home to care for her son and keep up the house. Hinckley was emotionally dependent upon his mother throughout his adolescence, but no one would ever have guessed that he would someday become notorious for an attempted presidential assassination.

The first signs of trouble came in the late 1970s when Hinckley first viewed the movie *Taxi Driver*. What began as a simple affinity for the film later became an all-consuming obsession. He adopted the dress, mannerisms, and lifestyle of the main character, and he developed a burning desire for the actress, Jodie Foster, who depicted a child sex worker in the film.

This obsession manifested itself outwardly in the form of stalking. As his mental health deteriorated and Jodie Foster remained unimpressed by his attempts to get her attention, Hinckley concluded that he needed to assassinate the president of the United States. By the time he acted on this decision, Ronald Reagan was the sitting president. Hinckley made his attempt on March 30, 1981, and was promptly taken into custody (figure 6.14).

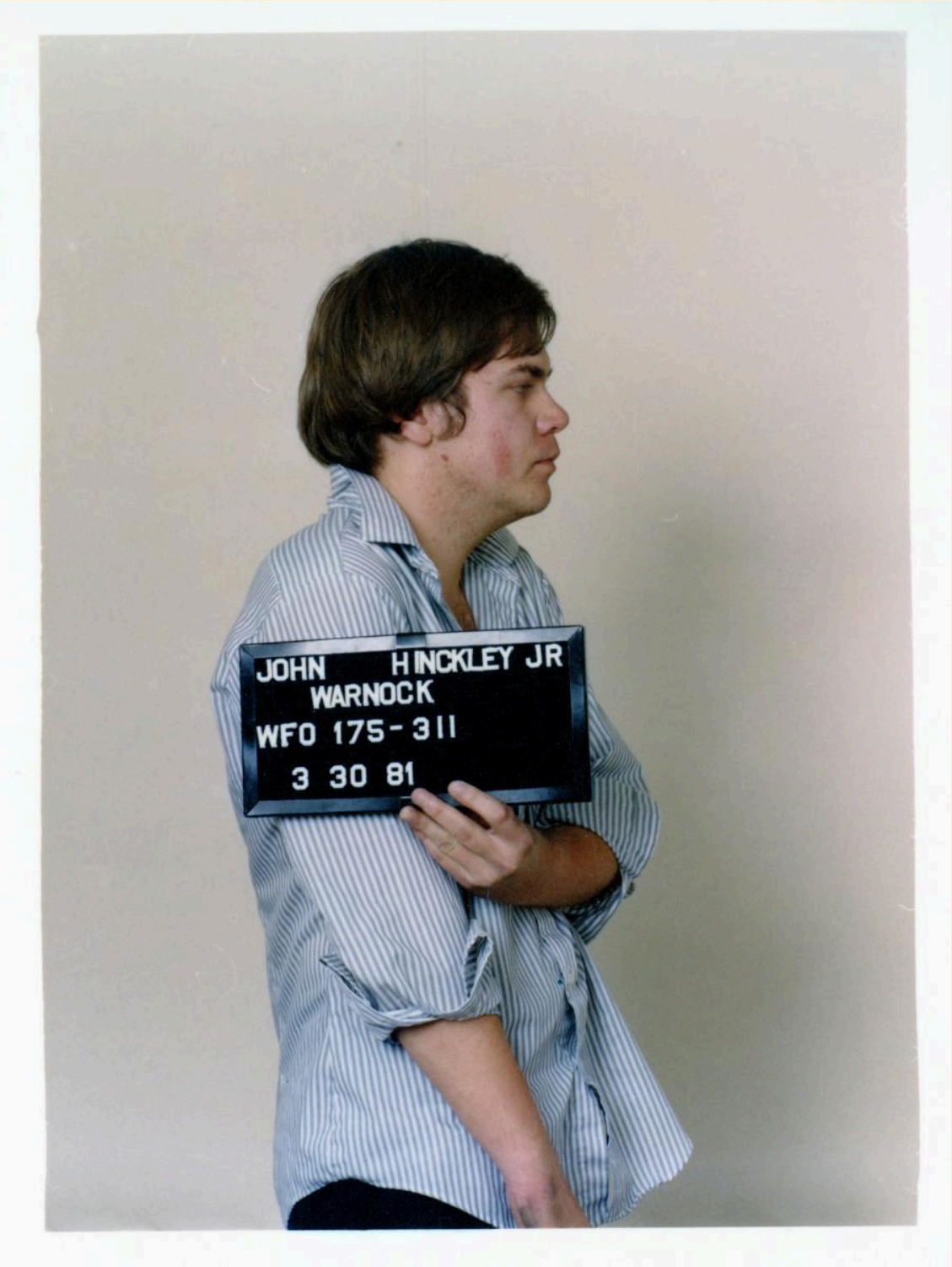

Figure 6.14. John Hinckley Jr. is pictured here in 1981 after attempting to assassinate President Ronald Reagan. Hinckley injured four men, including White House press secretary James Brady, who died from his injuries much later.

John Hinckley was tried in federal court in 1982, and many Americans were outraged when he was found not guilty by reason of insanity. An *ABC News* poll conducted the day after the verdict was read indicated that 83% of respondents believed "justice was not done" and Hinckley should have been found guilty of a crime. This public pressure spurred Congress—and many individual states—to enact major changes to the defense, all of which further limited defendants' access to the insanity defense in criminal trials (Collins, et al., n.d.).

As for Hickley, he was transferred to St. Elizabeth's Hospital in Washington. He was released back into the community in July 2016 after 41 years hospitalized under the supervision of mental health professionals.

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Figure 6.14. Photograph of John Hinckley is in the public domain.

6.6 Insanity and Criminal Sentencing

Many people with mental disorders face arrest, trial, and conviction in the criminal courts, despite the purported availability of diversion opportunities and the insanity defense. Diversion is appropriate in limited cases, and as we have learned, the insanity defense is exceedingly rarely successful. As a result of these convictions, many people with mental disorders are serving prison sentences throughout the United States, and some face the death penalty. As noted earlier in this chapter, Oregon is typical in identifying a significant number of its adults in custody as currently requiring high-level mental health treatment.

Depending on the jurisdiction, a defendant may be allowed to offer evidence of a mental disorder in **mitigation** of their crime(s). A mitigating factor is something that serves to explain the defendant's conduct, and, while not excusing the conduct, it may soften judgment of the conduct, thereby providing a reason for a judge or jury to impose a reduced sentence. For example, a mental disorder offered in mitigation of a murder might save the convicted person from the death penalty in favor of a life sentence. However, assuming the person is convicted of a crime, there is typically no legal requirement that the presence of a mental disorder impact a sentencing decision.

Mental Disorders and the Death Penalty

Even the death penalty may be imposed on a person with a severe mental disorder, despite mitigation efforts by the defense. The Supreme Court has made clear that only legal insanity in this specific context—defined as the inability to understand the punishment being imposed—renders the completion of an execution unconstitutional. The precise level of impairment needed to make execution unconstitutional is unclear. In its most recent pronouncement on the issue, the Supreme Court stopped the execution of Vernon Madison (pictured in figure 6.15), whose dementia had rendered him blind, confused, and with no memory of his crimes due to multiple strokes while in prison (*Madison v. Alabama*, 2019). Madison died in 2020 at Holman prison in Alabama (Equal Justice Initiative, 2020).

Figure 6.15. Vernon Madison was convicted of shooting a police officer and sentenced to death, but he lost all understanding of his legal situation in the ensuing years as his dementia progressed.

Even if granted, an insanity reprieve lasts only as long as the insanity lasts. For cases like Vernon Madison's, that would be the remainder of his life. But for a person with a treatable mental illness, competence could be restored in order to complete the execution. As in restoration of competence to stand trial, a person may be restored for execution if medication or other treatment can render them able to understand the procedure (*Ford v. Wainwright*, 1986; Dewan, 2017).

Some mental disorders can serve to prevent a death sentence from being imposed at all. For example, a person with significant intellectual developmental disability (which is not treatable in the sense of being subject to improvement from medication) may not be sentenced to execution, and if that sentence were imposed, it could be challenged. In 2002, the Supreme Court considered the issue and determined that the Eighth Amendment to the Constitution banned execution under these circumstances because it constituted cruel and unusual punishment to execute a person who was less culpable due to this impairment (*Atkins v. Virginia*, 2002). Similar reasoning supported a ban on executing children that was issued a few years later (*Roper v. Simmons*, 2005).

All states, however, have different standards for what constitutes intellectual disability in the criminal punishment context, and many of those standards do not correspond with modern medical practice for diagnosing intellectual developmental disability (LaPrade & Worrall, 2020). For example, in Idaho, a person with a tested IQ (intellectual quotient, the standard assessment for intelligence) score over 70 can be executed, without regard to other factors, such as functional life skills, that would typically inform a diagnosis of intellectual developmental disability (American Civil Liberties Union, 2003).

Barriers to proving that a person cannot be constitutionally executed are especially concerning when coupled with the reality of the prison population, where people with intellectual and other developmental disorders are found in much higher numbers than in the population at large. For example, people who experience intellectual developmental disabilities are far more likely than other people to falsely confess to crimes and to be wrongfully convicted and sentenced to death. The

story of Earl Washington, featured in the Spotlight in this chapter, is just one example of how this injustice can unfold. It is estimated that up to a quarter of the people who have been exonerated after false confessions are intellectually disabled—an overwhelmingly greater percentage than exists in the general public, where intellectual disability is estimated to impact about 1% of the population (American Psychiatric Association, 2021; Schatz, 2018).

SPOTLIGHT: Earl Washington

Before Rebecca Lynn Williams succumbed to the more than 30 stab wounds inflicted upon her during a violent rape, she was able to describe her lone assailant as, simply, a Black man. It was June 1982, and Williams's three children had now been robbed of their mother in a most vicious way.

In 1983, in a county not far from the location of Williams's murder, a young Black man was arrested for breaking into one of his neighbor's homes and wounding them during an alcohol-fueled dispute. This young man was Earl Washington, aged 23 (figure 6.16). Washington had an estimated IQ of 69, qualifying him for a diagnosis of intellectual disability. (For more information on intellectual developmental disability, as it is now called, see **Chapter 2**.) During a two-day interrogation, investigators were able to coerce five confessions out of Washington for five different crimes. One of these crimes was the murder of Rebecca Lynn Williams.

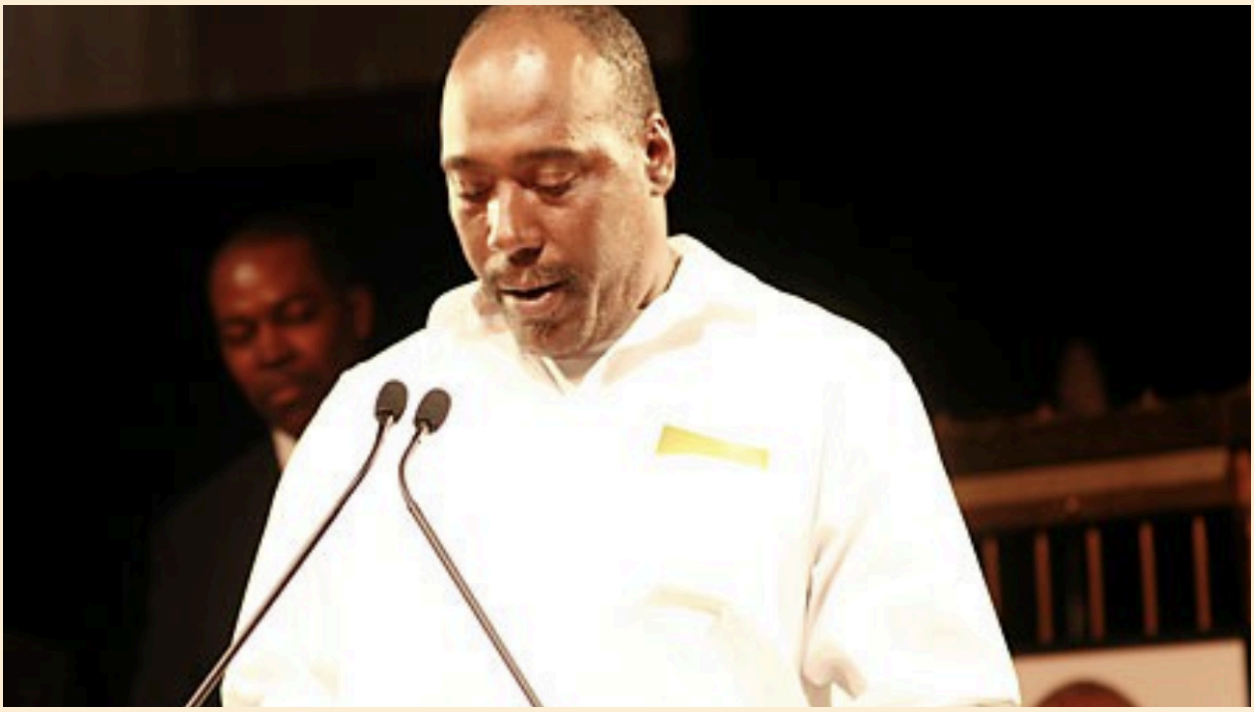

Figure 6.16. Earl Washington, pictured here speaking later in his life.

The confession to Williams' rape and murder was full of red flags that should have given investigators pause. Despite claiming responsibility, Washington wasn't even able to guess Williams's race correctly. The investigators continually corrected Washington's version of events to fit the evidence, prompting him to agree with their corrections and change his story accordingly. A good defense attorney could have poked holes in the prosecution's case, but Washington's defense was ineffective at best. Washington, an innocent man, was convicted of capital murder in 1984 and sentenced to death. At that time, and for another almost 20 years,

the execution of people with intellectual disability was not prohibited under the Supreme Court's interpretation of the Constitution.

Fortunately for Washington and others like him, the field of DNA forensic testing has evolved. In 1993, having already spent 9 years on death row, Earl's post-conviction defense attorneys were granted permission to analyze DNA evidence left at the scene of the murder. The results excluded Washington as a match. Even so, the appeals court refused to hear the case further. Washington came dangerously close to being executed in 1993, and his death sentence was commuted to a life sentence just 9 days before he was scheduled to die.

And so Washington continued to sit behind bars, albeit now no longer on death row, for a heinous murder he didn't commit. It wasn't until the year 2000 that even more advanced DNA testing was able to match the crime scene DNA to another man by the name of Kenneth Tinsley. Washington was finally given a full pardon and released from prison.

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Figure 6.15. Photo of Vernon Madison © Equal Justice Initiative is all rights reserved and included with permission.

Figure 6.16. Photo of Earl Washington from https://innocenceproject.org/cases/earl-washington/ is all rights reserved and included with permission.

6.7 Chapter Summary

- The presence of a mental disorder in a person charged with a criminal offense can impact that person's course through the justice system in a number of ways, depending upon the degree to which the mental disorder has impaired the person at the time of the criminal conduct, and later when the case is proceeding in the courts.
- If a mental disorder impairs a person's ability to participate in their own defense, or "aid and assist" their attorney, they may be deemed not competent to be tried. In this situation, the criminal case must pause. The case may proceed if and when competence is restored. Legal standards for competence and procedures for resolving competence issues vary by state and in the federal system, but at a minimum they must comply with the U.S. Constitution as interpreted by the Supreme Court.
- A mental disorder may, in very limited circumstances, provide a defense to criminal conduct: the insanity defense. This excuse defense appears in different versions in the states and the federal system, using one or more of four basic formulations: M'Naghten, Irresistible Impulse, Durham, and MPC. Some states do not recognize this defense at all.
- The insanity defense is rarely asserted by defendants, and it is even more rarely successful. The defense is difficult to prove in that it is complex, it places a heavy burden on defendants, and it is socially unpopular. There are racial discrepancies in outcomes related to the defense, suggesting that, like most criminal justice outcomes, its use is impacted by systemic racism.
- Mental disorders can impact sentencing options. The death penalty cannot be imposed on a person who is legally insane, though a person can be treated to become competent to be executed.

KEY TERM DEFINITIONS

- **Affirmative defense:** A type of defense requiring production of evidence by the defendant, rather than the state. Examples include the defenses of self-defense or insanity.

- **Aid and assist:** Another term for competence to stand trial. A person's ability to work with (or "aid and assist") their defense attorney is a key element of competence to proceed in a criminal case.
- **Competency evaluation:** An assessment that considers a person's mental capability in light of the legal standard for competence in their jurisdiction and then offers a professional opinion as to whether the person is legally competent.
- **Competence:** The ability of a criminal defendant to adequately participate in their own defense under the applicable legal standards.
- **Due process:** The idea of guaranteed fair treatment within the legal system based on established procedures.
- **Durham rule:** A formulation of the insanity defense eliminating criminal responsibility where a person's wrong act was the "product" of a mental disorder.
- **Dusky standard**: The federal legal standard for competence to stand trial, requiring that an accused person must have a rational and factual understanding of the proceedings and an ability to reasonably consult with their lawyer about the case.
- **Excuse defense**: A defense asserted by a criminally accused person stating that the accused person has done something wrong but bears no criminal responsibility due to the circumstances of their action. Examples are duress (the person was forced to do something wrong) or insanity (the conduct was attributable to a mental disorder resulting in legal insanity).
- **Guilty except for insanity (GEI)**: The terminology used in Oregon for a person who has successfully asserted the insanity defense and been excused from criminal responsibility. Other states use varying terms, often "not guilty by reason of insanity" or NGRI.
- **Insanity defense:** A defense asserted by a criminally accused person stating that they should be excused from criminal responsibility for their conduct due to their state of legal insanity at the time of the conduct.
- **Irresistible impulse test:** A formulation of the insanity defense eliminating criminal responsibility where a person's mental disorder prevented them from controlling their behavior or compelled them to do the bad act.
- **Justification defense**: A defense asserted by a criminally accused person stating that the accused person's conduct was not wrong, or criminal, because their behavior was warranted, or justified, by the circumstances. An example is self-defense.
- **Legal standard:** A law created by statute or a court decision that guides decisions and creates consistency in the legal system. For example, the legal standard of proof in criminal cases is "beyond a reasonable doubt," and the legal standard for competency was established in the *Dusky* case.
- **Mitigation:** Explaining a defendant's conduct in a way that does not excuse but may soften judgment of the conduct, thereby providing a reason for a judge or jury to impose a reduced sentence. Facts in explanation might be considered mitigating factors or circumstances.
- **Model Penal Code (MPC):** An example criminal code developed by experts to provide states with standard language on which to base their statutes. Many states have adapted MPC language for use in their state codes.

- **M'Naghten rule:** A formulation of the insanity defense eliminating criminal responsibility where a person, due to a mental disorder, did not know the difference between right and wrong in the context of their behavior.
- **Non-qualifying mental disorder:** Diagnoses that, while potentially very impactful, do not make a person eligible for the insanity defense under state law, generally because they are diagnosed based on rule-breaking behaviors. Examples include sexual disorders, substance use disorders, and personality disorders.
- **Qualifying mental disorder:** Diagnoses that are permitted to form the basis for an insanity defense, assuming other requirements of the defense are met. This includes mood disorders, psychotic disorders, and trauma-related disorders, among others.
- **Restoration of competence:** Targeted treatment provided to a criminally charged person who is incompetent, or unable to aid and assist in their defense. Treatment is intended to enable the person to constitutionally proceed with resolution of their criminal case.

DISCUSSION QUESTIONS

- Why do questions about a person's competence, or ability to "aid and assist," require halting the criminal process? Discuss the competing constitutional issues involved.
- What are some pros and cons of jail-based competency restoration programs? What specific problems might these solve or exacerbate?
- Think of examples—from real life or your imagination—where each of the four versions of the insanity defense would apply, and consider which versions would *not* apply to your examples. Which version do you believe is most likely to result in just outcomes?
- How might factors such as race, gender, sexuality, culture and language, socioeconomic status, and additional disabilities—or other factors—impact a defendant's ability to assert and succeed in presenting an insanity defense? How can the criminal justice system provide more equitable access to this defense?

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6.8 References

American Civil Liberties Union. (2003, September 4). *Intellectual Disability and the Death Penalty*. http://www.aclu.org/documents/intellectual-disability-and-death-penalty

American Psychiatric Association. (2021). *What is intellectual disability?* https://www.psychiatry.org/patients-families/intellectual-disability/what-is-intellectual-disability

Ash, P., Roberts, V. C., Egan, G. J., Coffman, K. L., Schwenke, T. J., & Bailey, K. (2020). A jail-based competency restoration unit as a component of a continuum of restoration services. *Journal of the American Academy of Psychiatry and the Law, 48*(1), 43–51.

Asokan, T. (2007). Daniel McNaughton (1813-1865). *Indian Journal of Psychiatry*, *49*(3), 223-224. https://pubmed.ncbi.nlm.nih.gov/31753967/

Atkins v. Virginia, 536 U.S. 304 (2002). https://supreme.justia.com/cases/federal/us/536/304/

Collins, K., Hinkebein, G., & Schorgl, S. (n.d.). *The Hinckley trial's effect on the insanity defense*. UMKC School of Law. https://famous-trials.com/johnhinckley/540-insanity

Cornell Law School, Legal Information Institute. (2021). *People v. William Freeman (1847)*. https://www.law.cornell.edu/wex/people_v._william_freeman_(1847)

Dewan, S. (2017, April 11). Does the U.S. execute people with mental illness? It's complicated. *The New York Times*. https://www.nytimes.com/interactive/2017/us/mental-illness-death-penalty.html

Durham v. United States, 214 F.2d 862 (D.C. Cir. 1954) https://law.justia.com/cases/federal/appellate-courts/F2/214/862/314341/

Dusky v. United States, 362 U.S. 402 (1960). https://supreme.justia.com/cases/federal/us/362/402/

Equal Justice Initiative. (2020, February 24). *Vernon Madison, Alabama death row prisoner with dementia, has died*. https://eji.org/news/vernon-madison-alabama-death-row-prisoner-with-dementia-has-died/

Felthous, A. R. (2011, February). Competence to stand trial should require rational understanding. *Journal of the American Academy of Psychiatry and the Law Online*, *39*(1), 19–30. https://jaapl.org/content/39/1/19

Ford v. Wainwright, 477 U.S. 399 (1986). https://supreme.justia.com/cases/federal/us/477/399/

Gramlich, J. (2019, June 11). *Only 2% of federal criminal defendants went to trial in 2018, and most who did were found guilty*. Pew Research Center. https://www.pewresearch.org/short-reads/2019/06/11/only-2-of-federal-criminal-defendants-go-to-trial-and-most-who-do-are-found-guilty/

Hans, V. P. (1986, May). An analysis of public attitudes toward the insanity defense. *Criminology*, *24*(2). https://scholarship.law.cornell.edu/facpub/330

Johnson, C. (2021, September 27). John Hinckley, who shot President Reagan, wins unconditional release. *NPR*. https://www.npr.org/2021/09/27/1040872498/john-hinckley-unconditional-release

Justia. (2023, October). *The insanity defense in criminal law cases*. https://www.justia.com/criminal/defenses/insanity/

Kahler v. Kansas, 589 U.S. ___ , 140 S.Ct. 1021 (2020). https://supreme.justia.com/cases/federal/us/589/18-6135/

LaPrade, J., & Worrall, J. L. (2020, December 22). ARTICLE: Determining intellectual disability in death penalty cases: a state-by-state analysis. *Journal of Criminal Justice and Law*, *3*(2). https://doi.org/10.21428/b6e95092.42571576

Madison v. Alabama, 586 U.S. ___, 139 S. Ct. 718 (2019). https://supreme.justia.com/cases/federal/us/586/17-7505/

Maeder, E. M., Yamamoto, S., & McLaughlin, K. J. (2020). The influence of defendant race and mental disorder type on mock juror decision-making in insanity trials. *International Journal of Law and Psychiatry*, *68*, No. 101536. https://doi.org/10.1016/j.ijlp.2019.101536

McClelland, M. (2017, September 27). When 'not guilty' is a life sentence. *The New York Times.*

https://www.nytimes.com/2017/09/27/magazine/when-not-guilty-is-a-life-sentence.html

Maroney, T. (2006). Emotional competence, rational understanding, and the criminal defendant. *American Criminal Law Review*, *43*(3), 1375–1435. https://scholarship.law.vanderbilt.edu/cgi/viewcontent.cgi?article=1847&context=faculty-publications

Oregon Department of Corrections. (2022). *Quick facts* [Issue Brief]. https://www.oregon.gov/doc/Documents/agency-quick-facts.pdf

Or. Admin R. 309-090-0025. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=301613

Oregon Health Authority. (2019). https://www.oregon.gov/oha/Documents/Aid-and-Assist-Fact-Sheet.pdf

Or. Rev. Stat. §§ 161.290, 161.295, 161.360, 161.370 (2023). https://www.oregonlegislature.gov/bills_laws/ors/ors161.html

Pate v. Robinson, 383 U.S. 375 (1966). https://supreme.justia.com/cases/federal/us/383/375/

Perzichilli, T. (2020, May 7). The historical roots of racial disparities in the mental health system. *Counseling Today*. https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/

Pinals, D. A., & Callahan, L. (2019). *Competence to stand trial flowchart*. Policy Research Associates. https://www.prainc.com/resources/competence-stand-trial-flowchart/

Reflective Democracy Campaign. (2019, October). *Tipping the scales: Challengers take on the old boys club of elected prosecutors*. Women Donors Network. https://wholeads.us/research/tipping-the-scales-elected-prosecutors/

Roper v. Simmons, 543 U.S. 551 (2005). https://supreme.justia.com/cases/federal/us/543/551/

Sanabria, L. (2023, November 28). *The insanity defense among the states*. FindLaw. https://www.findlaw.com/criminal/criminal-procedure/the-insanity-defense-among-the-states.html

Schatz, S. J. (2018, February). Interrogated with intellectual disabilities: The risks of false confession. *Stanford Law Review*, *70*, 643–690. https://law.stanford.edu/wp-content/uploads/2018/11/Samson-Schatz-Interrogated-with-Intellectual-Disabilities-The-Risks-of-False-Confession.pdf

Sell v. United States, 539 U.S. 166 (2003). https://supreme.justia.com/cases/federal/us/539/166/

Sorrentino & Musselman. (2019, July 24). Battered woman syndrome: Is it enough for a not guilty by reason of insanity plea? *Psychiatric Times. 36*(7). https://www.psychiatrictimes.com/view/battered-woman-syndrome-it-enough-not-guilty-reason-insanity-plea

State of Oregon Legislative Policy and Research Office. (2021, December). *Psychiatric Security Review Board work group report.* https://www.oregonlegislature.gov/lpro/Publications/PSRB%20Work%20Group%20Final%20Report%20December%202021.pdf

Strom, S. (2023, November). *The Durham rule.* Findlaw. https://www.findlaw.com/criminal/criminal-procedure/the-durham-rule.html

Thompson, C. (2023, June 28). *The never-ending murder case: How mental competency laws can trap people with dementia.* The Marshall Project. https://www.themarshallproject.org/2023/06/28/massachusetts-murder-courts-dementia

Vera Institute of Justice. (2019, December). *Incarceration trends in oregon*. https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf

CHAPTER

7

Rethinking Incarceration for People with Mental Disorders

7.1 Chapter Learning Objectives and Overview

LEARNING OBJECTIVES

The following learning objectives tell you what is most important in this chapter. Use these statements as a guide to make sure you get the most out of this chapter.

1. Evaluate settings where people with mental disorders may be incarcerated, considering the competing concerns and needs of the individual and the facility.
2. Discuss the use of restrictive and isolated housing for incarcerated people with mental disorders.
3. Describe the legal requirements that govern the provision of health care, including care for mental disorders, to incarcerated people.
4. Explain systems for, and barriers to, effectively assessing and treating incarcerated people with mental disorders.

KEY TERMS

Look for these important terms in the text in bold. Understanding these terms will help you meet the learning objectives of this chapter. You can find definitions for these terms at the end of the chapter.

- **APIC framework**
- **Assessment**
- **Eighth Amendment**
- **Fifth Amendment**
- **Fourteenth Amendment**
- **Medication-assisted treatment (MAT)**
- **Screening**
- **Solitary confinement**
- **Substance use treatement**
- **Telehealth**
- **Trauma-informed (training, care, or approach)**

Chapter Overview

Sedlis Dowdy, a tall, soft-spoken Black man with a diagnosis of schizophrenia, grew up poor and often hungry in Harlem. Dowdy's mother had nine other children, and she also experienced mental illness. Despite these barriers, Dowdy obtained his GED and made it to college. He did well during his first few terms until mental illness overwhelmed him. Although violence is not common among people who are mentally ill (only 4% of violent crime is attributable to people with mental illness), Dowdy was the exception (The Council of State Governments, 2021). In 1996, Dowdy experienced auditory hallucinations and shot a stranger in a New York park (Rodriguez, 2015).

We have learned about the importance of diverting people with mental disorders away from the criminal justice system. This aligns with our understanding that people with mental disorders are at risk of being improperly criminalized due to their mental disorders and that jail and prison can harm people with mental disorders. Diversion instead of prosecution, however, is more appropriate for people who have committed lower-level offenses, such as those connected to being unhoused or using substances.

We have also learned that the criminal justice system has mechanisms to remove more serious offenders from the criminal justice system when conviction is not appropriate due to a mental disorder. These mechanisms, including the insanity defense, are difficult to use and often unappealing. For example, Sedlis Dowdy might have pursued the insanity defense, but he says he chose not to because he feared the open-ended—possibly lifetime—hospital stay that can result from a criminal commitment (Rodriguez, 2015). We will discuss criminal commitments in more detail in Chapter 9 of this text.

Ultimately, Dowdy was prosecuted and convicted, and he received a 5- to 10-year prison sentence. For much of his time in prison, Dowdy was not on an effective medication regimen, and he was heavily impacted by his mental illness. Dowdy's behavior was uncooperative and violent.

To control and discipline him, prison officials repeatedly placed him in solitary confinement, where he spent about 9 of his prison years. In solitary, Dowdy suffered many indignities, including being fed prison "loaf"—a baked brick of mashed food that is reportedly disgusting and used as punishment (figure 7.1) (Rodriguez, 2015; Barclay, 2014). During his time inside, Dowdy, in anger, threw feces at guards—an offense for which he was prosecuted, adding four years to his sentence (Rodriguez, 2015).

Figure 7.1. A picture of prison veggie loaf. While nicely plated here, the food has been used as a form of punishment for incarcerated people in restrictive housing, where it is served repeatedly.

As we have learned, America's jails and prisons are full of people with mental disorders. Sedlis Dowdy is one of those people. This chapter focuses on the laws and practices, in both state and federal custodial environments, that govern and impact the experience of people like Dowdy. The criminal justice system bears obligations towards the vulnerable people who depend upon it for care while they are in custody. As you read and watch the linked videos in this chapter, consider how our system is meeting those obligations and how we might better serve people who are incarcerated.

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7.2 Custodial Environments for People with Mental Disorders

Because so many people in our jails and prisons have mental disorders—upwards of 40% by some estimates and even higher by others—all custodial environments are places where people with mental disorders may be incarcerated. The image in figure 7.2 highlights the major components of corrections in the United States. The criminal justice system is divided into state and federal systems at the law enforcement level. Federal officials enforce federal laws, and state or local officials (e.g., police, sheriffs) enforce state or local laws. State law violations are referred to local prosecuting attorneys and handled in state courts, while federal crimes are referred to federal prosecutors working in federal courts. Pre-trial detention and short terms of punishment are typically carried out within the system (state or federal) where a person is charged with a crime. If a lengthy sentence is imposed after conviction, the person will be transferred to prison in the system in which they were charged.

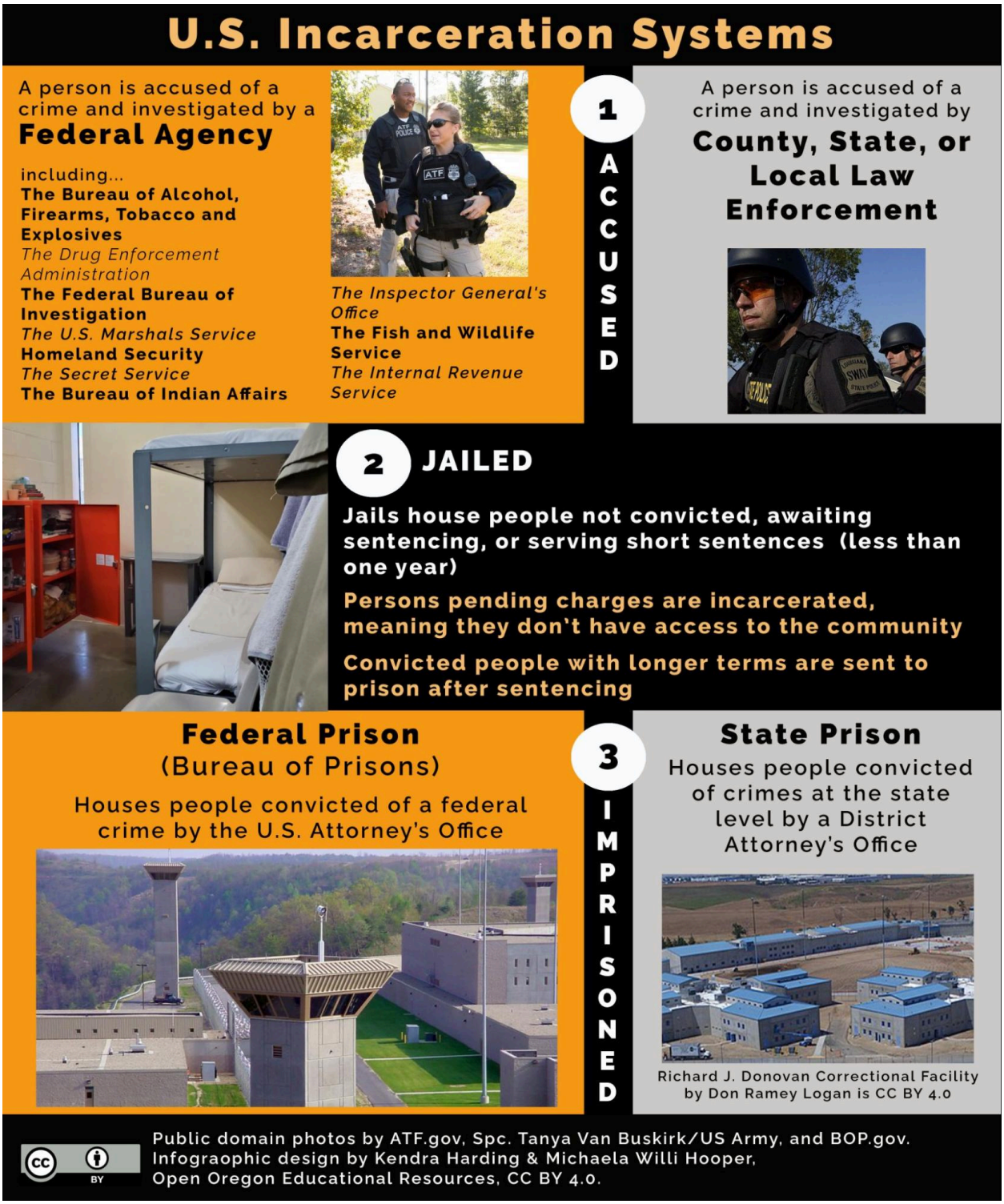

Figure 7.2. This graphic shows the components of the U.S. incarceration system from the time of arrest and incarceration to placement at a correctional facility. **Image description.**

State and federal correctional facilities vary in their physical setups, policies, and practices. All of this impacts the experience a person with a mental disorder will have in that custodial environment. Federal constitutional standards, discussed later in this chapter, set a "floor" for the treatment

of incarcerated people. These standards are met, or not, to varying degrees in different jurisdictions and facilities. Along with varying practices, jails and prison systems employ a range of terminology to describe what they do. One example is the practice of isolating an incarcerated person in a cell for most of every day. There can be great variability in how (and why) isolation is used, and the practice has different names, for example, solitary confinement, segregation, or use of restricted housing. Solitary confinement as a particular problem for people with mental disorders is discussed later in this chapter.

Note that the vast majority of people who are incarcerated in the United States are held in local jails and state prisons rather than in federal facilities (see figure 7.3 to compare these numbers). However, data are often more available from the federal system than from individual state, county, and local facilities, and that information is useful to our discussion in this text.

Incarceration in Jail

In the United States, almost 2 million people are currently incarcerated. As shown in the chart in figure 7.3, just over half a million of these people are held in local jails. While that is a huge number of people, that is merely the number in jail at any given moment. The people who make up that population are in constant flux; the average person will be in jail for just a few weeks before they are released or transferred (Prison Policy Initiative, n.d.). More than 10 million people are booked into jails each year, 80% of whom are charged with low-level and non-violent misdemeanors. **Only 5% of people booked into jails are charged with violent offenses (Dholakia, 2023).**

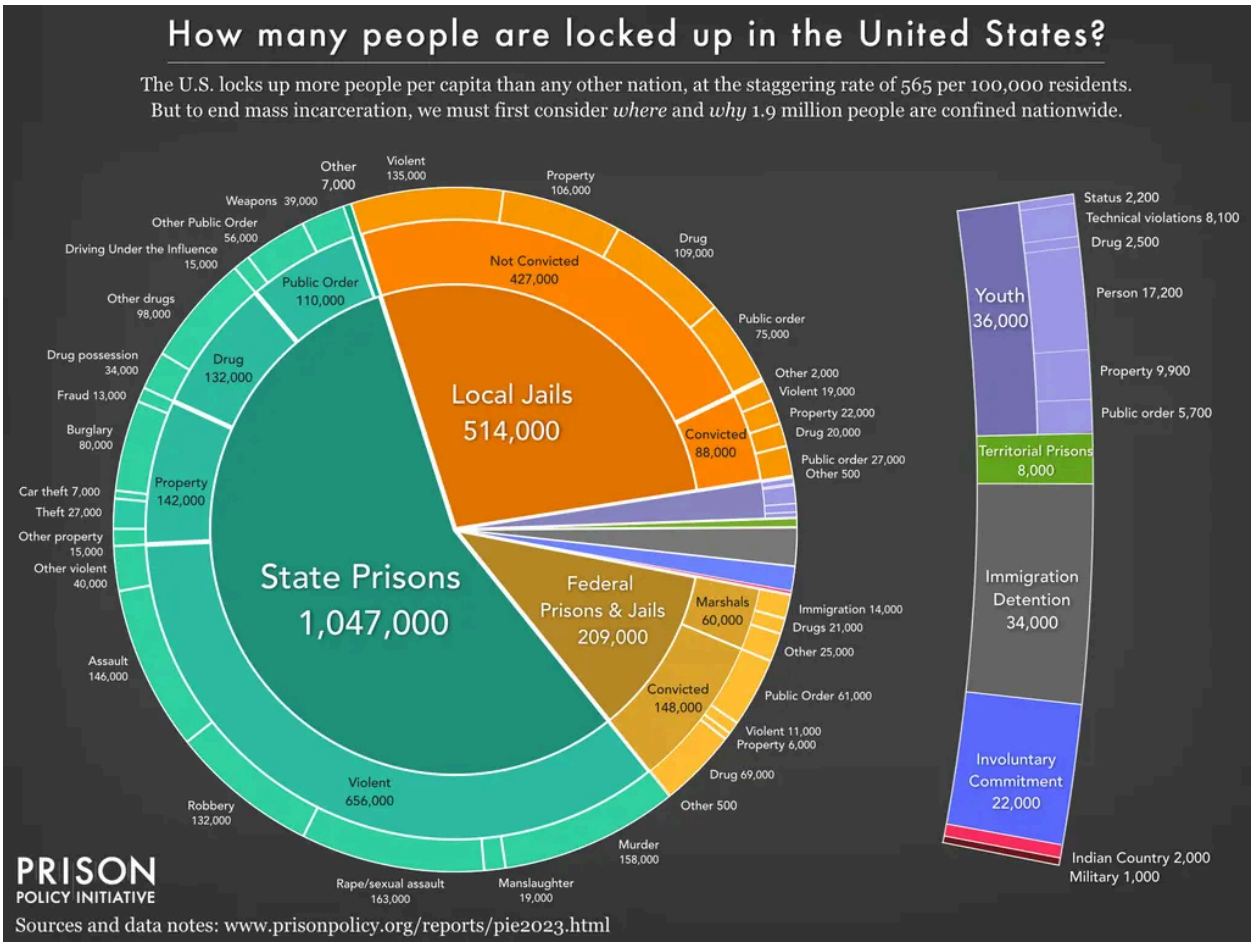

Figure 7.3. This chart illustrates the distribution of the nearly two million people incarcerated in the United States at a snapshot in time in 2023. Incarcerated people are primarily in state prisons and jails rather than in federal facilities. Notably, most jail residents have not been convicted of a crime and are awaiting resolution of nonviolent charges.

Although we often hear about people in "jails and prisons," the reality is that these are two very different placements in many ways. As noted, the jail population is a short-term one, and most residents are legally innocent—they have been arrested and charged with, but not convicted of a crime. A majority of the jail population remains incarcerated due to the inability to post bail pending resolution of their charges. This means that the jail population skews heavily toward people who are poor and unhoused, a demographic with high rates of mental disorders (estimated at around 75%) (James & Glaze, 2006; Gutwinski, et al., 2021). In Atlanta, for example, unhoused people make up less than one-half percent of the overall population, yet they comprise 12.5% of the bookings into the city jail (Harrell & Nam-Sonenstein, 2023). About 44% of people in jail have mental disorders—a higher number than in prisons (37%)—again in part because this group is less likely to make bail than people without mental disorders (National Alliance on Mental Illness [NAMI], 2023; Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). People of color (especially Black and Indigenous people) are significantly overrepresented in jails across the country. Black people are overwhelmingly more likely than white people to be sent to jail for pre-trial detention and to have an unaffordable bail set—compounding the impact of other factors, such as mental illness or poverty

(Pew Charitable Trust, 2023; Dholakia, 2023; Sawyer, 2019).

Given the relative lack of power and visibility of most jail inhabitants, there is an enormous need for advocacy on their behalf. The Amplifying Voices of Individuals with Disabilities (AVID) Jail and AVID Prison Projects, both carried out by Disability Rights Washington, are advocacy efforts for incarcerated people who experience disabilities, primarily mental disorders. The attorneys who staffed the AVID Jail Project advocate for their clients in jails in Washington state and document the particular struggles of people with mental disorders in jail environments (Disability Rights Washington, 2016). Several AVID videos are linked in this chapter to allow students to hear directly from impacted groups about their experience in custody.

Watch the videos from the AVID Jail Project in figures 7.4 and 7.5, and consider how the speakers' mental disorders and the jails' response (or lack of response) to their needs shaped each person's jail experience. What changes might have reshaped these experiences and led to different outcomes?

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=A_Zs9Ma2PnQ

Figure 7.4. Siyad Shamo speaks from jail in King County, Washington, about his struggle with Post Traumatic Stress Disorder. **Transcript.**

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=MYZW7Pfz7S0

Figure 7.5. Tallon Satiacum, speaking from a Washington jail, has several mental disorders, including fetal alcohol syndrome and bipolar disorder. **Transcript.**

If you are interested in the AVID Jail Project, consider learning more and watching additional videos at the **AVID Jail Project [Website]**.

Incarceration in Prison

While jails are short-term facilities, prisons hold people convicted of crimes who are serving longer-term sentences. Prisons are more apt than jails to determine that a person has a mental disorder and make placement or housing decisions based on that information. In prison, programming—education, life-skills training, and substance use treatment—can be provided for people who will spend years at the facility. Additionally, time and attention can be given to preparing people for eventual reentry into the community after prison. While these things are possible in prison, there is variation in facilities' use of these opportunities.

Sedlis Dowdy, introduced at the beginning of this chapter, served 14 years in prison before being released to a psychiatric hospital where he spent 2 additional years. A friend recalls her optimism when Dowdy was finally freed for the first time in 16 years and placed into transitional housing. However, just 1 day after his release, Dowdy stabbed a man. He was sentenced to 8 more years in prison (Rodriguez, 2015). Watch the 3-minute video in figure 7.6, where Dowdy describes and compares his experiences in jail and prison, as well as in the community. Consider how the described incarceration of people like Dowdy serves, and

fails to serve, the interests of community and individual safety.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=oE2PDvHAzyc

Figure 7.6. A short video introduces us to Sedlis Dowdy, one of many thousands of people incarcerated in New York state with a mental disorder. Dowdy, age 42, relates and compares his experiences in jail and prison. **Transcript.**

Like jails, prisons accept anyone placed into their custody, including people with serious, even debilitating, mental disorders. Prisons are expected and required to keep all incarcerated people safe in long-term settings, which is not always an easy proposition. Ideally, prisons meet this demand by housing incarcerated people in environments that balance the need for immediate safety with the need for treatment, socialization, and other resources aimed at rehabilitation. Most people who experience mental disorders in prison are housed in the same places and ways as other incarcerated people, which is in keeping with the appropriate goal of housing people in the least restrictive environment where they can succeed. However, some incarcerated people are better served in a more specialized environment, despite the additional restrictions that may entail.

The Oregon state prison system, for example, has several levels of care and housing for people with mental disorders. The highest level—called a mental health infirmary—provides the most intensive care in Oregon prisons and is correspondingly quite restrictive. A person in this level of care would be closely supervised, which can be limiting as well as supportive. An incarcerated person with known, serious psychiatric needs might start in the infirmary level of care, with the potential to move on when they can be successful at a lower level of supervision. Oregon's highest level of psychiatric care is available at only one high-security facility (figure 7.7) (Or. Admin. R. 291-048-0200 *et seq*).

Figure 7.7. A view of Oregon's highest-security facility, the Oregon State Penitentiary, from the outside. States vary in the continuum of facilities available for housing incarcerated people with higher needs.

Other Oregon prison facilities, however, offer lower and less-restrictive levels of care for people with mental disorders. At lower levels of care, people in custody may have access to ongoing support related to mental disorders, while being integrated with the general prison population. (Or. Admin. R. 291-048-0200 *et seq.*; Townsend, 2021). A wider range of placements for people at lower levels of care allows incarcerated people to receive care for mental disorders as well as access other therapeutic programs, or potentially be placed in facilities that are closer to their home communities.

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Figure 7.3. How many people are locked up in the United States © The Prison Policy Initiative. All Rights Reserved, included with permission.

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Figure 7.6. Living With Schizophrenia, in Prison and Out by WNYC is licensed under the Standard YouTube License.

Figure 7.7. Oregon State Penitentiary by Katherine H is licensed under CC BY-NC-ND 2.0.

7.3 The Problem of Solitary Confinement

As described by Pulitzer-Prize-winning journalist Ron Powers in his book *No One Cares About Crazy People*:

> Among the most gruesome and least forgivable forms of sanctioned torture by prison [staff] is "punitive segregation," as the delicate euphemism has it. The more familiar term is "solitary confinement." Solitary confinement, even for brief periods—several days, say, with an hour's respite each day—is known to trigger hallucinations and paranoia among sane and insane prisoners alike. For people already mad, it is a quick route to deep and lasting psychosis. The human psyche is essentially social and abhors isolation; enforced separation from others thus amounts to an act of sanctioned depravity.
>
> Solitary confinement has been used as a short-duration measure in the past. In recent decades, overwhelmed wardens increasingly have turned to it in a hair-trigger way, popping prisoners into tiny, badly ventilated cells, often restricting food, water, and medications as part of the bargain. (Powers, 2017, pp. 147-48)

Solitary confinement, also called isolation or segregation, involves the placement of an incar-

cerated person in a cell alone, with their interactions strictly limited. Solitary confinement is generally used as a form of discipline for prison rule violations or as a method of keeping the isolated person or others safe (Cornell Law School, Legal Information Institute, 2021). The reality of confinement to a very small cell for days, hours, weeks, and even years is unthinkable for most people and hard to imagine for anyone who has not had this experience. Watch the short video linked in figure 7.8 to see and hear about the experience of solitary confinement as shared by inmates at a maximum security federal prison in California.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=Q7ajzsh-i54

Figure 7.8. This video provides a brief glimpse into the lives and thoughts of inmates living in segregation, or solitary confinement, in a federal prison in California. **Transcript.**

Solitary confinement is overused for people with mental disorders, and its ill effects are especially harmful for people with preexisting mental disorders. In addition, solitary is used disproportionately among people in other marginalized groups in criminal justice: transgender or gender nonconforming people, young people, and people of color, particularly Black and Hispanic men (Sandoval, 2023; Lantigua-Williams, 2016).

Overuse of Solitary Confinement

The use of solitary confinement has, deservedly, come under heightened scrutiny as its devastating harms are increasingly understood. For years, concerns have been raised from as high as the presidency that America's prisons are overusing solitary confinement, in part as a by-product of prisons'—and society's—failure to adequately treat and otherwise safely manage people with mental disorders. Despite pressure from the top and efforts in state and federal systems to limit its use, solitary confinement in various forms is still a frequent practice in jail and prison environments (U.S. Government Accountability Office [GAO], 2024).

The presence of a mental disorder, especially one that is not adequately treated, increases the likelihood of behavioral issues that correctional staff are ill-equipped to manage—and that may prompt the use of solitary confinement. The AVID Jail and Prison Projects both have a particular focus on the problem of segregating and isolating incarcerated people with mental disorders because this is a common and exceptionally harmful occurrence (Guy, 2016). The AVID Projects share stories that give specific names and faces to the reality that solitary confinement is routinely used to manage behaviors directly related to mental disorders. Watch the short videos from the AVID Jail Project (figure 7.9) and the AVID Prison Project (figure 7.10) to hear two men share their experiences enduring solitary confinement amidst mental illness. As you watch the videos, consider: Why should prisons try to maintain people with mental disorders in less restrictive environments, and how might that be accomplished?

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=a0Q_4y6YCSQ

Figure 7.9. Ricardo Rodriguez speaks from a jail in King County Washington, where he has spent 6 months. Rodriguez has multiple serious mental illnesses and engages in self-harm driven by hallucinations. **Transcript.**

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=DJZQAd5dkOs

Figure 7.10. Five Mualimm-ak, a formerly incarcerated, prison reform advocate, shares what it was like to be in prison with a mental disorder. Mualimm-ak served a substantial amount of time in solitary confinement due to rule violations. **Transcript.**

Harms of Solitary Confinement

Isolation in solitary confinement is known to be harmful to incarcerated people generally. For example, there is a clear connection between time in solitary confinement and physical harm or even death. A 2022 report indicated that while less than 10% of federal prisoners are in solitary confinement at any given time, those prisoners are at far greater risk of grave harm. Almost 40% of homicides and nearly half of suicides in custody occur among that group (Lartey & Thompson, 2024). For people with mental disorders, the risks of isolation and segregation are intensified, as solitary is likely to worsen pre-existing symptoms (Sandoval, 2023).

Consider the video linked in Figure 7.11, where a man in custody shares the lasting effects of his extended time in solitary confinement.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=zmzSjbKu6UI

Figure 7.11. Daniel Perez, a Washington State inmate with several mental health diagnoses, describes his time in prison. Perez explains that after spending many years in solitary confinement, he struggles to function—or even believe that he can function—in the typical prison environment. **Transcript.**

If you are interested in learning more about solitary confinement among people with mental disorders in prison and about collaborative advocacy efforts on their behalf, please consider exploring the **AVID Prison Project webpage**.

SPOTLIGHT: Solitary Confinement in Federal Prisons

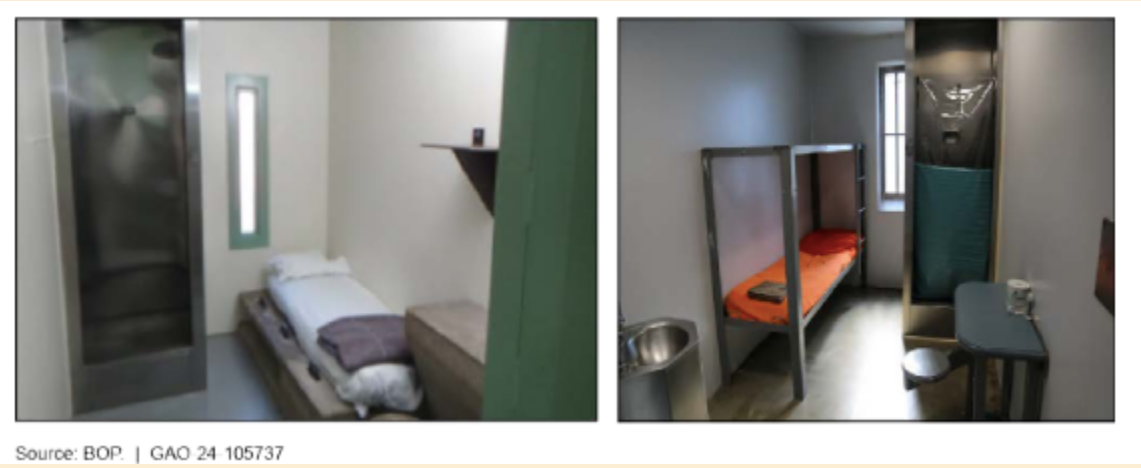

Figure 7.12. Examples of two unoccupied restrictive housing cells in federal facilities.

As of 2023, the federal prison system, officially called the Federal Bureau of Prisons (BOP), routinely employed what it calls *restrictive housing* and what is commonly known as solitary confinement: isolating incarcerated people in cells for up to 23 hours per day (figure 7.12). People in restrictive housing are not permitted to leave their cells to attend programming or recreation or to intermingle with others in their unit. Numerous reports, admonitions, and proposals later, BOP continues to house about 8% of its population (about 12,000 inmates) in these settings, including a significant number of people with serious mental disorders.

The most common form of restrictive housing in federal prisons is the Special Housing Unit (SHU). These units are located at most federal facilities. People can be placed in a SHU for administrative or disciplinary reasons. Administrative segregation is intended to be "non-punitive," so it might involve a person whose behavior is not controlled or who needs protection from others. SHU cells can be double- or single-bunked. Although isolation is not as severe as in a single cell, the dangers posed by a cellmate in these facilities can be substantial.

The federal system also has an entire facility, known as an Administrative Maximum Facility (ADX) that is located in Florence, Colorado. The ADX has only single cells, and it houses people who require the tightest controls and supervision. The unit has four programs, the most restrictive of which is the Control Unit, meant to house the most dangerous, violent, and disruptive incarcerated individuals (e.g., people who have assaulted or killed staff or other incarcerated people or who have escaped from another facility).

Additional restrictive housing intended to ensure safety was previously located in a "Special Management Unit (SMU)" located at Thomson Penitentiary in Illinois. However, the SMU was closed in 2023 after outside reporting revealed it to be incredibly unsafe—numerous homicides and suicides occurred there over a short period. All of the incarcerated people at the Thomson unit were relocated to a SHU in another facility. It is unclear whether the BOP will reopen this or another similar unit in the future (Khalid & Shapiro, 2023). If you are interested

in learning more about the grim conditions at Thomson, consider reading **this article about the people who were killed there [Website]**.

The BOP officially allows the housing of people with mental disorders in any of its restrictive options, with some loose limitations. Every new federal prisoner is required to receive a screening, intended to identify those who may need mental health or substance abuse treatment, and if necessary, evaluation of the identified concern. People with identified needs related to a mental disorder are assigned a care "level" from one to four that indicates the significance of their impairment and the degree of intervention required. People who are at the higher levels (levels 3 or 4) require more significant interventions, and BOP policy discourages "prolonged" placement of these people in the SHU or ADX. However, they continue to be placed there at higher rates than desired by BOP or observers. For example, more than 65,000 people at mental health levels 1 through 4 spent time in a SHU in 2022—a number that represents an increase of a few thousand from 2018. Around 450 people with mental health levels of 3 or 4 were held in either a SHU, SMU, or ADX in 2022, a slight increase over 2018 numbers.

Attempts to divert people with serious mental illness from restrictive housing in the federal prison system are ongoing. The BOP currently has only a few secure mental health treatment programs that could serve as alternatives to the standard solitary confinement options, but it plans to expand that capacity.

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Figure 7.12. Examples of Two Bureau of Prisons' Restrictive Housing Unit Types by United States Government Accountability Office, which is in the Public Domain.

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7.4 Staffing in Jails and Prisons

While Sedlis Dowdy, introduced earlier in this chapter, was the exception in committing a violent crime due to his mental disorder, the way he experienced prison as a person with a mental disorder was not so unusual. According to the National Alliance on Mental Illness (NAMI), most people with mental illness (about three in five) do not receive treatment at all while in prison. (NAMI, n.d.). Oregon's record is better, but it is far from perfect. In 2023, an estimated 62% of Oregon state prisoners needed mental health care, and according to the state Department of Corrections, about 42% of Oregon inmates are actually getting the care they need (Frost, 2023).

Why is care lacking despite the acknowledged need? The problem of staffing seems relatively mundane, but it is a central barrier to proper care in custody, and it leads to serious problems, especially for higher-needs people in custody (figure 7.13). Shortages of corrections and/or mental health staff exist for various reasons, including the rural locations of prisons, lack of competitive pay, and after-effects of the COVID-19 pandemic. The federal prison system maintains that it simply cannot find and hire enough workers to fill hundreds of vacancies at many facilities, even while the federal prison population is on the rise. Regardless of the cause, shortages result in inadequate support for all incarcerated people, especially those experiencing mental disorders. Lack of adequate support creates unacceptable outcomes, including abuse and violence against incarcerated people, vast overuse of solitary confinement, and increased rates of prisoner self-harm (Lartey & Thompson, 2024).

Figure 7.13. Corrections officers speaking in the hallway of a facility. Correctional facilities must be properly staffed to serve large numbers of people with high needs, such as those with serious mental disorders.

Staffing problems were at the heart of a 2007 lawsuit against the Illinois Department of Corrections (DOC) brought by a man named Ashoor Rasho, who was eventually joined by 12,000 other incarcerated plaintiffs. Rasho's lawsuit challenged the Illinois DOC's pattern of punishing people like Rasho instead of treating them for their mental disorders. Rasho had been sentenced to a few years in prison and ended up serving far more—about five times the original time he was expected to serve. This was due to behaviors in prison that were related to Rasho's mental disorders but were handled with punishments, including decades in solitary confinement. A central issue in Rasho's lawsuit was that the prison did not have the staff to allow people who were mentally ill or suicidal out of their cells. Instead, they were locked up alone, even though this was devastating to their mental health (Herman, 2019). Rasho's litigation remains ongoing as of this writing, nearly 20 years after it first began, but it has forced some changes. For example, the Illinois DOC has made efforts to hire hundreds of mental health professionals and hundreds more corrections officers. It has also constructed a prison hospital, a higher level of care that serves as a critical alternative to solitary confinement for incarcerated people displaying severe symptoms of mental disorders (Strom, 2016). According to the director of the Illinois DOC: "Corrections in Illinois was a little slow to recognize we are the mental health system for Illinois. Whether we want to be or not, we are; and we have to start acting like it" (Herman, 2019).

The state of Oregon also faces staffing challenges in its prisons. Oregon is certainly not unique in facing this challenge, but it is perhaps additionally frustrating for a system that has received some notice for being progressive and

reform-minded and has taken steps to reduce the punitive culture in its facilities. This approach has been called the "Oregon Way" and includes efforts to humanize incarcerated people and as well as improve prison staff well-being in the state (Wilson, 2022).

Figure 7.14. The Eastern Oregon Correctional Institution in Pendleton, Oregon, maintains high expectations for its operations but struggles to adequately staff the facility.

Oregon correctional officers who endorse these institutional goals, however, are stymied by the reality of staffing shortages. A Pendleton, Oregon, correctional officer interviewed in 2023 affirmed that he "likes the idea of a more humane approach to incarceration . . . [that includes] humanizing adults in custody, addressing their mental health needs and talking to them about their trauma" (Dake, 2023). However, these ideals feel impossible to realize amidst the conditions at his workplace, the Eastern Oregon Correctional Institution (figure 7.14). Due to staffing shortages, there is only one correctional officer per 80 adults in custody. Correctional staff are expected to work extraordinarily long shifts and have mandated overtime, "so they show up for shifts having missed a kid's birthday or important anniversary" (Dake, 2023). While staff might fully embrace the idea of improving services for people in custody, significant staffing shortages make even basic required services—like ensuring time outside of cells—hard to deliver (Dake, 2023).

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Figure 7.14. "The Eastern Oregon Correctional Institution in Pendleton, Oregon" by Sam Beebe is licensed under CC BY 2.0.

7.5 Legal Right to Care in Custody

Given the enormous number of people with mental disorders who are confined in our nation's jails and prisons, there is a significant, complex, and continuous need for support and care related to those mental disorders (figure 7.15). This section provides introductory information about the law governing incarcerated peoples' access to and control over their mental health care. Legal rulings related to care for incarcerated people outline the extent to which the government is obligated to provide medical care, including mental health care, to incarcerated people and whether people in prison have autonomy with respect to their mental health care.

Figure 7.15. A medical provider at work in federal prison. People who are in custody have the right to receive necessary care from the government.

Courts have decided these issues based on the Constitution, specifically the **Eighth Amendment** to the U.S. Constitution, which prohibits "cruel and unusual punishment," and the "due process" clauses of the **Fifth Amendment** and **Fourteenth Amendment** to the U.S. Constitution, which require fair procedures and treatment when important decisions are made impacting people in the criminal justice system. The concept of *due process* is discussed more in Chapter 6 of this text. While the federal government and all states must follow the directives of the U.S. Constitution as a minimum standard, be aware that some state laws may place additional or higher demands on their own facilities.

Eighth Amendment and Deliberate Indifference

One of the most important and often-cited cases related to health care in prison is that of *Estelle v. Gamble* (1976). In November 1973, Texas inmate J.W. Gamble sustained a back injury when a hay bale fell on him while he was working his prison job. Gamble complained of excruciating pain and later developed secondary health problems related to his heart. Gamble was seen by medical personnel who provided him with some care but did not resolve his pain. When Gamble was cleared to go back to work but refused, he was punished and

placed in solitary confinement. Eventually, Gamble filed a lawsuit claiming that he had been subjected to "cruel and unusual punishment" in violation of the Eighth Amendment (*Estelle v. Gamble*, 1976).

The Supreme Court affirmed that the Eighth Amendment ban on cruel and unusual punishment prohibited "unnecessary and wanton infliction of pain" and agreed that failure to provide medical care could, in some cases, rise to a level that would violate that directive (figure 7.16). The Supreme Court clarified, however, that only *deliberate indifference* by prison officials concerning providing medical care can be a constitutional violation. The standard of deliberate indifference, introduced in **Chapter 3**, is quite a difficult standard for plaintiffs to prove.

Figure 7.16. Doctors conferring over an unseen patient in a custodial setting in the 1940s in the Seattle, Washington, area. Prior to *Estelle v. Gamble*, it was not legally established that failure to provide medical care violated an incarcerated person's right to be free of cruel and unusual punishment.

Proof of deliberate indifference requires showing that an official was aware of the concerns identified, yet chose not to take action to avoid harm. Accidental failures or poor judgment by a doctor or by the prison are not considered deliberate indifference, and thus they are not violations of the Constitution: "Medical malpractice does not become a constitutional violation merely because the victim is a prisoner" (*Estelle v. Gamble*, 429 U.S. at 106). In Gamble's case, doctors had seen Gamble repeatedly and tried to care for him. While that care was perhaps poor, it was not deliberately indifferent because it did not evidence callous disregard for Gamble's well-being. In short, Gamble lost his case.

If a person who is incarcerated believes they have not been provided needed medical care, they can self-advocate or file an internal complaint, or, if certain conditions are met, they might be able to file a lawsuit—but they are unlikely to succeed in a lawsuit based on a constitutional claim. While *Estelle v. Gamble* does allow incarcerated people to sue based on failure to provide medical care, the deliberate indifference standard severely limits their ability to prevail. To hold a prison liable for failing to provide adequate care, an incarcerated plaintiff must be able to prove that the prison was aware of the need for care and consciously chose not to provide it.

Access to Mental Health Care

Another important case in discussions of prison care for mental disorders is *Bowring v. Godwin* (1978). While *Bowring* is not a Supreme Court case and technically governs only federal courts in certain areas, it represents the general agreement among federal courts that, like other medical care, mental health care must be provided to incarcerated people, and certain denials of care may violate the Constitution (A Jailhouse Lawyer's Manual, 2020).

In the *Bowring* case, plaintiff Larry Bowring had been convicted of multiple felonies and sentenced to prison time in Virginia. When he became eligible for parole, Bowring was denied release due to, among other reasons, the symptoms of his mental disorder that were deemed likely to make him unsuccessful on parole (Hoard, 1978). Bowring sued, asserting that the prison unconstitutionally failed to provide him with care to alleviate those symptoms and allow him to be considered for

release. Ultimately, the *Bowring* court applied a similar standard as in the *Estelle v. Gamble* case, holding that incarcerated people are entitled to treatment for mental disorders, within reasonable bounds (figure 7.17). The court declined to "second guess" prison medical decisions, deferring to the expertise of medical professionals, but the court did say that prisons are required to provide care according to their judgment. Generally, only necessary and not overly burdensome mental health care is required, and failure to provide proper care does not violate the Eighth Amendment to the Constitution unless, as established in *Estelle*, the jail or prison officials act with deliberate indifference (A Jailhouse Lawyer's Manual, 2020).

Figure 7.17. Prisons regularly house people with a range of mental disorders, and the Constitution requires that they be provided with a minimum level of care.

Right to Refuse Care

An important aspect of medical care, including care for mental disorders, is making choices about that care, which may include refusing recommended care. The issue of whether and to what extent an incarcerated person can be forced to accept treatment for a mental disorder was addressed in the 1990 case of *Washington v. Harper*.

Walter Harper was incarcerated in a Washington state prison for many years on robbery charges. He had resided in a mental health unit for much of that time and had willingly taken medications to treat psychosis. However, when he stopped taking medications, Harper engaged in assaultive behavior that resulted in his transfer to a prison hospital setting. There, after a process involving the approval of multiple doctors and a finding that he was dangerous if not medicated, Harper was given antipsychotic medication against his will.

Harper sued, claiming that his due process rights under the Fourteenth Amendment were violated when the prison forced medication on him without additional court proceedings. The Supreme Court considered the case and ruled that the Washington prison procedures were adequate to protect Harper's rights and that the prison could administer involuntary medication using these procedures if their action was rationally related to a legitimate prison interest (e.g., maintaining safety and order). An incarcerated person with a mental disorder can refuse medication, but that can be overruled if the prison procedures determine that the person is dangerous without the medication and that giving the medication is in the person's best medical interests (*Washington v. Harper*, 1990).

Under the *Washington v. Harper* case, incarcerated people who are seriously impacted by mental disorders such that they may harm themselves or others when unmedicated will have a difficult time refusing medications. Although the law may represent a reasonable balancing of diverse interests, the loss of autonomy for the incarcerated person can be very difficult. Forced medication can also bring other indignities, such as undesired side effects from the medication and facility hearings that violate the privacy of the incarcerated person. In contrast, prisons have a directive to maintain safety and order, as well as to treat people who may be too impaired to act in their own self-interest.

Watch the video in figure 7.18 for a discussion of the issues at stake in forcing medication in the jail setting: the due process rights of incarcerated people, the autonomy of an unconvicted person, and the desire to protect a person from psychiatric decompensation. These issues are often explored at extremely limited hearings that may not suit the gravity of the matter from the incarcerated person's perspective.

This interactive content is not available in this version of the text. It can be accessed online here:
https://youtu.be/tl2pPSth5gM

Figure 7.18. This video explains the *Washington v. Harper* decision and its application to people incarcerated in jails specifically. As you watch, consider how you would weigh the important interests at stake in making decisions about involuntary medication administration. **Transcript.**

Further information about the topic of prisoner lawsuits is beyond the scope of this text, but if you are interested in learning more, feel free to explore materials specifically addressing this topic such as the **Columbia University Jailhouse Lawyer's Manual [Website]**.

SPOTLIGHT: Preventing Suicide in Jail

Among the most devastating outcomes of mental health problems are self-harm and suicide, which are significant threats to people in custody. This is especially true for certain more vulnerable groups (e.g., juveniles), but the risk spans all incarcerated populations, among which suicide rates are much higher than in the general population (National Institute of Corrections, n.d.). In February of 2024, the Federal Bureau of Prisons reported on all prison deaths in the federal system during the period from 2014 to 2021. The most frequent cause of death in prison was suicide, which accounted for more than half of the 344 total deaths during that period. Staffing deficiencies, inadequate assessments, and inappropriate mental health care assignments (e.g., failure to provide treatment or follow-up) were all identified as contributing factors to these deaths (U.S. Department of Justice, Office of the Inspector General, 2024).

In a survey of state facilities done in 2019, the Department of Justice found that about a fifth of prisons and a tenth of local jails had at least one suicide that year. Suicide accounted for a startling 30% of deaths in local jails in 2019—representing a 13% increase from 2000 numbers (U.S. Department of Justice, Office of Justice Programs, 2021). The numbers also point to particular risks for certain groups: half of the people who died by suicide in local jails had been there for 7 or fewer days, and most of them were unconvicted and awaiting court proceedings (figure 7.19). The highest rates of suicide were among inmates aged 55 and older (U.S. Department of Justice, Office of Justice Programs, 2021).

Figure 7.19. People in jail for short periods, awaiting resolution of charges, are at higher risk for suicide than people incarcerated for longer terms or people who have already been convicted and sent to prison.

How do we prevent these tragic deaths? Jails and prisons can, and must, do a better job of identifying those at risk and providing necessary supervision and care. One example of a jail taking an active role in suicide prevention is the Clackamas County Jail in Oregon. Take a look at the **jail's suicide prevention resources [Website]**, if you are interested. The jail emphasizes recognition of the problem ("The problem is real. Know the signs.") and requests action from people in custody as well as from their loved ones (e.g., by contacting jail staff at a given phone number). The Clackamas County website acknowledges common barriers to taking action, including the idea that "someone else" will do something. The site also alerts readers to numerous suicide warning signs that should not be ignored (e.g., talking about death, withdrawing from friends, giving away possessions) (Clackamas County Sheriff, State of Oregon, n.d.).

For a comprehensive report on the problems of suicide and self-harm in custodial environments, including best practices for prevention, you may consider reviewing the **Suicide Prevention Resource Guide: National Response Plan for Suicide Prevention in Corrections [Website]** created by the National Commission on Correctional Health Care. Although this additional reading is not required, you are encouraged to be aware of this resource and the risks it seeks to prevent. As stated in the introduction to the guide:

> Suicide is a profoundly solitary act. The response to it, however, must not be. Suicide prevention requires a coordinated, multifaceted team effort. Nowhere is that more true than in jails and prisons.
>
> Incarcerated men and women are a socially excluded population characterized by a multitude of personal and social problems and, often, mental health or substance abuse issues. Those risk factors for suicide are compounded by confinement, leaving some people feeling overwhelmed and hopeless. Tragically, too many of them die by suicide as a means of ending what feels like inescapable pain (Barboza, et al., 2019, p.4).

Licenses and Attributions for Legal Right to Care in Custody

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Figure 7.19. Photo by Aaron Robinson on Unsplash.

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Figure 7.18. Forced Medication Behind Bars by Rooted in Rights is licensed under the Standard YouTube License.

7.6 Ensuring Care for People with Mental Disorders in Custody

As we have established throughout this text, many people in custody need care for mental disorders, and receiving that care is not only their right but also central to their ability to conform and succeed in custody. One of the best ways to think about caring for people in custody is to consider an objective identified throughout this text: the goal of guiding people out of more restrictive environments and into progressively less restrictive ones in ways that help them succeed (figure 7.20). Providing thoughtful and effective care for mental disorders in custody is an important aspect of this work.

Actions that support the progress of a person in custody who experiences a mental disorder can take various forms depending on the individual and their circumstances. A person may be focused on transferring from a high-security facility to a lower-security one, from restrictive behavioral health housing to the general population, or from prison to the community. Regardless of the specifics, these transitions are steps toward increasing autonomy and successfully reducing restrictions. Ensuring that incarcerated people are successful in these steps is a positive outcome for the individual as well as for the system that realizes reductions in crime and the associated costs, including imprisonment (SAMHSA, 2017). The process of transitioning to release or to a less restrictive setting should start immediately after a person enters custody.

Figure 7.20. Success for a person in custody may not be direct; it likely involves stepwise progress toward less restrictive environments.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) offers guidelines for supporting the transition of incarcerated people with mental disorders from jail or prison settings using the **APIC framework**, which includes the following actions:

- **ASSESS**: Assessing a person's needs and safety risks
- **PLAN**: Planning for the treatment and services a person needs
- **IDENTIFY**: Identifying suitable services and programs
- **COORDINATE**: Coordinating a transition plan to avoid gaps in services

(SAMHSA, 2017).

Assessing Needs and Risks

Properly assessing the needs and risks of incarcerated people requires that facilities conduct universal **screening** as early as possible in the booking or intake process and again as necessary to ensure the detection of mental disorders (figure 7.21). Screenings do not provide diagnostic information. Rather, they are sets of standard questions intended to flag or detect individuals who are at risk for a targeted problem, such as a mental disorder. Jurisdictions vary in how they perform screenings, depending on what resources and treatment options they have.

For example, at the Gwinnett County jail in Georgia, the jail staff screens every person for veteran status and for mental illness. At the same time, staff identify each person's needs (e.g., housing, treatment, employment, and education) and required safety precautions. Similarly, the Hancock County Justice Center in Ohio universally administers a screening instrument called the Global Appraisal of Individual Needs Short Screener (GAIN-SS), which consists of 23 questions. The screening looks for behavioral health issues as well as propensity for criminal behavior. The screening is designed to take just a few minutes to administer and can help find people who are more likely to have a mental disorder and need further assessment (Chestnut Health Systems, n.d.).

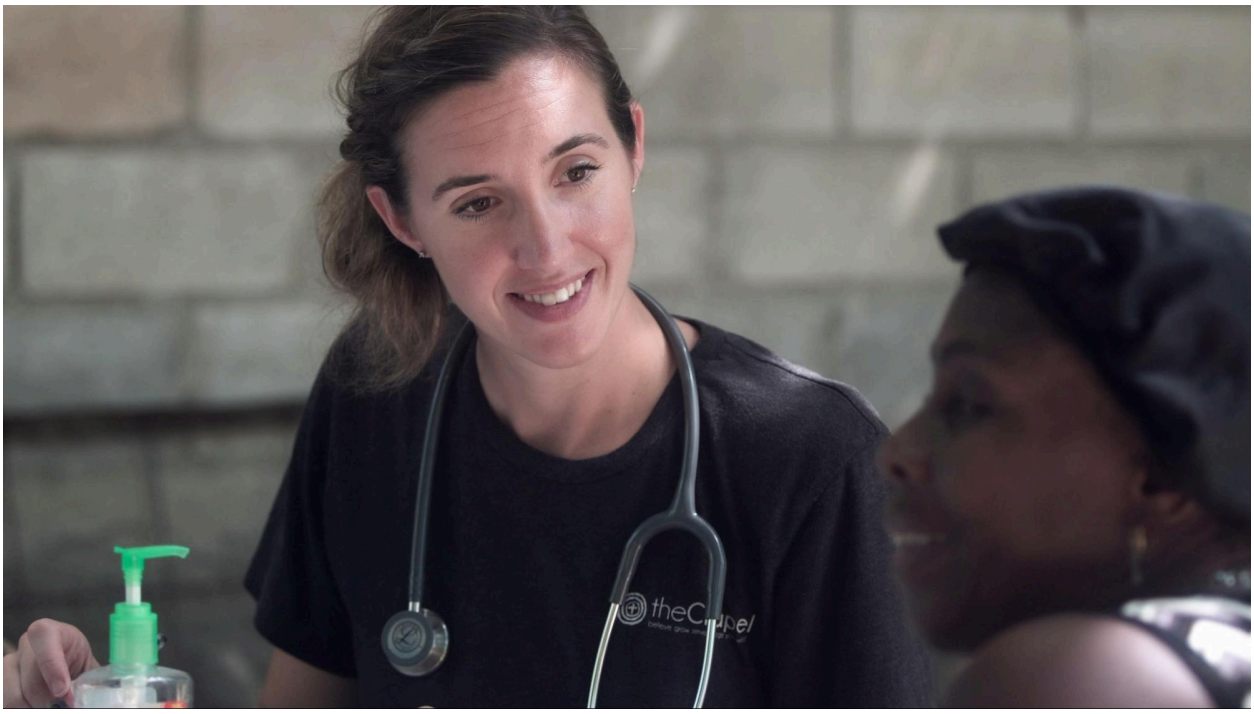

Figure 7.21. Initial screening and follow-up assessments of people entering custody are critical to ensure their needs are being met from the start and that they are prepared to succeed in the next steps.

If a screened person is flagged "positive" for concerns, the facility should follow up with a more in-depth **assessment** that informs the facility about the services a person will need. In comparison to a screening, an assessment involves more in-depth questioning administered by a behavioral health professional. Assessments examine the nature and severity of a detected mental disorder. The assessment should also gather additional information, including demographics, the pathway to criminal involvement, strengths and protective factors, and the person's safety risks and needs.

At the Oregon Department of Corrections, all newcomers are evaluated during a central intake process that looks for the presence of mental disorders as well as criminal risk and other needs. (Oregon Department of Corrections, n.d.-b; Oregon Department of Corrections, n.d.-a). To look for mental disorders, Oregon uses a tool called the Personality Assessment Inventory (PAI). The PAI takes around 45 minutes and requires a fourth-grade reading level to complete, so some people do need alternative means of screening (Psychological Assessment Resources, n.d.; Oregon Department of Corrections, n.d.-a). Incarcerated people with elevated PAI scores or who are identified as having recent mental health problems, who are taking psychiatric medications, or who are engaging in suicidal behaviors will receive additional evaluations, including one-on-one interviews, to determine the next steps. According to the Oregon DOC, about 60% of incarcerated people qualify for one-on-one interviews to assess mental disorders (Oregon Department of Corrections, n.d.-a).

Planning Treatment and Services

The second step under the APIC framework is planning: using information from assessments to plan care for people in custody. A key aspect of planning is collaboration between behavioral health and criminal justice professionals to deter-

mine what level of supervision and treatment an incarcerated person needs. The planning stage also includes taking immediate steps to stabilize people so that they can engage in treatment and avoid reoffending.

As with screenings and assessments, jurisdictions can approach planning in different ways. For example, some facilities hire mental health staff, while others work with outside agencies to help them develop and provide treatment for people in custody. Increased use of **telehealth**, which can include phone or video appointments as well as electronic exchange of medical records, increases access to mental health professionals in prisons and jails. Video calls are a cost- and time-effective way to make sure corrections staff are properly advised on how to help people be more successful in custody (figure 7.22) (Police Executive Research Forum, 2018).

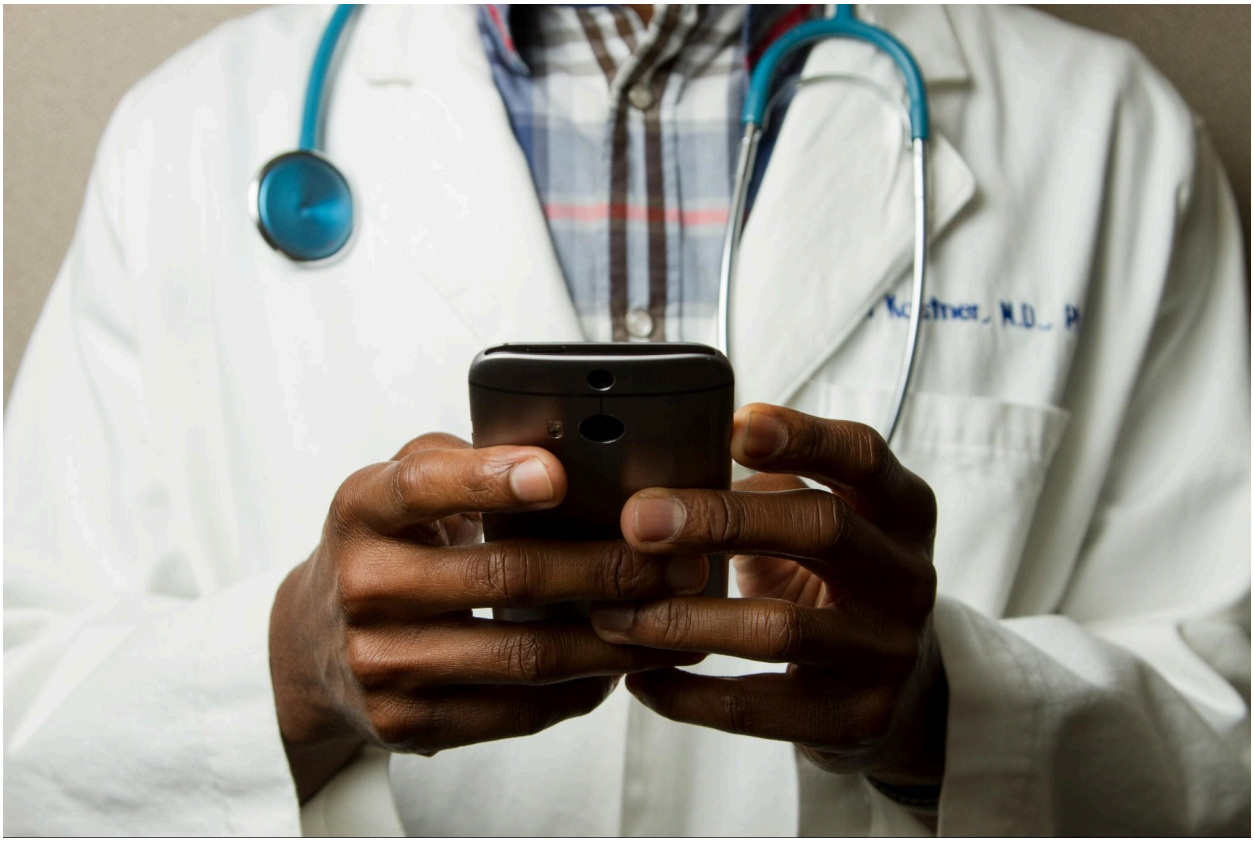

Figure 7.22. Telehealth via a phone or video call went mainstream during the COVID-19 pandemic, but it was already in use in many correctional facilities. Telehealth can help prisons and jails provide care despite shortages of mental health and other care providers in the facility or the area.

Planning may anticipate that treatment and services will be delivered in the general population or in specialized housing units. Plans may include treatment with different focuses, such as managing medication, providing education, or supporting employment. Some facilities direct people into programs with phases that allow a person to graduate from one phase to another, gaining access to additional privileges and lower levels of supervision. Planning will look very different for a person expected to spend 72 hours in jail than it will for a person anticipating a longer prison stay.

Regardless of specifics, the priority is that jails and prisons engage in planning and that those plans include proven-effective treatments that will help reduce a person's likelihood of reoffending.

As we saw in our introductory example of Sedlis Dowdy, reoffending can and does occur within the correctional setting. Criminal reoffense, or simply problem behaviors in custody, are detrimental and can result in longer and more restrictive stays in custody (figure 7.23). Proper planning, based on proper assessment, helps ensure that a person in custody has the treatment and tools to succeed.

Figure 7.23. Prompt assessment and planning for people in custody can reduce problem behaviors that give rise to additional punitive measures, a negative outcome for the individual and the system.

Identifying Programs

The third step of the APIC framework is the identification of specific programs that fulfill the plans for the incarcerated person that were developed based on assessments. Programs can be identified within a facility or elsewhere for people who are moving on to other facilities (e.g., transferring from jail to prison). For people who are leaving custody, especially those with mental disorders who are being released from short stays in jail, identification of and direct connection with supportive programming are critical.

Lack of access to medication, housing, or food can force a person into a revolving cycle of jail admissions and releases. In contrast, identifying a program where a person can get their needs met can disrupt that cycle, which has an enormous benefit to individuals and the system. Ideally, a facility will directly connect the person with identified resources and provide a supported transition to the next service provider. This type of transition can be accomplished via a meeting, which can be virtual, or by providing the person with transportation to the new resource if it is in the community (SAMHSA, 2022b). More specifics on the transfer of care to the community and services that should be provided there post-incarceration are discussed in **Chapter 8** of this text.

Coordinating Transition Plans

Facilities recognize that no long-term treatment progress can be made if, as soon as a person moves or is transferred, their services end or drastically change. The APIC framework thus concludes with the coordination of transition plans. Coordination includes sharing information (from earlier assessments or treatment) within the criminal justice system—between facilities or with community supervision staff. When information is shared, diagnoses and medication do not need to be reestablished, needs can be met more quickly, and people in custody are relieved of some self-advocacy needs.

Coordination also includes training and education. These elements promote collaboration between criminal justice professionals and treatment or mental health professionals. Correctional

personnel can be more effective and empathetic when they understand how mental disorders present (Police Executive Research Forum, 2018). Likewise, behavioral health experts benefit from a better understanding of correctional issues and public safety concerns. For both sets of professionals, understanding more about what the other does can reduce the mistrust and tension that interfere with the teamwork needed to produce effective outcomes (figure 7.24).

Figure 7.24. Corrections staff interacting with another person. Education about the work and struggles of others increases empathy and allows professionals to provide better, more effective service.

A variety of training approaches can be effective aspects of coordination. Crisis Intervention Team (CIT) training, discussed in **Chapter 5**, can be used in the corrections environment to support officers working in tandem with mental health professionals to help people with mental disorders. If you are interested in learning more about CIT training in the corrections environment, watch **Crisis Intervention Training for Corrections Officers [Streaming Video]**, which describes this training approach and its outcomes. Trauma-informed training for corrections officers can also improve interactions between prison staff and incarcerated people, making the prison environment safer for everyone.

Trauma-informed, whether referring to care, training, or any approach to a problem, recognizes the impacts of trauma and how it may present in individuals. An officer's approach is adjusted so that trauma is addressed and the person involved is less likely to be re-traumatized in their interaction with the officer. Actions taken with a trauma-informed approach can include simple changes like carefully explaining what a pat-down will entail before it happens, reducing the anxiety of a person who may be expecting abuse (Stringer,

2019). Trauma-informed care as a critical element of community care after release is discussed more in **Chapter 8** of this text. For an excellent resource and accessible information on trauma, consider exploring the **website for Trauma Informed Oregon**.

One specific and interesting example of instituting trauma-informed care in a prison setting is in Hawaii's Women's Community Correctional Center (WCCC). In contrast to a traditional correctional setting, but consistent with Native Hawaiian cultural practices, the WCCC approach was guided by a belief in the transformative nature of a *pu'uhonua*, a Hawaiian term that means a protected site for healing. The WCCC initiative recognizes the significant role of trauma in most women's paths into the criminal justice system, which are often linked to childhood abuse. It also acknowledges the particular ways in which Native Hawaiian women who are incarcerated are impacted by trauma. Many women in prison are separated from their children, a circumstance that is devastating generally but has unique consequences for women in a culture that highly values family places and connections. This is in addition to historical trauma impacting Native Hawaiian women who are part of a severely oppressed larger group (Patterson et al., 2013). Hawaii's approach includes several days of intensive trauma-informed training for staff, treatment and service practitioners, and incarcerated individuals. The training includes identifying systemic sources of trauma; recognizing the psychological, physiological, neurobiological, and social effects of trauma; and avoiding further trauma caused by practices such as seclusion and restraint. For correctional staff, the training provides knowledge and develops skills to help them reduce the trauma and trauma-related problems of incarcerated people. For incarcerated women, the creation of the *pu'uhonua* reinforces trauma-informed principles by promoting empowerment and personal recovery and strengthening family and community relationships (figure 7.25).

Figure 7.25. Programming at a women's correctional facility. Facilities must provide services that meet the needs of and are appropriate for the populations they serve.

Importantly, the coordination aspect of APIC also includes supporting people in adhering to appropriate treatment and supervision. Generally, support for adherence involves supervision with incentives that encourage compliance and sanctions that promote safety. For example, in the Massachusetts state prison system, incarcerated people who are close to release are transferred to a lower security facility. They are assigned to staff who review service plans and help schedule appointments with parole officers or treatment providers. Completing the review is a condition of discharge, providing an incentive to be sure it happens. These same staff then continue to be available to people who have been discharged from custody and can be consulted for mentoring, crisis intervention, or referrals. Especially high-risk people (e.g., very violent records, gun charges) are linked with specially trained staff who stay even more closely involved by transporting clients to treatment appointments and supervision meetings. These connections are examples of coordination that keeps people on track.

Licenses and Attributions for Ensuring Care for People with Mental Disorders in Custody

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Figure 7.25. Female Inmates in a RDAP Program by CoreCivic is licensed under CC BY-ND 2.0.

7.7 Substance Use Treatment in Custody

This chapter has discussed the importance of ensuring care for people in custody, but what does that care look like? The details of treatment that can be provided in custody are beyond the scope of this criminal justice-focused text, but treatment can and does include the psychological (counseling) and psychiatric (medication) treatments that were mentioned in Chapter 2 of this text. You have also heard a little about treatment that may occur in jails and prisons from the AVID videos embedded throughout this chapter. If you are interested in learning more about what it is like to be a mental health provider in a controlled environment, you may also hear from several of those professionals via the videos linked in Chapter 10 of this text. Additionally, feel free to take a look at this interview with a supervising psychiatrist who works in the California prison system [Website]. The interview touches on approaches to treatment within prison, as well as the challenges and satisfactions of treatment in this environment from the perspective of a mental health provider.

One specific and important type of treatment in custody that will be briefly addressed here is treatment for substance use disorders. **Substance use treatment** can include any number of approaches that help a person manage and recover from a substance use disorder, a diagnosis discussed more in Chapter 2. Evidence-based therapies, such as cognitive behavioral therapy, can be part of treatment, as can medication-based treatments (U.S. Department of Veterans Affairs, 2024).

Availability of Substance Use Treatment in Custody

In custody, substance use disorders can be detected at the assessment stage, and treatment should be planned, identified, and coordinated—though that does not always occur. There is an enormous unmet need for substance use treatment in custody. Substance use disorders are common in U.S. jails and prisons. Although this text uses the term mental disorders broadly to include substance use disorders, many statistics do

not take that approach. SAMHSA estimates that close to 60% of people in jails and prisons have substance use disorders, while rates are closer to 10% outside of custody (SAMHSA, 2022a). However, adequate screening and assessment are frequently lacking. Even when problems are identified, many people do not have access to treatment in custody, and symptoms of these disorders (like other mental disorders) are frequently worsened by incarceration (figure 7.26) (SAMHSA, 2022a).

Figure 7.26. Ideally, people who are assessed to need substance use treatment are provided with that treatment in custody.

For example, in Oregon, it is estimated that two-thirds of all state prisoners (about 8,000 total) have substance use disorders needing treatment. Yet, only 4 of Oregon's 12 prisons have intensive substance use treatment programs, so access remains very limited. For example, the Oregon State Correctional Institution outside of Salem houses 800 people, but the intensive substance use treatment program there takes only 24 participants who are close to their release date—rendering this type of treatment unavailable to most (Frost, 2023).

Recognizing the huge need, Oregon is engaged in efforts to expand substance use treatment in innovative ways. The Oregon DOC has recently created a new program that is located at the high-security Oregon State Penitentiary. This program uses prison-trained certified recovery mentors (peer mentors) alongside certified drug and alcohol counselors to provide treatment to incarcerated people. Reportedly, the program is in high demand, and it is very meaningful to its participants, many of whom are in the facility for lengthy terms. If you are interested, watch the video in figure 7.27 to hear from some of the Oregon participants in this initiative.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=hRrIoDmttqA

Figure 7.27. This optional 9-minute video shares the experience of several participants in Oregon's innovative peer-supported substance use treatment program that is by and for people in custody. **Transcript.**

Medication Treatment for Substance Use Disorders

An important form of treatment for substance use disorders is medication, which can be used alone or in combination with counseling and behavioral therapies to provide a "whole-patient" approach to treatment. This type of treatment is often referred to as **medication-assisted treatment (MAT)**. Medications are uniquely effective for difficult-to-treat alcohol and opioid use disorders, and sometimes these approaches are referred to in more specific terms as either *medication for opioid use disorder (MOUD)* or *medication for alcohol use disorder (MAUD)*. Both MOUD and MAUD are discussed in more detail in **Chapter 8** as critical post-incarceration interventions for people in the community (figure 7.28).

Figure 7.28. A community clinic that provides medications for substance use treatment. These medications are more easily provided in the community than in custody, but they have great benefits for people in either setting.

The FDA has approved several different medications that can be safely used to treat substance use disorders. These medications relieve withdrawal symptoms and cravings that a person with a substance use disorder would otherwise experience, without the negative or euphoric effects of the substance. The medications are also safe to use for extended periods. Medication treatment for substance use has been shown to have significant benefits: it reduces drug use, prevents overdose events, and promotes recovery among substance users. It is also effective in reducing criminal activity and arrests, including probation revocations that result in incarceration (SAMHSA, n.d.).

Medication-Assisted Treatment (MAT) in Custody

Despite its effectiveness, the use of medications for substances has been limited in many criminal justice settings, including prisons. The reasons for this are numerous. Misunderstandings associated with the use of these medications are one barrier. Some people believe—incorrectly—that medication treatment involves "substituting one drug for another." The idea that medication functions like a drug of abuse leads to resistance to its use in the criminal justice field, even though medication treatment is a tested and proven approach with strong positive outcomes.

Misuse of medication, sometimes called diversion of medication, is another concern that limits

prison (and other criminal justice program) use of these treatments. While misuse is a valid concern, criminal justice programs and facilities can limit this risk, even in the prison setting. Strategies might include the use of dedicated staff for oversight, ensuring safe storage of medications, and conducting drug testing.

The costs of medication treatment are an additional concern for many correctional programs. Although long-term benefits abound, the immediate costs of medication, staffing, and training may be prohibitive. Often, the required medications are not on correctional facilities' formularies, or lists of allowed and funded medications. In a related concern, formerly incarcerated people without insurance coverage may not be able to continue medication treatment when they are released, limiting the value of the investment during incarceration. Additionally, setting aside affordability, many communities do not even have sufficient medication treatment providers or ones who can effectively serve the justice-involved population.

Because medication treatment can be so helpful to a person in recovery from a substance use disorder, its use has been expanded across many custodial environments in recent years, despite identified barriers (Homans, et al., 2023). With these efforts, medication treatment for substance use, particularly in custodial settings, is evolving rapidly. Ask a criminal justice or mental health professional in your community: what are the current approaches to medications for substance use, or MAT, in correctional settings? What terminology is used to describe the approach? What have we learned, and what changes are on the horizon?

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Figure 7.28. IMG_1607 Dispensing area for medication assisted treatment by NYS OASAS is licensed under CC BY-NC-ND 2.0.

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Figure 7.27. **Oregon State Penitentiary Diversion Program** by **Oregon DOC** is licensed under the **Standard YouTube License**.

7.8 Chapter Summary

- People with mental disorders are found in all parts of the criminal justice system, including jails and prisons, where they can be housed in a variety of settings from more to less restrictive.
- Segregated or isolative housing in custody, known as solitary confinement, is both overused and particularly damaging for people with mental disorders. It is also overused with other marginalized populations in custody.
- Staffing shortages in prisons and jails contribute to inadequate support for all people in custody, and particularly for people with mental disorders who may have higher support needs. Inadequate staffing can lead to the use of approaches like solitary confinement to manage challenging situations.
- People in custody have a constitutional right to care, but that right is difficult to enforce, based on the law that has developed around these issues. Additionally, to medicate a person in custody on an involuntary basis, a facility is required to go through certain procedures. Otherwise, a person has a right to decline treatment.
- Given that jails and prisons are naturally places of transition, ensuring that people receive the care they need in custody requires systems that anticipate those transitions. One such system is the APIC framework, which suggests an approach to ensuring care that begins with assessment and planning and progresses to identifying services and coordinating those services.
- Care in custody can include treatment from numerous professionals in the field of mental health. One type of care that is very important for many—if not most—people in custody is substance use treatment, including medication-based treatment for substance use.

KEY TERM DEFINITIONS

- **APIC framework:** A set of guidelines for ensuring people in custody receive treatment that continues and is effective across transitions. The APIC framework includes four steps: assessing, planning, identifying, and coordinating treatment.
- **Assessment:** A follow-up evaluation triggered by a screening that flags a potential problem or issue. An assessment is more in-depth than a screening, is performed by a mental health professional, and informs the facility about the services a person will need.

- **Eighth Amendment**: The amendment to the U.S. Constitution that prohibits cruel and unusual punishment and regulates excessive fines and bail.
- **Fifth Amendment:** The amendment to the U.S. Constitution that creates numerous important rights. Among those rights is the right to receive "due process" of law, or fair treatment, when a person may be deprived of life, liberty, or property.
- **Fourteenth Amendment**: The amendment to the U.S. Constitution that governs the rights of citizens in the states. The due process clause of the Fourteenth Amendment is understood to guarantee fairness in proceedings in the criminal justice systems in the states, just as the Fifth Amendment due process clause requires fairness in the federal system.
- **Medication-assisted treatment (MAT)**: The use of medication, sometimes along with other therapies, to treat substance use disorders. There are several medications that target alcohol use, as well as medications that treat opioid use disorder.
- **Screening:** A standardized set of questions designed to flag people who are at risk for a targeted problem, such as a mental disorder. A screening does not provide a diagnosis or guidance on the severity of any disorder; rather it informs that a person needs further assessment.
- **Solitary confinement**: Also called isolation or segregation, a form of incarceration where the person is isolated in a cell. Solitary confinement is generally used as a form of discipline for prison rule violations or as a method to keep the isolated person or others safe.
- **Substance use treatment:** Treatment that helps a person manage and recover from a substance use disorder, typically including evidence-based therapies, such as cognitive behavioral therapy and/or other therapeutic approaches, and increasingly including medication-based approaches.
- **Telehealth:** The provision of health care, including mental health care, via means such as phone or video appointments, as well as electronic transfer of medical data.
- **Trauma-informed (training, care, or approach)**: A system or action that realizes the widespread impact of trauma, recognizes its signs and symptoms, and responds by integrating this information into policy and practice, while seeking to actively resist re-traumatization.

DISCUSSION QUESTIONS

1. What are the needs and problems associated with the use of very restrictive or isolative housing for people with mental disorders in custody? What changes to our system can you imagine that could reduce the use of solitary confinement for this population?
2. How does the "deliberate indifference" standard impact a prisoner's ability to bring a lawsuit or otherwise enforce their right to care in custody? How might this legal standard impact care provided in prisons generally?
3. What are the barriers to providing substance use treatment in custody, and how can/should

those barriers be addressed? Should the use of medication-based treatments be expanded? Why or why not?

Licenses and Attributions for Chapter Summary

7.9 References

Barboza, S., Blair, R., Cook, G., Elliot, W. & Kern, E. (2019). *Suicide prevention resource guide,*

National response plan for suicide prevention in corrections. National Commission on Correctional Health Care. https://www.ncchc.org/wp-content/uploads/Suicide_Prevention_Resource_Guide.pdf

Barclay, E. (2014, January 2). Food as punishment: Giving U.S. inmates "The Loaf" persists. *NPR.* https://www.npr.org/sections/thesalt/2014/01/02/256605441/punishing-inmates-with-the-loaf-persists-in-the-u-s

Bowring vs. Godwin, 580 F.2d 1047 (4th Cir. 1978). https://law.justia.com/cases/federal/appellate-courts/F2/580/1047/84090/

Chestnut Health Systems. (n.d.). *GAIN Coordinating Center*, *GAIN instruments*. https://gaincc.org/instruments/

Clackamas County Sheriff, State of Oregon. (n.d.). *You are not alone. Clackamas County Jail: Suicide prevention resources*. Clackamas County. https://www.clackamas.us/sheriff/jail-suicideresources.html

Cornell Law School, Legal Information Institute. (2021). *Solitary confinement.* https://www.law.cornell.edu/wex/solitary_confinement

The Council of State Governments, Justice Center. (2021, August). *Addressing misconceptions about mental health and violence* [Field Notes, Behavioral Health]. https://csgjusticecenter.org/wp-content/uploads/2021/08/CSGJC_Field-Notes_Addressing-Misconceptions-about-Mental-Health-and-Violence_2019-MO-BX-K001_508.pdf

Dake, L. (2023, April 25). Oregon state government workers struggle to deliver services amid staffing shortages. *Oregon Public Broadcasting*. https://www.opb.org/article/2023/04/25/oregon-state-government-workers-struggle-to-deliver-services-amid-staffing-shortages/

Dholakia, N. (2023, February, 21). The difference between jail and prison. *Vera, Institute of Justice.* https://www.vera.org/news/u-s-jails-and-prisons-explained

Disability Rights Washington. (2016, August). *The AVID jail project and SCORE.* https://disabilityrightswa.org/reports/avid-jail-project-score/#AVID_Jail_Project

Estelle v. Gamble, 429 U.S. 97 (1976). https://supreme.justia.com/cases/federal/us/429/97/

Frost, A. (2023, May 16). Oregon bill would provide prisoners substance use and mental health treatment. *Oregon Public Broadcasting*. https://www.opb.org/article/2023/05/16/think-out-loud-oregon-bill-would-provide-prisoners-substance-use-mental-health-treatment/

Gutwinski, S., Schreiter, S., Deutscher, K. & Fazel, S. (2021, September 7). The prevalence of mental disorders among homeless people in high-

income countries: An updated systematic review and meta-regression analysis. *PLoS Medicine*. https://doi.org/10.1371%2Fjournal.pmed.1003750

Guy, A. (2016, September 8). *Locked up and locked down, Segregation of inmates with mental illness*. http://www.avidprisonproject.org/

Harrell, L. & Nam-Sonenstein, B. (2023, June 8). *Unhoused and under arrest: How Atlanta polices poverty*. https://www.prisonpolicy.org/blog/2023/06/08/atlanta-poverty/

Herman, C. (2019, February 3). Most inmates with mental illness still wait for decent care. *National Public Radio*. https://www.npr.org/sections/health-shots/2019/02/03/690872394/most-inmates-with-mental-illness-still-wait-for-decent-care

Hoard, S. L. (1978). Prisoners' rights – *Bowring v. Godwin*: The limited right of state prisoners to psychological and psychiatric treatment. *North Carolina Law Review 56*(3), 612–621. https://scholarship.law.unc.edu/cgi/viewcontent.cgi?article=6631&context=nclr

Homans, M., Allen, D. M. & Mazariegos, Y. (2023, June). *A review of Medication Assisted Treatment (MAT) in United States jails and prisons*. California Correctional Health Care Services. https://cchcs.ca.gov/wp-content/uploads/sites/60/MAT-in-United-States-Jails-and-Prisons-Final.pdf

A Jailhouse Lawyer's Manual. (2020). *Chapter 23: Your right to adequate medical care, 12th edition* [Original work published 1989]. *Columbia Human Rights Law Review*, *20*(2), 783-816. https://jlm.law.columbia.edu/files/2021/02/30.-Chapter-23.pdf

James, D. J. & Glaze, L. E. (2006, September). *Bureau of Justice Statistics, Special Report, Mental health problems of prison and jail inmates*. U.S. Department of Justice, Office of Justice. https://static.prisonpolicy.org/scans/bjs/mhppji.pdf

Khalid, A. & Shapiro, J. (2023, February 16). Federal Bureau of Prisons is closing its deadliest unit over violence abuse reports. *National Public Radio*. https://docs.google.com/document/d/1jP5sUnZODrvtr6P9Kqx-JBJ_Ukpl2aIj46ItM_3ctaw/edit?disco=AAABM0vbEjo

Lantigua-Williams, J. (2016, December 5). The link between race and solitary confinement, Men of color are overrepresented in isolation, while whites are typically underrepresented. *The Atlantic*. https://www.theatlantic.com/politics/archive/2016/12/race-solitary-confinement/509456/

Lartey, J. & Thompson, C. (2024, March 2). How federal prisons are getting worse. *The Marshall Project's Closing Argument* [Newsletter]. https://www.themarshallproject.org/2024/03/02/senate-federal-prison-senate-deaths

National Alliance on Mental Illness [NAMI]. (n.d.). *Mental health treatment while incarcerated*. https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Treatment-While-Incarcerated

National Alliance on Mental Illness [NAMI]. (2023, April). *Mental illness by the numbers*. https://nami.org/mhstats

National Institute of Corrections. (n.d.). *Suicide in corrections.* https://nicic.gov/resources/resources-topics-and-roles/topics/suicide-corrections

Or. Admin. R. 291-048-0200 *et seq*. (2024) https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=900

Oregon Department of Corrections. (n.d.-a). *Intake and assessment, Information on the intake and assessment process at Oregon facilities, Assessments and case planning*. https://www.oregon.gov/doc/intake-and-assessment/pages/assessments-and-case-planning.aspx

Oregon Department of Corrections. (n.d.-b). *Prison locations*. https://www.oregon.gov/doc/about/pages/prison-locations.aspx

Patterson, M. K., Uchigakiuchi, P. & Bissen T. (2013). Can prison be a place of healing? The Trauma-Informed Care Initiative at the Women's Community Correctional Center.

Hulili, 9(11). https://kamehamehapublishing.org/wp-content/uploads/sites/38/2020/09/Hulili_Vol9_11.pdf

Pew Charitable Trust. (2023, May 16). *Racial disparities persist in many U.S. jails* [Issue Brief]. https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2023/05/racial-disparities-persist-in-many-us-jails

Police Executive Research Forum. (2018, September). *Managing mental illness in jails: Sheriffs are finding promising new approaches.* https://www.policeforum.org/assets/mentalillnessinjails.pdf

Powers, R. (2017). *No one cares about crazy people: the chaos and heartbreak of mental health in America* [First edition]. New York, Hachette Books.

Prison Policy Initiative. (n.d.). *Incarceration in the U.S.: The big picture.* https://www.prisonpolicy.org/national/

Psychological Assessment Resources. (n.d.). *Personality Assessment Inventory* [PAI]. https://www.parinc.com/Products/Pkey/287

Rodriguez, C. (2015, February 2). Voices from Inside. *WNYC*. https://www.wnyc.org/story/voices-inside/

Sandoval, J. (2023, March 17). *How solitary confinement contributes to the mental health crisis*. National Alliance on Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/March-2023/How-Solitary-Confinement-Contributes-to-the-Mental-Health-Crisis

Sawyer, W. (2019, October 9). *How race impacts who is detained pretrial*. Prison Policy Initiative. https://www.prisonpolicy.org/blog/2019/10/09/pretrial_race/

Stringer, H., (2019, March). *Improving mental health for inmates*. American Psychological Association. https://www.apa.org/monitor/2019/03/mental-heath-inmates

Strom, R. (2016). *Settlement may help resolve one prison problem*. Chicago Daily Law Bulletin. https://www.chicagolawbulletin.com/archives/2016/01/05/prisons-01-05-16.aspx

Substance Abuse and Mental Health Services Administration. (n.d.). *Medication-Assisted Treatment (MAT) in the criminal justice system: Brief guidance to the states* [Brief]. https://store.samhsa.gov/sites/default/files/pep19-matbriefcjs_0.pdf

Substance Abuse and Mental Health Services Administration. (2017). *Guidelines for successful transition of people with mental or substance use disorders from jail and prison: Implementation guide*. [No. (SMA)-16-4998]. https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4998.pdf

Substance Abuse and Mental Health Services Administration. (2022a). *About criminal and juvenile justice*. https://www.samhsa.gov/criminal-juvenile-justice/about

Substance Abuse and Mental Health Services Administration. (2022b). *Intercept 4:ReEntry*. https://www.samhsa.gov/criminal-juvenile-justice/sim-overview/intercept-4

Substance Abuse and Mental Health Services Administration (2023). *Best practices for successful reentry from criminal justice settings for people living with mental health conditions and/or substance use disorders* [No. PEP23-06-06-001]. https://store.samhsa.gov/sites/default/files/pep23-06-06-001.pdf

Townsend, C. (2021, December, 16). *The Oregon way: Responding to mental illness in corrections*. International Association for Correctional and Forensic Psychology. https://www.myiacfp.org/the-oregon-way-responding-to-mental-illness-in-corrections/

U.S. Department of Justice, Office of the Inspector General. (2024, February 15). *DOJ OIG releases report on issues surrounding inmate deaths in Federal Bureau of Prisons institutions*. https://oig.justice.gov/news/doj-oig-releases-report-issues-surrounding-inmate-deaths-federal-bureau-prisons-institutions

U.S. Department of Justice, Office of Justice Programs. (2021, October 7). *Nearly a fifth of*

state and federal prisons and a tenth of local jails had at least one suicide in 2019. https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/sljsfp0019st_pr.pdf

U.S. Department of Veterans Affairs. (2024). *Mental health, Substance abuse, Treatment*. https://www.mentalhealth.va.gov/substance-use/treatment.asp

U.S. Government Accountability Office. (2024, February). *Bureau of Prisons, Additional actions needed to improve restrictive housing practices.* https://www.gao.gov/assets/d24105737.pdf

Washington v. Harper, 494 U.S. 210 (1990). https://supreme.justia.com/cases/federal/us/494/210/

Wilson, C. (2022, August 2). Former head of Oregon prisons now leads nation's prisons. *Oregon Public Broadcasting*. https://www.opb.org/article/2022/08/02/colette-peters-oregon-prison-director-federal-bureau-prisons/

CHAPTER

8

Successful Community Reentry for People with Mental Disorders

8.1 Chapter Learning Objectives and Overview

LEARNING OBJECTIVES

The following learning objectives tell you what is most important in this chapter. Use these statements as a guide to make sure you get the most out of this chapter.

1. Discuss the needs of people with mental disorders who are reentering the community, considering possible supports to meet those needs.
2. Evaluate how success in reentry is defined, describing factors that contribute to success.
3. Describe the relationship of risks, needs, and responsive services to successful community reentry.
4. Explain key interventions that support successful community reentry for people with mental disorders, and discuss how these may be implemented in reentry programs.

KEY TERMS

Look for these important terms in the text in bold. Understanding these terms will help you meet the learning objectives of this chapter. You can find definitions for these terms at the end of the chapter.

- **Alcohol use disorder**
- **Case management**
- **Continuity of care**
- **Criminogenic risk**
- **Evidence-based**
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
- **In-reach**
- **Lived experience**
- **Medications for alcohol use disorder (MAUD)**
- **Medications for opioid use disorder (MOUD)**
- **Opioid use disorder**
- **Opioid drugs**
- **Patient navigation**
- **Peer support workers**
- **Recidivism**
- **Recovery**
- **Risk-Need-Responsivity (RNR)**
- **Supported employment**
- **Warm hand-off**

Chapter Overview

In March of 2024, Arturo Ruiz, aged 49, had been living in the community for about a year after serving more than 6 years in prison for a violent crime. When he entered prison in 2017, Ruiz was one of 37,000 people with mental disorders who were incarcerated in California (figure 8.1). Ruiz had previously struggled with substance use, and while in prison, he was diagnosed with bipolar disorder. While Ruiz's in-prison treatment for his bipolar disorder was imperfect, it was consistent, and he was prescribed medication that improved his symptoms (Naroozi, 2024).

Figure 8.1. The challenges facing a typical person reentering the community from prison or jail can be overwhelming, and many people need help managing them.

However, when Ruiz was preparing to reenter the community, he was given little guidance for connecting to appropriate care. He secured an appointment with a community psychiatrist, but

the relationship yielded little more than prescription refills and monthly calls to inquire if Ruiz was suicidal. As Ruiz describes it, the care was distant and lacked human connection. Yet Ruiz considers himself fortunate in being educated and resourceful enough to find care at all (Naroozi, 2024).

As with others leaving prison, Ruiz is trying to rebuild a life from scratch—but the process is complex and difficult. Ruiz works to support himself and to pay the restitution he owes his victim. He attends college to improve his future, but he juggles that with other priorities, including personal life changes to maintain his mental health, meeting criminal justice system obligations related to parole, and coping with challenging roommates in sober housing. Faced with these pressures, Ruiz stopped taking the medication he began in prison, worried the side effects impaired his ability to be productive (Naroozi, 2024).

Like Ruiz, many people emerge from the criminal justice system managing co-occurring disorders of substance use and mental illness. Without proper and timely access to care for mental disorders, this group faces potential recurrence of symptoms and serious threats, such as drug overdoses. They are also at greater risk of reoffense and re-incarceration than other groups (National Alliance on Mental Illness [NAMI], n.d.-b). Simply connecting people like Ruiz to care and medication may not be enough. Life post-prison is, as demonstrated by Arturo Ruiz's story, complex. Success requires juggling and compromising, with difficult decisions that may impact risk. As Ruiz acknowledges, he is unusual in possessing the education, motivation, and advocacy skills to get his needs met.

To succeed in the longer term, people reentering the community with mental disorders may need help addressing numerous issues, including but not limited to mental health, substance use, and trauma. This chapter discusses some important considerations around supporting people with mental disorders reentering the community from prison or jail. Several established interventions can improve outcomes for this population and should be prioritized when considering how to help people returning to the community from jail or prison.

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8.2 Reentry Population

Who are the people reentering the community from jails and prisons? They are about 95% of the people who now occupy jails and prisons. Almost all people who are incarcerated will leave custody to return to the community eventually, and everyone benefits when they can do so successfully. However, numerous characteristics of this population make success challenging.

Many people reentering the community are doing so with a criminal record that can interfere with access to public housing, food assistance, and other resources. Additionally, a large number of

people reentering the community have one or more mental disorders (figure 8.2). As this population navigates community life, they are multiply-challenged by their justice involvement and their experience of mental illness, substance use, disability—or all of these. This group may also have other vulnerabilities (e.g., youth) and marginalizing factors (e.g., race) that further increase the difficulty of their reentry journeys. Race, for example, has been demonstrated to impact a person's access to community housing due to racial discrimination in the housing and rental markets.

Figure 8.2. A community-based center for behavioral health, one of the many services that a person living with a mental disorder will need upon release from custody.

Trauma is another burden carried by many people in the reentry process. Some groups of formerly incarcerated people are more likely than others to have trauma experiences, including retraumatization in jail and prison, before they begin the reentry process. Women, and Black women in particular, are at much greater risk of coming into the criminal justice system with prior experiences of trauma from events like intimate partner violence (Mason, 2021; Johnson et al., 2022). Lesbian, gay, bisexual, transgender, queer/questioning, and intersex (LGBTQI+) individuals are also more likely to have experienced trauma-inducing violent victimization, including some forms of sexual assault, compared to others (Truman & Morgan, 2022).

Incarceration itself (figure 8.3) has negative impacts on health, including mental health. Jail and prison settings involve increased risk of coercion, isolation, sexual and physical violence, and intimidation. Unfortunately, people living with mental disorders are more likely than other people to experience victimization or exploitation while in jail or prison. They are also more likely than other incarcerated people to incur disciplinary infractions and suffer punishment as a result. The increased likelihood of punishment and traumatic events for people with mental disorders can have long-term consequences that extend beyond incarceration into the reentry period. It is critical that reentry services be provided in ways that are mindful of the presence of trauma in this group.

Figure 8.3. Incarceration can be incredibly difficult and even damaging to people who must then manage the impact of trauma and other after-effects when they reenter the community.

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Figure 8.3. **Photo** by **Robert Klank** is licensed under the **Unsplash License**.

8.3 Successful Reentry

"Success" during reentry is most commonly understood to mean reentering the community without **recidivism**, which refers to a return to criminal activity (figure 8.4). "Return to criminal activity," however, can mean incurring an arrest, a probation violation, or a new term of incarceration. When discussing recidivism, be sure to understand how that term is being used in a particular context, as re-arrest rates can look different from re-conviction rates.

Figure 8.4. Success in reentry is generally understood to mean reducing recidivism.

The stark numbers of recidivism may be available to track, but they do not tell the whole story of reentry "success." Several factors can impact rates of reoffense. For example, a person's age strongly predicts their likelihood of committing a crime, no matter what support they receive (or

do not receive) upon reentering the community. Additionally, not all offenses are equal; some reoffending may involve very minor misconduct, while other reoffending involves violent acts that injure victims. Both are technically recidivism, but one might suggest success over the other.

Additionally, "success" can mean more than avoiding reoffense. People reentering the community face many barriers to accessing treatment, services, health care, housing, employment, and transportation (figure 8.5). Thus, effectively addressing and overcoming these barriers is certainly a form of success. An improved personal sense of well-being, access to stable housing, and connection to social supports are all important positive outcomes that should be noted, and they may or may not coincide with a reduction in recidivism in a particular situation. Other outcomes that may be measures of success in reentry include reduced substance use, management of mental illness symptoms, and sustained treatment engagement.

Figure 8.5. People reentering the community from custody face numerous barriers to success, however success is defined.

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8.4 Achieving Success in Reentry

As discussed in Chapter 7, the process of reentry should begin while a person is still incarcerated. Assessment and planning within the facility should guide the person's eventual transition out of custody, informing what the person needs to succeed in the community. This planning aspect of reentry will differ for a person incarcerated in a jail setting versus a prison setting. Jails, compared to prisons, have fewer opportunities for long-term reentry planning and smaller budgets for programming. While prisons, compared to jails, may have more resources for treatment programs and longer-term planning, there are downsides as well. For example, prisons are often located farther away from a person's home community, making reentry connections more challenging (figure 8.6).

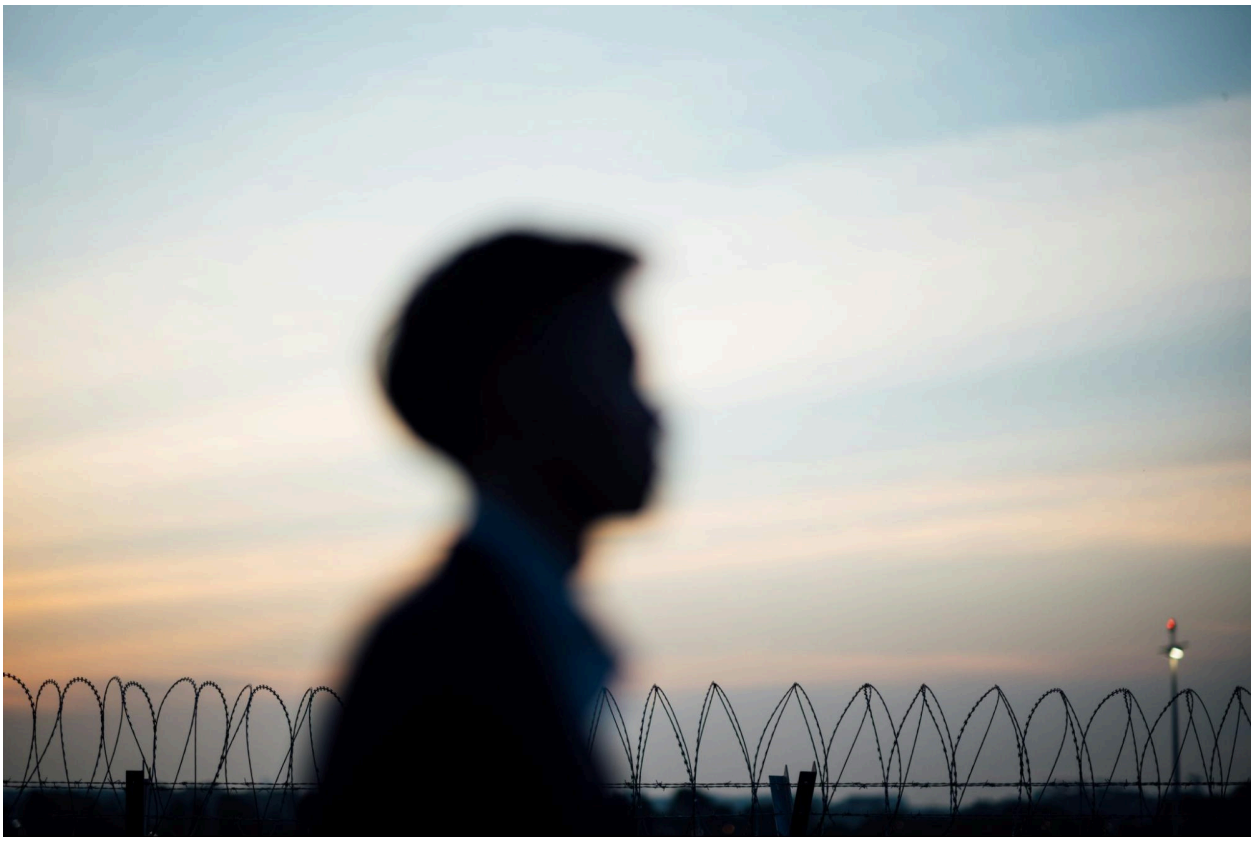

Figure 8.6. An organized transition from custody to community is an important element of successful reentry, especially for people with mental disorders.

Planning that leads to appropriate support during reentry into the community reduces the risk of re-incarceration and other bad outcomes, including recurrence of symptoms of a mental disorder, drug overdose, and death by suicide. For people recently released from incarceration, all of these risks are very high. For example, one study found that the risk of death from overdose among for-

merly incarcerated people was 20.2 times higher than for the general population at 1 year post-release (Ranapurwala et al., 2018). People who are released from prison also have disproportionately high rates of death by suicide compared to the general population, especially during the first weeks following release. Rearrest rates are striking: about 43% of people released from state prisons are rearrested in the first year following their release (Antenangeli & Durose, 2021).

Responding to Risk and Needs

A key step in helping people succeed after incarceration is understanding their **criminogenic risk**, or risk of criminally reoffending. That information can be gathered in assessments and used to provide proper support; addressing the factors that impact the person's likelihood of reoffending can reduce that risk and increase success. The **Risk-Need-Responsivity (RNR)** model is a set of principles that guides the process of identifying and prioritizing individuals for appropriate treatment.

The idea behind the RNR model is that assessment of risk and needs should be used to reduce criminal reoffending. This is done by assessing risk among a population and using that information to determine (1) who to help, (2) what help they need, and (3) how to provide that help. The RNR model suggests that people with a very high risk of reoffense should get the most support because there is the greatest opportunity to reduce recidivism when we treat those individuals. Treating this group represents the best use of limited resources. Conversely, people with a low risk of reoffense should get little or no treatment. This is an efficient allocation of resources and a recognition that when we over-resource low-risk people—or give people more help than they need—that does not boost their success.

The principles of the RNR model—risk, need, and responsivity—guide whether, how much, and how a person should be supported to reduce the risk of reoffending, based on that person's characteristics (National Institute of Corrections, n.d.).

- *The risk principle* looks at who should receive treatment, based on their assessed criminogenic risk, or risk of reoffending (Lutz et al., 2022). Assessments look at specific risk factors (pictured in figure 8.7) that have been found to impact a person's likelihood of reoffense. The risk principle generally dictates that people with higher risk of reoffending, based on assessments, should get more intensive support or intervention. People with low risk may need little or no support (National Institute of Corrections, n.d.).
- *The need principle* identifies what problems should be treated with specific services (Lutz et al., 2022). Identifying a person's specific needs and targeting them can help reduce a person's risk. Changeable risk factors are associated with "needs." For example, substance abuse increases a person's risk and represents a "need" because it can be targeted and potentially addressed with treatment (National Institute of Corrections, n.d.). Some needs, like serious mental illness, are not necessarily associated with the likelihood of criminal reoffending, so they are not considered criminogenic risks. However, these needs can be destabilizing, and they must be addressed for a person to benefit from other services (Lutz et al., 2022).
- *The responsivity principle* considers how we treat a person or what treatment should look like (Lutz et al., 2022). Responsivity requires that support be provided in a way that is effective for the person being helped. An intervention or support needs to be both generally effective and specifically adjusted to the identity or circumstances of the person being

helped (e.g., culturally appropriate) (National Institute of Corrections, n.d..; Bonta & Andrews, 2022).

Figure 8.7. This diagram shows the primary criminogenic risk factors that can be assessed in a person reentering the community after incarceration. These eight factors are all associated with an increased risk of offending, as well as a need that can (and should) be addressed in treatment to reduce the likelihood of reoffense. Image description available. **Image description.**

Additional Needs: Housing and Employment

Compared to the general public, formerly incarcerated people are almost 10 times more likely to be unhoused (The Council of State Governments Justice Center, 2021). Although lack of housing is not considered one of the primary criminogenic risk factors for the RNR model, access to housing is critical to a person's well-being, and there is some evidence that access to housing reduces recidivism (Jacobs & Gottlieb, 2020). However, people leaving criminal custody often do not have adequate housing support.

While housing support is lacking, there are plenty of barriers to obtaining housing. Some public housing programs, for example, exclude those with violent criminal records. Mental disorders are another barrier; people who experience these disorders are already at increased risk of being unhoused due to factors such as stigma (Coyne, 2021). The housing problem is further exacerbated for people of color in the reentry process, as racism reduces access to housing and increases the likelihood of a person living in an under-resourced community with higher homelessness rates overall. Furthermore, while people leaving incarceration are more likely to be unhoused, they are typically denied related government assistance if they have resided in an institution for more than 90 days. In these cases, the person must be out of jail or prison and unhoused for another year before qualifying as "chronically homeless" and becoming eligible for benefits (U.S. Department of Housing and Urban Development, 2024).

The ability to find meaningful employment is another significant and well-established challenge for formerly incarcerated people. People who are employed are less likely to recidivate, but, problematically, rates of unemployment are much higher for formerly incarcerated people than for others (Couloute & Kopf, 2018). Even brief incarceration can lead to unemployment and impair future opportunities. Disclosure of a criminal justice record can negatively impact employer callbacks for job applications, making expungement an important avenue to increase employment opportunities for those with criminal records.

Notably, the challenge of employment, like that of housing, is often related to social factors that are not specific to the formerly incarcerated person. Best practices for reentry may be focused on offsetting some of these external barriers rather than treating anything specific in the individual. One way to do that is the development of employment-focused programs that are inclusive for people reentering the community from jail or prison.

SPOTLIGHT: Reentry Support Programs

Some reentry programs serve many roles for their clients, providing housing assistance, peer support, case management, and more. Others are more focused on a specific need, such as job support. This Spotlight shares just a few programs that attempt to meet the needs of people reentering the community post-incarceration. Consider researching reentry programs in your area that help people with and without mental disorders.

Homeboy Industries, located in Los Angeles, California, is the largest gang rehabilitation and reentry program in the world. This program offers a variety of reentry services, including tattoo removal, case management, substance use support, education services, and a variety of job training programs. Mental health programming includes a needed focus on trauma, according to a program director: "Many of our clients have complex, or developmental, trauma. In addition to experiencing childhood trauma, they have experienced multiple traumas, throughout their lives" (Homeboy Industries, 2022).

The idea of peer mentorship is built into the successful Homeboy Industries program. Take a look at the optional video in figure 8.8 for an introduction to several Homeboy "Navigators" who support incoming trainees at Homeboy. Consider as you watch, how does this role benefit newly released people, as well as the person offering support?

This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=WXvr4HNq0_o**

Figure 8.8. Homeboy Industries "Navigators" share the reentry work they do and its value. **Transcript.**

In the Portland, Oregon, area, SE Works is a program that connects many people to employment opportunities. The program's NewStart Reentry Resource Center is meant to support people who have been released from Portland-area jails. Employment is a focus of SE Works, but navigators and case managers also provide program participants with resources for housing and family reunification, as well as treatment resources and disability services (SE Works: One-stop career center, 2016).

Consider visiting **SE Works [Website]**, or take a look at this **video about the program [Streaming Video]** for more information.

Also in the greater Portland, Oregon, area is the Clackamas County Transition Center (figure 8.9), which opened in 2016 as the first facility of its kind in the state: an "all-in-one" service center for people leaving jail or prison and at risk of returning. The stated goal of the program is to "break patterns and change lives" (Clackamas County Sheriff, State of Oregon, 2024). Situated a short walk from the local jail, the center offers many of the supports discussed in this chapter that are vital to recently-released people: employment and housing assistance, peer mentorship, mental health assessments, and referrals to medication treatment for substance use disorders. Probation officers at the center also conduct "reach-ins" (discussed in

this chapter) at the jail and local prisons to assess and plan for future clients even before they are released from custody (Clackamas County Sheriff, State of Oregon, 2024).

This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=PHuCmlwO3FE**

Figure 8.9. The short video linked here provides a brief introduction to the Clackamas County Transition Center. Watch and consider perceived barriers to providing this type of support. Should more support of this type be available to the population discussed in this text? **Transcript.**

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Figure 8.7. "**Criminogenic Risk and Need Factors**" by SAMHSA is in the **Public Domain**.

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Figure 8.8. "**Behind the Tattoos – Episode 2: Navigators at Homeboy Industries**" by **Homeboy Industries** is licensed under the **Standard YouTube License**.

Figure 8.9. "**Inside the Transition Center**" by **Clackamas County Sheriff's Office** is licensed under the **Standard YouTube License**.

8.5 Interventions for Successful Reentry

Although we may appreciate many of the needs and challenges facing a person in the reentry process, the question remains: how do we meet these needs? Numerous interventions exist that can help people living with mental disorders who are reentering the community from jail or prison. These interventions can reduce recidivism as well as accomplish other goals and measures of success, such as addressing mental health symptoms or increasing access to housing and social support.

Three specific forms of intervention are discussed here, chosen because there is significant evidence to support their use in helping formerly incarcerated people with mental disorders. As you read, consider why the interventions discussed here may be particularly helpful to the population that is the focus of our text. These three **evidence-based**, or proven effective by research, interventions are:

1. Medications for substance use disorders
2. Case management services
3. Peer support and patient navigation

Medications for Substance Use: MOUD and MAUD

Chapter 7 discussed the use of medications for substance use disorders in prisons and jails. Although these medications are highly effective when started in custody and continued in the community, there are barriers to their use in custody. These barriers include security concerns, lack of qualified medical staff to oversee medications, and state or local regulations that limit the prescription of the medications. In the community, there are fewer barriers to medication use, and medications are more frequently employed as a highly effective tool for treating people who experience substance use disorders alone or in combination with other mental disorders.

Medications for opioid use disorder (MOUD) and **medications for alcohol use disorder (MAUD)** are terms used for these medication-based treatments for specific substance use disorders. Medication-assisted treatment, or MAT, is a more general term that is still frequently used to describe these same treatments. The specific and slightly different terms *MOUD* and *MAUD* are preferred by some to avoid the word "assisted" in MAT, which implies that medication is merely supplemental or temporary—of "assistance"—in substance use treatment. Instead, the terms *MOUD* and *MAUD* indicate that medications for substance use disorders are central to a patient's treatment, similar to the way other psychiatric medications (e.g., antidepressants or antipsychotics) are used to treat mental disorders (National Institute on Drug Abuse, 2021).

MOUD and MAUD are important reentry interventions because of the very high numbers of people leaving incarceration who meet the criteria for substance use disorders: around 58% of people in state prisons and 63% of people in jails. By comparison, only about 5% of the general adult population meets these criteria (SAMHSA, 2023). MOUD and MAUD are also important because they work. For people reentering the community from criminal justice settings who have certain substance use disorders, MOUD and MAUD are key components of **recovery**, the process of change through which people improve their health and wellness. These medication approaches lower rates of opioid misuse, decrease fatal and non-fatal overdoses, increase treatment retention, and lower rates of re-incarceration.

Despite the effectiveness of MOUD and MAUD, they are still underused—in some cases due to real barriers and in others due to misperceptions. For example, there is a misunderstanding that these medications must be used alongside other substance use treatment modalities. However, while MOUD and MAUD can be used in combination with counseling and other behavioral health interventions to provide a more comprehensive approach to recovery, the medications are also beneficial alone. Additionally, the use of these medications is not as strictly regulated as some may believe. In fact, most forms of MOUD and MAUD can be provided in various settings, including outpatient treatment programs, physician offices, clinics, and residential treatment programs.

Medications for Opioid Use Disorder

The FDA has approved three medications for treating **opioid use disorder**, a substance use disorder involving the use of **opioid drugs**, which include heroin, fentanyl, and prescription opioids (e.g., OxyContin). The medications for opioid use disorder—buprenorphine, methadone, and naltrexone—help prevent deadly overdoses and sustain recovery, and they accomplish these goals using slightly different mechanisms. Buprenorphine works to lower physical dependence on opioids and increase safety in case of overdose. It can be prescribed or dispensed in physician offices. Methadone reduces opioid craving and withdrawal, and it blocks the effects of opioids. Methadone must be dispensed by certified opioid treatment programs. Naltrexone lowers opioid cravings by binding and blocking opioid receptors. Naltrexone (figure 8.10) can be prescribed by any practitioner who is licensed to prescribe medications, and it can be administered in oral form or as an extended-release intramuscular injectable.

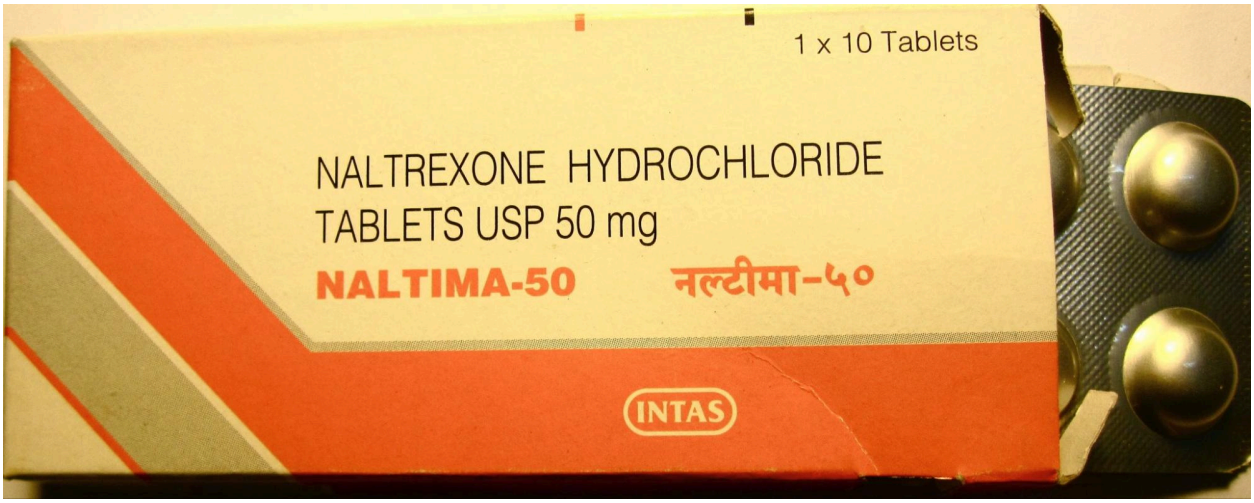

Figure 8.10. Naltrexone tablets are an oral medication for opioid use disorder that can be ordered by any licensed prescriber.

Medications for Alcohol Use Disorder

Medications for Alcohol Use Disorder (MAUD) is an approach for treating **alcohol use disorder**, a substance use disorder involving recurrent and harmful use of alcohol. Treatment with MAUD reduces alcohol use and helps sustain recovery. The most common FDA-approved medications used to treat alcohol use disorder are acamprosate, disulfiram, and naltrexone (figure 8.11). Disulfiram is an oral medication used to prevent and limit alcohol use for individuals by causing negative physical symptoms, such as nausea and vomiting, that can deter alcohol use. Acamprosate is an oral medication that is used to maintain recovery by reducing the negative symptoms related to alcohol withdrawal. Naltrexone is used to treat alcohol use disorders in the same way it treats MOUD—by reducing alcohol cravings by binding to endorphin receptors and blocking the effects of alcohol. Naltrexone in pill or injectable form can be prescribed by any practitioner who is licensed to prescribe medications.

Figure 8.11. All of the medications used for MAUD can be prescribed and taken orally.

Outcomes Associated With MOUD and MAUD

Studies gathered and relied upon by the federal government demonstrate that, for people reentering communities from criminal justice settings, MOUD and MAUD have strong positive outcomes in the areas of recidivism, substance use, and treatment engagement. For example, people treated with MOUD or MAUD have lower rates of re-incarceration than people who are only given counseling. People treated with MOUD and MAUD have lower self-reported drug and alcohol use and lower rates of positive drug screens. They also have a decrease in overdoses. Finally, people treated with MOUD and MAUD are more likely to engage in other substance use treatment in the community and more likely to continue participation. For details of the various studies supporting these conclusions, feel free to take a look at **SAMHSA's publication upon which this chapter is based [PDF]**.

For people with opioid use disorders, starting MOUD before leaving jail or prison is associated with the best outcomes. Providing MOUD, in addition to a strong referral to a community-based MOUD treatment provider upon release, is effective and results in significant positive outcomes for individuals with opioid use disorders. However, as noted, this may not always be possible given barriers to in-custody use of these treatments.

Case Management Services

Case management is another intervention that helps people with mental disorders as they reenter the community. In case management, a provider connects clients to services in the community, including mental health and substance use treatment. For people returning to the community from prison or jail, case management is most effective when it includes a direct handoff from in-custody providers to community services. A direct link ensures **continuity of care**—or uninterrupted access to care—between criminal justice and community settings. Case managers can serve in various roles (e.g., social workers, therapists, probation officers) depending on the setting, and they often have behavioral health degrees, such as in psychology or social work (figure 8.12).

Figure 8.12. Case managers are an essential support for people who may otherwise be overwhelmed by the many demands of community reentry.

Case Management Guidelines

In keeping with the RNR model of directing service where it is needed, case management services are generally provided to people who are at medium or high risk of reoffending. A case manager enacts a plan that is built on a person's identified needs, specifying appropriate interventions or services. All agencies interacting with the person (including jail, probation, and community-based service providers) should use a single case plan that, ideally, is created in custody and follows the person into the community upon release.

The intensity and duration of case management can be tailored to fit the person being supported. It can begin before or after a person is released from custody, and it can continue for just a few months or longer. Case managers typically interact with clients more frequently at the beginning and then at a lower frequency as the intervention continues. For example, a case manager might meet with a person receiving services 1 month before release, then for three sessions in the 1st month after release, and then monthly for the remainder of a year. Or, for a shorter term, the case manager might meet with the person before release, then every week for 3 months with an option to follow up as desired. Case managers can have contact via visits in the field, office visits, or by phone.

Case Management Outcomes

Studies have considered the impact of case management on recidivism as well as other factors, such as mental health and general well-being, substance use, treatment engagement and retention, employment, education, and housing. Overall

there are significant, positive outcomes on these factors. Case management has certainly emerged as an effective tool in decreasing recidivism, including both arrests for serious charges and rates of conviction. Case management is associated with increased participation in mental health and substance use treatment, higher levels of social support, and reduction in substance use. People receiving case management after release also received more employment and education services in the months after release than those without case management. They had increased rates of employment and increased educational attainment (for example, attending a college or vocational program upon release). There have also been studies suggesting positive impacts on housing. Notably, these outcomes point to successes beyond measures of recidivism. Case management appears to produce these positive results across gender, racial, and ethnic lines. For details of the various studies supporting these conclusions, feel free to take a look at **SAMHSA's publication upon which this chapter is based [PDF]**.

Peer Support and Patient Navigation

Peer support and patient navigation are, together, a third form of intervention that positively impacts people living with mental disorders after their release from custody (figure 8.13). Both of these forms of support involve hands-on services that are typically combined with other interventions, such as case management or medications for substance use disorders.

Figure 8.13. Peers and patient navigators take a hands-on role in supporting people during reentry, an effective strategy for reducing recidivism and creating other positive outcomes.

Peer Support

Peer support workers (also known as peer navigators, peer recovery coaches, or simply peers) have **lived experience** of mental health conditions and/or substance use disorders, and in some cases, criminal justice involvement. Peers have experienced these events themselves, have been successful in the recovery process, and now help others experiencing similar challenges. Peers share their lived experiences with the person they are helping, as they improve access to mental health services, substance use treatment, and other social services (e.g., housing, transportation, food, training and education, and employment). Through shared understanding, respect, and mutual empowerment, peer support workers help clients enter and stay engaged in the recovery process and reduce the likelihood of a recurrence of symptoms.

Patient Navigation

Patient navigation is the use of trained healthcare workers to reduce barriers to care. Patient navigators, like peers, can help clients navigate care and treatment, with a particular focus on dealing with complex healthcare and social services systems. Navigators help connect their clients with services, schedule appointments, and communicate with providers. While peers always have lived experience, patient navigators sometimes have lived experience in addition to other expertise.

Peer Support and Patient Navigation Outcomes

Peer support and patient navigation have positive impacts on several factors, including mental health and general well-being, substance use recovery, and treatment engagement—often for significant periods after release from custody. Although peer support is less studied than patient navigation, peer support is well-understood to be effective in improving mental health and treatment motivation, while reducing the use of substances. These outcomes are especially important when researchers want to look beyond recidivism as a measure of "success" in understanding how to help people in reentry. While these outcomes may be difficult to measure, they are important to acknowledge.

Peer support and patient navigation can occur in any setting and can be effective for any gender, racial, or ethnic group. These interventions often begin before release from custody, allowing the same peer or navigator to support a person as they move into the community. The intensity and duration of peer and patient navigation can vary based on individual needs. These supports have been effective in studies where they were provided for periods ranging from three months to twelve months, with meeting frequency and length adjusted for individual preferences. For details of the various studies supporting these conclusions, feel free to take a look at **SAMHSA's publication upon which this chapter is based [PDF]**.

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Figure 8.13. Photo by Priscilla Du Preez is licensed under the Unsplash License.

8.6 Implementing Effective Reentry Programs

Once effective supports and interventions are identified, the challenge remains to offer these supports to real people who are leaving custody and entering the community—and to do so in a way that helps them and avoids harm. Several general considerations should guide the implementation of reentry support, including the three discussed in this chapter.

Need for Training

For any program to provide effective support, program participants and staff must have specific training and skills. For example, reentry programs must include trauma-informed training (discussed in Chapter 7) that supports staff in identifying signs of trauma and avoiding retraumatizing anyone involved with the program. Training staff at all levels and across all service areas (e.g., corrections, health and social services, and peer workers) ensures that everyone in a program is aware of the sources and effects of trauma for both clients and staff.

Anti-stigma training is also important for providers who serve reentry populations with mental disorders. Anti-stigma training, such as that provided by the National Alliance on Mental Illness (NAMI) can increase understanding and empathy towards the reentry population. NAMI's 15-hour training program is specifically designed for anyone working directly with people affected by mental disorders: "It's an experience that equips participants with a deeper understanding of mental [disorders] and the confidence to serve individuals and families in a collaborative manner" (National Alliance on Mental Illness [NAMI], n.d.-a). Consider reading more about the training offered by NAMI for providers at this link: NAMI Provider—National Alliance on Mental Illness [Website].

Monitoring and Evaluation

Another consideration when implementing reentry programming is ensuring that there are ways to monitor the interventions offered and evaluate their impact. People with mental disorders who are reentering the community from criminal custody have complex needs that can change over time. Services for this population will also change and grow, and it is important to track this evolution. Programs should be looking at and measuring outcomes for participants related to criminal justice involvement (e.g., recidivism) as well as to other factors, including substance use, mental health, housing, employment, education, and overall well-being. Organizations should be able to share their findings. People want to see results, and results translate into continued support and funding.

Equitable Implementation

Yet another key consideration is ensuring equity in reentry programs. Historical inequities in both the behavioral health and criminal justice systems adversely affect many people (e.g., people of color and people with disabilities) who are returning to their communities from jail and prison. Understanding and explicitly addressing disparities and inequities in program planning and implementation ensures the culture, history, values, experiences, and needs of people reentering the community are central to reentry programs and services. Equitable hiring, pay, and promotion policies will ensure staff and peers feel supported and should increase staff retention. Data can be used to ensure that a program is implemented equitably and to avoid disparate outcomes or access issues. For example, programs should monitor—with attention to equity—questions such as: who has access to peer support, who receives supportive housing, and who returns to jail within 30 days (figure 8.14).

Figure 8.14. It is critical for programs providing reentry support to be inclusive and respectful of participants' varying identities.

Additionally, program materials and services should support and be respectful of clients' race, ethnicity, culture, sexual orientation, gender identity, age, disability, incarceration history, and other individual characteristics or experiences. Considering individuals' intersecting identities and experiences is key to ensuring equitable access to programs for all participants.

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Figure 8.14. **Photo** by **BETZY AROSEMENA** is licensed under the **Unsplash License**.

8.7 Best Practices for Reentry Services

In keeping with the general considerations of training, monitoring, and equity discussed in the previous section, there are also several specific best practices to keep in mind for providing the effective interventions we have discussed in this chapter. These include creating a single, unifying case plan; engaging in pre-release preparation; providing in-person community guidance; directing a range of services; and preparing for re-incarceration. Each of these is discussed briefly in this section.

Unifying Case Plan

A case plan for reentry should include goals, timelines, and the supported person's responsibility to meet them. The plan should also clarify the person's risk level and needs and share the services they are receiving, including those related to mental disorders. When substance use is a concern, plans should include relapse prevention approaches and connections to treatment or recovery supports. Finally, the plan should contain probation/parole requirements, outstanding warrants in other jurisdictions, child support orders, and any other information relevant to the conditions of a person's release.

The person receiving services should provide input on their case plan. The more collaborative the process of creating a case plan and setting goals, the more likely a client will be committed to achieving them. All agencies and organizations should use the same case plan. This requires interagency collaboration and ongoing sharing of information to ensure details are current and everyone is working toward the same goals.

Sometimes, the sharing of information—particularly matters of health care and mental health—can create privacy concerns. Many people are vaguely aware of the requirements of federal and state laws that are intended to protect patient privacy, primarily the law known as HIPAA—the **Health Insurance Portability and Accountability Act of 1996**. Under HIPAA, health entities (like providers and insurance companies) are prohibited from sharing patient information or records without permission. Those healthcare providers and their associates are called "covered entities," and covered entities must be cautious in how they share any protected health information (U.S. Department of Health and Human Services, n.d.). Thus, HIPAA is sometimes a barrier to agencies sharing information to create continuity of care. Nevertheless, those barriers are important to protect confidential health information.

In the criminal justice context, HIPAA is sometimes perceived as a barrier when it is not. Therefore, criminal justice professionals need to be aware of the rules that apply to them and understand what does not apply to them. For example, probation officers sharing information is generally not restricted by HIPAA; the information they share is part of the legal system, not information shared by a health-care entity. Likewise, police officers, employers, and schools are not HIPAA-covered entities, although other laws may apply to ensure the privacy of certain records (U.S. Department of Health and Human Services, n.d.).

Preparation and Rapport

Case managers, peer support workers, and patient navigators who engage with a person in custody have an opportunity to build rapport and facilitate continuity of care as people move from jail or prison to the community. This step is sometimes called **in-reach**. In-reach may be a single visit immediately preceding release, or it may involve multiple visits a few months before release. In-reach is especially effective if conducted by the same provider who will work with the person post-release. In-reach meetings can focus on rapport building, re-screening/assessing the person, and reviewing and updating an existing case plan. If prison or jail reentry staff did not create a case plan, the case manager, peer, navigator, or treatment provider can create one as part of their in-reach activities.

People leaving prisons and jails, especially those living with mental disorders, are extremely vulnerable to poor outcomes in the initial period following release. Outcomes improve when people have what they need to support their physical and mental health immediately upon leaving the facility. For example, at release, a person who uses medications should receive a supply of any prescribed medication as well as an active prescription that will last them until their first appointment with a provider. This includes medications for mental health conditions and substance use disorders, as well as any chronic illnesses (e.g., diabetes or asthma). Additionally, people being released from custody should have a government-issued photo identification, which will allow them to obtain treatment, support services, and government benefits.

In-Person Community Connections

Case managers and peer and patient navigators can play an important hands-on role at release by physically meeting clients, providing access to transportation to ensure they get to their first behavioral health treatment appointment or residence, and ensuring they have what they need when they leave. These steps increase the likelihood that a person engages with treatment services.

One way to provide hands-on support (figure 8.15) is with a "welcome to the community" experience. A "welcome to the community" experience is structured, supportive, and proactive in avoiding risks for re-incarceration. A case manager, peer support worker, or patient navigator is best suited for these guided experiences, which may involve picking up the client at the facility and "walking with them" through the first hours (and even days) after release. Ideally, this same support provider already provided in-reach services to the incarcerated person pre-release and became a trusted partner. A "welcome to the community" can include ensuring the recently released person has clothes that fit and do not look like they were issued by the prison, transferring cash the person had in their account at the facility (so they do not have to cash a check or pay fees to use a debit card), and supplying hygiene items and food to meet immediate basic needs.

Figure 8.15. In-person connections can be critical for people entering the community to get off to a good start with basic needs met, connections to care, and the support of another person.

People living with mental disorders who are reentering community life from prison or jail will be accessing behavioral health and often other health treatments. Linking or connecting a person with care at the appropriate level of treatment (e.g., outpatient, intensive outpatient, inpatient, residential) based on an individual's assessments and case plan is critical. With the appropriate permissions and information waivers, case managers, peer support workers, or patient navigators can make the initial linkage to a treatment provider on behalf of a client (making the appointment or informing the provider someone is coming in). Case managers, peer support workers, or patient navigators can then provide a **warm hand-off** to these providers in the community. A warm hand-off involves directly introducing the released person to the receiving provider, ensuring the person has all the necessary information to continue services, and, if appropriate, even attending an initial appointment to advocate and hear information. Understanding the conditions of a person's probation or parole that may affect access to services, such as the distance from home they are allowed to travel, is imperative to providing people with access to care that will not violate the conditions of their release.

When a recently released person misses appointments, a reentry provider can and should proactively follow up with the person. Timely reengagement is critical, and case managers, peers, or patient navigators should conduct home, shelter, or residential treatment visits whenever possible to help the person reengage in services. For those who are unstably housed, this may mean seeking the person out where they stay most often. To provide this level of follow-up, appropriate releases of information must be in place authoriz-

ing treatment providers to contact case managers, peers, or patient navigators if a person misses an appointment.

Range of Services

After release from custody, an entire range of support services—including housing, employment, medical care for chronic health conditions, family reunification, and access to government benefits—can be critical to a person's successful reentry. Case planning and peer support can help people engage with all of these services as soon as possible upon entering the community.

Housing is one of the most significant needs for individuals reentering the community. For people who have substance use disorders, housing should meet the recovery and support needs of the person, whether that means living alone or with friends or family, in a halfway house, or in supportive housing. Case managers should be aware of community housing or shelters that do not accept individuals using MOUD or MAUD. For some people, reentry involves community placement (e.g., at a halfway house) while they are still serving sentences and under criminal justice supervision (probation or parole).

Reentry programming can also help a person secure employment with a livable wage (figure 8.16). Many people reentering the community from jail or prison face barriers and stigma associated with their involvement with the criminal justice system, sometimes in addition to the challenges associated with experiencing a mental disorder. Case managers can connect individuals to supported employment and community-based employment programs. Community-based employment programs provide job training, job resources, and job placement services. Reentry programs can also create explicit pathways to hire former or existing clients as peers or help connect them to other reentry or recovery programs that hire peers with lived experience.

Figure 8.16. Employment is an important reentry support, and there are many programs available to help people access work after release from custody.

Supported employment, an evidence-based intervention, provides job development and placement, job coaching and training, and problem-solving skills development to people with disabilities and behavioral health conditions. Reentry programs can help identify supported employment providers through a local Department of Vocational or Rehabilitation Services database, the Veterans Health Administration, a state mental health agency, and/or the Social Security Administration. The Social Security Administration's free **Ticket to Work [Website]** Program supports career development for people

ages 18 through 64 who receive Social Security disability benefits and want to work. The Ticket to Work Program is intended to help people with disabilities move toward financial independence (Social Security Administration, n.d.).

For many people leaving prison or jail, a positive connection to family is important to successful reentry. Case managers and peers can connect a person with family reunification resources, when appropriate. This may include family counseling, parenting assistance, childcare, and other reunification services when restraining orders are not present. Case managers and peers should assist the people they support in identifying family members with whom it is safe to reconnect. People without supportive family members should foster positive healthy connections with friends, peers, and mentors.

For people living with serious mental illnesses, such as schizophrenia, reentry service providers can offer intensive mental health services, some of which were discussed earlier in this text, such as Forensic Assertive Community Treatment (FACT). The FACT model, discussed more in **Chapter 5**, provides all-hours access to comprehensive services delivered by a multidisciplinary mental health and criminal justice team. Individualized psychiatric treatment and recovery support services address the immediate needs of people living with serious mental illness and provide services that address criminogenic risks and needs.

Preparation for Re-incarceration

Re-incarceration is a reality that reentry programs need to anticipate (figure 8.17). In the period immediately after release from prison or jail, people have an increased risk of re-arrest and re-incarceration. The highest rates of re-arrest occur in the first year post-release. If this occurs, reentry providers can support the person's connections to treatment while they are incarcerated. If possible, conducting in-reach or providing additional information to prison or jail staff can help ensure the re-incarcerated person maintains some level of treatment or support while incarcerated.

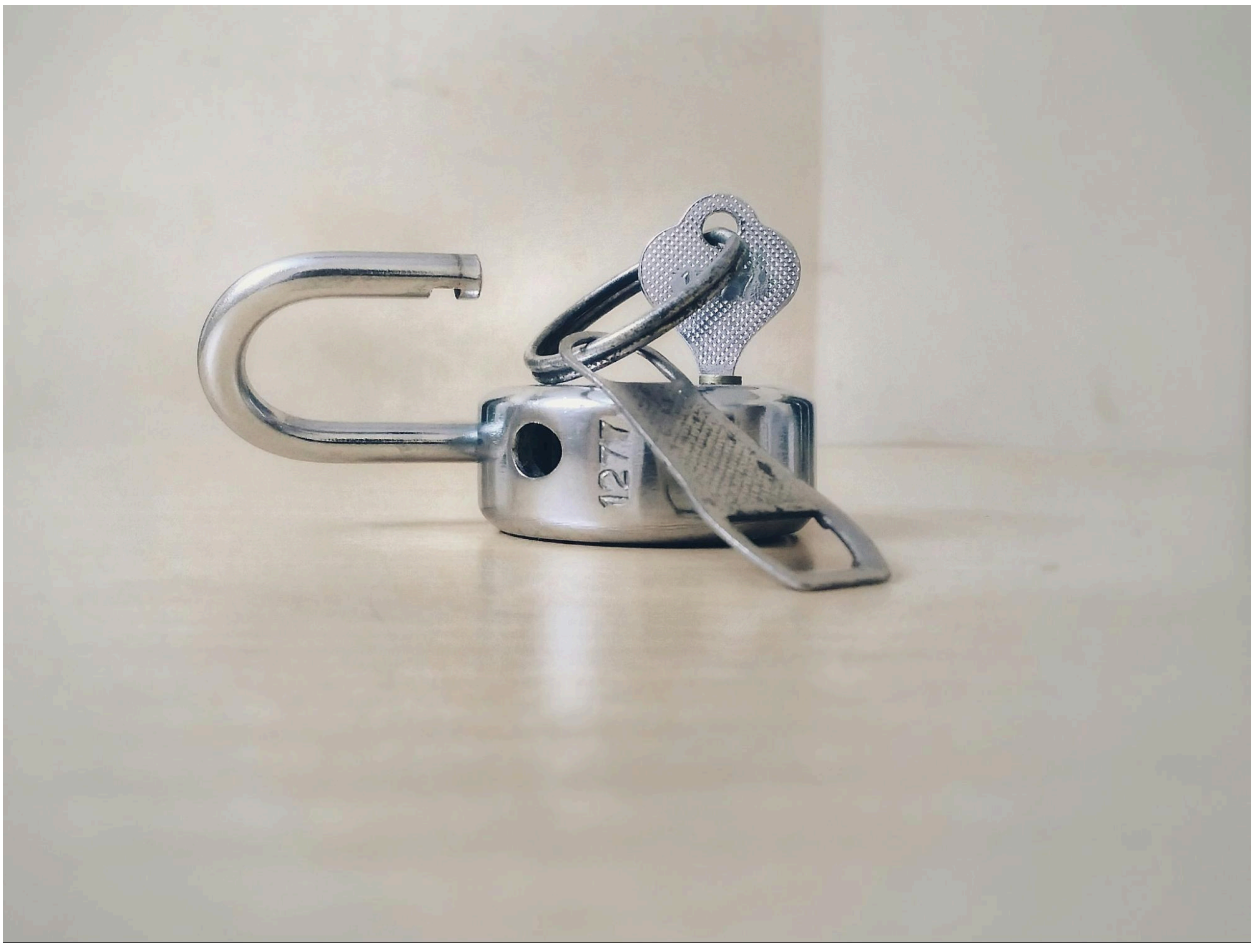

Figure 8.17. Re-incarceration will occur in many cases during the reentry period, but it does not need to signal the end of treatment or a permanent derailment of progress.

If re-incarceration is for an extended duration, a closure session should be provided along with a plan for how to reengage the person upon their next release. In cases where re-incarceration is short, such as a brief jail stay, reentry staff may be able to reengage the person with the same staff at their next release. Providing a reconnection to the same staff and treatment providers will help smooth the person's next transition into the community.

Licenses and Attributions for Best Practices for Reentry Programs

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Figure 8.15. **Photo** by **Centre for Ageing Better** is licensed under the **Unsplash License**.

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Figure 8.17. Photo by Basil James is licensed under the Unsplash License.

8.8 Success: Movement from Incarceration

This chapter has highlighted and discussed interventions that increase success for people with mental disorders reentering the community after incarceration. What do these approaches look like in real life? There are many different ways these tools and strategies are employed to suit the needs of different populations. A person emerging from jail with an opioid use disorder will naturally have different support requirements than, for example, a person with a serious mental illness or a developmental disorder who is being released after years in prison.

The Felton Institute's *Success: Movement from Incarceration (SMI)*, is just one example of a program employing some of the approaches we have learned about in this chapter. The Felton SMI program serves people returning to the community from jail in Alameda County, California (figure 8.18), who are experiencing severe and persistent behavioral health challenges. The program receives funding from the state of California and Alameda County, as well as from private contributions. Some details of the Felton SMI program are described below. Consider how the specifics of this program strive to meet the goals discussed in the previous sections of this chapter.

Felton SMI Participants

The Felton SMI program deals with a very specific population: non-violent offenders who serve their sentences in county jails rather than prisons and are to report to county probation officers upon their release. Due to legal changes shifting this group away from prison and into county jails, a significant increase in California jail populations—and, accordingly, an increase in the number of people with mental disorders being released from jail custody—gave rise to the need for the program. The Felton Institute developed the SMI program to support this group by providing intensive psychiatric-focused case management in the Alameda County community.

Figure 8.18. The Felton SMI program serves a very specific group in a limited area, enabling the program to properly tailor its offerings.

Participants in the Felton SMI program are referred to the program directly by the jail or by

their defense attorneys. Participants are typically on probation for a felony and are experiencing post-traumatic stress disorder (PTSD), schizophrenia, bipolar disorder, depression, and/or anxiety, often in addition to a substance use disorder. Among participants with both mental health conditions and substance use disorders, the use of methamphetamine, heroin, and/or alcohol is most common. As of April 2023, 68% of participants were male, just over half were Black or African American, 16% were White, and 8% were Asian. The program details are summarized in this section but feel free to review more specifics about the Felton SMI program in **this SAMHSA publication [Website]**.

Felton SMI Staff

Once enrolled in the Felton SMI program, a participant is supported by a multidisciplinary team. A clinical, or mental health, case manager conducts a mental health assessment and provides counseling. Medical staff provide a medical evaluation, and a nurse practitioner provides medication, if needed. Peer support workers help participants gain social security benefits and acquire driver's licenses or other documentation. A case manager works with participants to obtain Medicaid, secure housing, enroll in education or training, and prepare resumes.

Case managers must have a bachelor's degree, and clinical case managers must have a master's degree. All Felton SMI program staff are trained in cognitive behavioral therapy, trauma-informed care, cultural sensitivity, and de-escalation—among other skills. The program offers these trainings several times each month, and collaborators from the Alameda County Probation Department provide additional training on probation and compliance.

Felton SMI Approaches and Outcomes

The Felton SMI program uses wraparound services and case management to support approximately 160 participants a year through three program phases: stabilization, transition, and sustainability. During stabilization, staff assess a participant's mental health and immediate needs, such as housing, food, vital documents, and transportation. During the transition phase, participants receive mental health treatment, substance use treatment if appropriate, and case management services. When participants are ready to be self-sufficient and transition into long-term or short-term community support, they are in the sustainability phase.

To accomplish its three phases, the Felton SMI program employs a variety of techniques, including cognitive behavioral therapy (discussed in this text in **Chapter 2**), to support participants' behavioral health needs. At the same time, program staff, including peer support workers, help participants locate housing, access transportation, acquire food, secure employment, and connect to other social services. The program also helps participants with family reunification.

Felton SMI program staff (case managers, peer support workers, clinical or mental health case manager, and the program manager) visit the county jail weekly to meet with potential program participants and provide information about the program. The program manager monitors referrals daily. Once the program accepts an individual, a case manager reaches out to the person within 48 hours. If the person is unhoused upon release, the case manager will go into the community to locate the person and meet them wherever they are. Upon enrollment, program staff conduct a needs assessment and connect participants to services.

Participants typically remain in the Felton SMI program for one year. The frequency of visits

varies depending on the program phase. Participants in the stabilization phase need more support, but as they become more independent during the transition phase, they require less support and fewer visits. When participants reach the sustainability phase, they are independent and connected with external services as needed. Felton SMI staff report that participants have been able to advance their education, remain employed for longer periods, and reunify with family members. By the end of the program, participants report they have gained self-agency and feel empowered.

Evaluations of the Felton SMI program identify important factors that contribute to its strength, including:

- **Being participant-centered.** Participants are allowed to share their needs and stay focused on their readiness for change. What worked for one participant may not work for another participant.
- **Being physically present.** Working with people who are reentering the community from jail and are unhoused requires outreach on the ground, and this cannot be accomplished from a distance. To engage a person in treatment, program staff must be willing to go to encampments, parks, and other locations in the community.
- **Hiring staff that mirrors the participants.** It is important that staff reflect participants' race, ethnicity, gender, language, and experience. Staff with lived experience can mitigate some of the stigma associated with being incarcerated and help participants feel comfortable sharing their own lived experiences and trauma.

The information in this section comes from the federal agency SAMHSA, which holds the Felton SMI program out as an example of success (see more details in **SAMHSA's report [PDF]**, if you wish). More information about the Felton Institute and all of its programs is available, if you are interested, at the **Felton Institute website** (Felton Institute, 2024).

Licenses and Attributions for Success: Movement from Incarceration

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Figure 8.18. **Photo** by **Spencer DeMera** is licensed under the **Unsplash License**.

8.9 Chapter Summary

- The reentry population served in the community is made up of people who, frequently, experience mental disorders and other marginalizing factors that predate or arise from their time in jail or prison.
- Successful reentry is often defined as reduced recidivism, but success may be viewed more broadly, especially for marginalized populations, to include measures such as a positive

outlook on life and access to basic needs (e.g., mental health care, housing, and food).
- Effective reentry support should respond to a person's assessed level of risk and specific needs. The RNR model emphasizes the importance of providing correctly directed interventions that are responsive to a person and reduce risk by meeting needs.
- Three types of interventions that have proven successful in reentry programs for people with mental disorders are medications for the treatment of substance use disorders (MOUD and MAUD), case management, and peer support or patient navigation. There are several guidelines for the best use of these services, including the use of training, ensuring equity, and following best practices for implementation.
- The Felton Institute's SMI program is an example of a targeted local program that employs the reentry interventions described in this chapter, illustrating how those can be put into practice to support people impacted by significant mental disorders (serious mental illness and substance use disorders).

KEY TERM DEFINITIONS

- **Alcohol use disorder:** Substance use disorder that involves the recurrent use of alcohol, despite significant impairment or problems associated with continued use.
- **Case management:** Supporting clients by planning, coordinating, and connecting them to services e.g., (health care, mental health care, substance use treatment, and social services) to address their needs and goals.
- **Continuity of care:** The ability to access uninterrupted health and mental health services during a setting transition.
- **Criminogenic risk:** A person's likelihood of criminally reoffending that is assessed based on factors that directly relate to whether the person is likely to commit another crime (criminogenic risk factors).
- **Evidence-based:** A descriptor of a treatment, practice, or intervention that has been proven, via research, to be effective for achieving desired outcomes.
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**: A law that prohibits health entities from sharing protected patient medical records without authorization.
- **In-reach:** A strategy in which providers from community-based organizations meet with individuals before their release from custody to begin service planning and establish continuity of care.
- **Lived experience:** Personal knowledge gained through direct, first-hand involvement. In the context of this text, lived experience refers to experience with mental disorders, including substance use disorders, and/or criminal justice system involvement.
- **Medications for alcohol use disorder (MAUD):** A medication-based approach for treating alcohol use disorders, reducing alcohol use, and sustaining recovery. The most common FDA-approved medications used to treat alcohol use disorders are acamprosate, disulfiram, and naltrexone.

- **Medications for opioid use disorder (MOUD):** A medication-based approach for treating opioid use disorders, preventing overdose, and sustaining recovery. The FDA has approved three medications for opioid use disorders: buprenorphine, methadone, and naltrexone.
- **Opioid use disorder:** A substance use disorder involving opioid drugs, such as heroin, fentanyl, or prescription opioids (e.g., OxyContin).
- **Opioid drugs:** A class of drugs that includes legal and illegal substances, such as heroin, fentanyl, and prescription pain relievers like oxycodone, morphine, and others.
- **Patient navigation:** The use of trained healthcare workers to reduce barriers to care for individuals returning from criminal justice settings. Patient navigators help people navigate complex healthcare and social services systems to improve access to care and treatment.
- **Peer support workers** or **peers:** People with lived experience, including with mental disorders and/or criminal justice system involvement, who have been successful in the recovery process and are trained to help others experiencing similar situations. Peers can have various titles: peer support workers, peer specialists, peer recovery coaches, peer advocates, or peer recovery support specialists.
- **Recidivism**: The return to criminal offending, as measured by re-offense, re-arrest, re-conviction, or re-incarceration.
- **Recovery:** Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential.
- **Risk-Need-Responsivity (RNR)**: A model of providing services that informs who receives services based on risk, what services are provided based on need, and how services are provided to maximize effectiveness.
- **Supported employment**: Evidence-based intervention that provides job development and placement, job coaching and training, and problem-solving skills development to people with disabilities and behavioral health conditions.
- **Warm hand-off:** A transfer of care between support people or care providers (e.g., from correctional health to community-based services) that includes direct introductions, provision of required information, and if appropriate, transportation to the receiving service provider. Warm hand-offs are a technique to ensure continuity of care for people being released from custody.

DISCUSSION QUESTIONS

1. What factors may make reentry after incarceration more difficult, and how can the specific interventions discussed in this chapter ease barriers and increase success?
2. What specific risk is targeted in the RNR model? Why is it important to direct the most services to higher-risk individuals?
3. Why were the approaches of MOUD and MAUD, case management, and patient navigation/peer support highlighted in this chapter? What about those three approaches makes them important for our study?

4. Can you locate and describe local programs in your area that employ some of the approaches and strategies discussed in this chapter?

Licenses and Attributions for Chapter Summary

8.10 References

Antenangeli, L., & Durose, M. R. (2021, September). Recidivism of prisoners released in 24 states in 2008: A 10-year follow-up period (2008-2018) [Abstract]. U.S. Department of Justice, Bureau of Justice Statistics https://bjs.ojp.gov/library/publications/recidivism-prisoners-released-24-states-2008-10-year-follow-period-2008-2018

Bonta, J. & Andrews, D. A. (2022, July 21). Risk-Need-Responsivity model for offender assessment and rehabilitation. Public Safety Canada. https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-en.aspx

Clackamas County Sheriff, State of Oregon. (2024). Clackamas county transition Center. https://www.clackamas.us/sheriff/transitioncenter.html

Couloute, L., & Kopf, D. (2018). Out of prison & out of work: Unemployment among formerly incarcerated people. Prison Policy Initiative. www.prisonpolicy.org/reports/outofwork.html

The Council of State Governments Justice Center. (2021, February). Reducing homelessness for people with behavioral health needs leaving prisons and jails, Recommendations to California's Council on Criminal Justice and Behavioral Health. https://csgjusticecenter.org/wp-content/uploads/2021/02/Reducing-Homelessness-CA_Final.pdf

Coyne, T. (2021, March). The role of probation and parole in making housing a priority for people with behavioral health needs [Field Notes, Behavioral Health]. The Council of State Governments Justice Center, Bureau of Justice Assistance. https://csgjusticecenter.org/wp-content/uploads/2022/05/CSGJC_Field-Notes_The-Role-of-Probation-and-Parole_50873.pdf

Duran, L., Plotkin, M., Potter, P. & Rosen, H. (2013, September). Integrated reentry and employment strategies: Reducing recidivism and promoting job readiness. U.S. Department of Justice, Office of Justice Programs. https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG-Reentry-and-Employment.pdf

Felton Institute. (2024). Success: Movement from incarceration (SMI). https://felton.org/social-services/justice-services/success-movement-from-incarceration-smi/

Homeboy Industries. (2022). https://homeboyindustries.org/services/mental-health/

Jacobs, L. A., & Gottlieb, A. (2020, August 6). The effect of housing circumstances on recidivism: Evidence from a sample of people on probation in San Francisco [Abstract]. Criminal Justice and Behavior, 47(9), 1097-1115. https://doi.org/10.1177/0093854820942285

Johnson, K. A., Hunt, T., Puglisi, L. B., Maeng, D., Epa-Llop, A., Elumn, J. E., Nguyen, A., Leung, A., Chen, R., Shah, Z., Wang, J., Johnson, R., Chapman, B. P., Gilbert, L., El-Bassel, N. & Morse, D.

S. (2022, May 20). *Trauma, mental health distress, and infectious disease prevention among women recently released from incarceration.* Frontiers. https://doi.org/10.3389%2Ffpsyt.2022.867445

Lutz, M., Zani, D., Fritz, M., Dudeck, M. & Franke, I. (2022, October 31). *A review and comparative analysis of the risk-needs-responsivity, good lives, and recovery models in forensic psychiatric treatment*. National Center for Biotechnology, National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9659584/

Naroozi, A. (2024, March 19). A hold that won't let go: A system lacks access to mental health resources. *Black Voice News*. https://blackvoicenews.com/tag/jorge-arturo-ruiz/

National Alliance on Mental Illness [NAMI]. (n.d.-a). *NAMI provider*. https://www.nami.org/Support-Education/Mental-Health-Education/NAMI-Provider

National Alliance on Mental Illness [NAMI]. (n.d.-b). *Re-entry post incarceration*. https://www.nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Re-entry-Post-Incarceration/

Mason, T. (2021, September 23). *Extreme sentences disproportionately impact and harm black women*. National Back Women's Justice Institute. https://www.nbwji.org/post/extreme-sentences-disproportionately-impact-and-harm-black-women&sa=D&source=docs&ust=1717913447162616&usg=AOvVaw0tzOkl100lqXmKYiNkzlVT

National Institute of Corrections. (n.d.). *Module 5: Section 2. The Risk-Need-Responsivity Model for assessment and rehabilitation*. https://info.nicic.gov/tjc/module-5-section-2-risk-need-responsivity-model-assessment-and-rehabilitation

National Institute on Drug Abuse. (2021, November 29). *Words matter – Terms to use and avoid when talking about addiction*. National Institutes of Health. https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction

Ranapurwala, S. I., Shanahan, M. E., Alexandridis, A. A., Proescholdbell, S. K., Naumann, R. B., Edwards Jr, D., & Marshall, S. W. (2018, August 18). Opioid overdose mortality among former North Carolina inmates: 2000–2015. *American Journal of Public Health (10)*9. pp. 1207-1213. https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304514

SE Works: One-stop career center. (2016). https://seworks.org/newstart/

Social Security Administration. (n.d.). *Welcome to the Ticket to Work program!* https://www.ssa.gov/work/

Substance Abuse and Mental Health Services Administration. (2023). *Best practices for successful reentry from criminal justice settings for people living with mental health conditions and/or substance use disorders* [Publication No. PEP23-06-06-001]. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9659584/

Truman, J. L., & Morgan, R. E. (2022, June). *Violent victimization by sexual orientation and gender identity, 2017–2020* [Statistical Brief]. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. https://bjs.ojp.gov/content/pub/pdf/vvsogi1720.pdf

U.S. Department of Health and Human Services. (n.d.). *Health insurance portability and accountability act (HIPAA) privacy rule: A guide for law enforcement*. https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/final_hipaa_guide_law_enforcement.pdf

U.S. Department of Housing and Urban Development, HUD Exchange. (2024). Definition of Chronic Homelessness. https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/definition-of-chronic-homelessness/

CHAPTER

9

When Courts Order Treatment: Civil and Criminal Commitments

9.1 Chapter Learning Objectives and Overview

LEARNING OBJECTIVES

The following learning objectives tell you what is most important in this chapter. Use these statements as a guide to make sure you get the most out of this chapter.

1. Explain why and how civil commitment is used to manage people with mental disorders outside of the criminal justice system.
2. Describe the basic steps involved in accomplishing a civil commitment, with attention to how this process may connect or relate to the criminal justice system.
3. Discuss potential benefits and harms of civil commitment.
4. Compare different types of commitments that are used to manage justice-involved people with mental disorders.

KEY TERMS

Look for these important terms in the text in bold. Understanding these terms will help you meet the learning objectives of this chapter. You can find definitions for these terms at the end of the chapter.

- **Beyond a reasonable doubt**
- **Burden of proof**
- **Civil commitment**
- **Clear and convincing evidence**
- **Commitment hearing**
- **Conditional release**
- **Criminal commitment**
- **Emergency hold (hospital hold or hold)**
- **Grave disability**
- **Imminent danger**
- **Notice of Mental Illness (NMI)**
- **Oregon Psychiatric Security Review Board (PSRB)**
- **Pre-commitment investigation**
- **Preponderance of the evidence**
- **Section 1983**

Chapter Overview

Imagine a person who has a serious mental illness. This person lives with family in the community, where they receive treatment and support. The person decides to stop taking their prescribed medications, and their symptoms escalate. Perhaps they begin hearing voices, and the voices direct them to start fires; they have thus far resisted the commands, but they find them compelling. Or maybe the person has severe depression, and their current presentation is similar to that which preceded an earlier suicide attempt, causing grave concern for their safety. The person refuses treatment, but their condition is deteriorating. In these circumstances, or many other scenarios we might imagine, the question is the same: How do we keep this person and those around them safe while respecting the person's rights to freedom and autonomy?

This text is largely focused on people with mental disorders as they enter and proceed through the criminal justice system. In this chapter, we consider a specific legal tool used to manage people with mental disorders outside of or adjacent to the criminal justice system: involuntary treatment, also known as commitment.

If you are familiar with the idea of civil commitment, you may know it as a process that allows a court to order care and treatment for a person with a mental disorder, and even confine them to a hospital to receive that care, if necessary. Because civil commitment is a restriction on freedom, it is used only in specific and limited circumstances.

There are also commitments that are closely connected to the criminal justice system. These are sometimes referred to as "criminal commit-

ments" because they are used to manage people who are already engaged in the criminal justice system. However, it is important to understand that these "criminal" commitments are not convictions, nor are they punishments.

In this chapter you will learn about different varieties of commitment: what they are, how and when they are used, the process for obtaining them, and the issues that surround them.

Licenses and Attributions for Chapter Learning Objectives and Overview

9.2 Fundamentals of Civil Commitment

Civil commitment provides a way for the legal system to respond to a person who has become unsafe due to a mental disorder. Initiation of the civil commitment process allows a person to be transported to and/or held at a hospital for intervention. A completed civil commitment allows a court to order the person to receive long-term treatment for their mental disorder. A civil commitment order can, but does not always, require psychiatric hospitalization; some commitments can occur in the community.

A civil commitment does not involve punishing a person for doing something wrong (which makes it different from a criminal case), but it *does* involve supervising a person and limiting their freedom—even potentially confining them (which is, in some ways, like a criminal case). Because civil commitment is a significant infringement on the freedom of a person who may have done nothing wrong or criminal, it is important to be extremely cautious in its use. There are processes and procedures laid out in every state's civil commitment laws to ensure that commitment is used properly and that freedom and autonomy are protected.

Although all states have involuntary commitment processes, civil commitments are very unusual. After a long history of forced confinement and mistreatment, people with mental disorders today are almost always treated on a voluntary basis. This includes people with serious mental illness, a group generally estimated to include less than 5% of the population. In 2015, an estimated 9 out of every 1,000 people with serious mental illness were involuntarily committed in the United States (Substance Abuse and Mental Health Services Administration (SAMHSA), 2019). Numbers in many states have fallen significantly since then, often due to a lack of capacity for treatment rather than a lack of need. In Oregon, for example, the Oregon State Hospital admitted only 15 civil commitment patients in 2023, compared to more than 1,000 people admitted in connection with criminal cases (Watson, 2024).

More commitments are initiated than are completed. Some people who find themselves facing civil commitment decide to consent to voluntary services, preferring that to being ordered into care (SAMHSA, 2019). Many others are found inappropriate for commitment at some time during the process (for example, if they do not present a danger to themselves or the community). Additionally, sometimes, though it would be difficult to quantify exactly how often this occurs, commitment is not even attempted for people who do need care. Reluctance to initiate civil commitment proceedings can be based on two accurate perceptions about the process: that commitment is very

difficult to obtain and that there are few resources to treat these patients.

Civil Commitment Process Overview

The civil commitment process differs from state to state—and sometimes even county to county within a state—because each jurisdiction has its own involuntary commitment rules with unique language and procedures. Before the 1960s, when most civil commitment laws were developed, people with mental disorders tended to be confined or segregated as a matter of course, rather than based on strict legal standards. So it is important to note that civil commitment laws do permit court-ordered treatment, but they evolved as a protective *limitation* on the practice of forcing people with mental disorders into treatment and institutions (SAMHSA, 2019).

Some states, including Oregon, have separate but parallel commitment statutes, one addressing people with mental illness (Or. Rev. Stat. §§ 426.070 – .170) and another for people with intellectual or developmental disability (Or. Rev. Stat. §§ 427.215 -.306). These laws have differing specifics suited to the protection of the populations addressed. References to Oregon law in this chapter relate to civil commitment due to mental illness. Many of the specific Oregon terms and procedures mentioned in this section are defined in Oregon Administrative Rules (Or. Admin. R. 309-033-0200 *et seq.*).

The flowchart in figure 9.1 shows the general progression of the civil commitment process in Multnomah County, Oregon. It is just one example of commitment procedures. As you can see, the commitment process is first triggered by a concern about safety due to a mental disorder, indicated by the white circle in the upper left of the chart. If the person does not agree to treatment, then a care provider may issue a preliminary "hold," which can be followed by an investigation, a hearing, and an involuntary commitment. The proceedings can terminate at several points prior to a finalized commitment, including with a decision by the person to accept treatment on a voluntary basis. Each part of the process shown in the flowchart is discussed in more detail in this section.

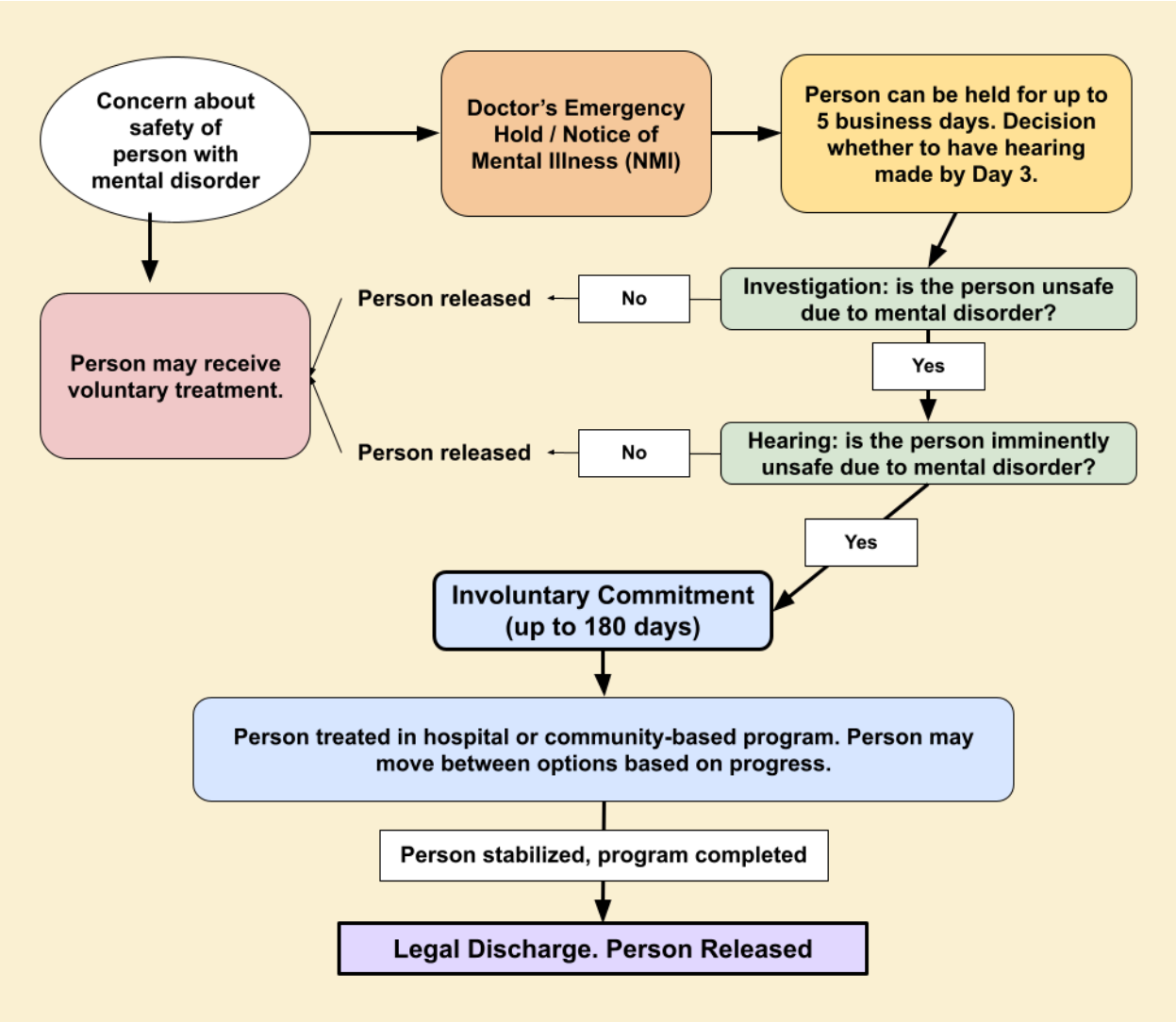


Figure 9.1. This flowchart shows the progression of the civil commitment process based on the steps in Multnomah County, Oregon. Other states' procedures will vary in specifics but follow the same general trajectory. Image description available. **Image description.**

As illustrated in figure 9.1, the civil commitment process starts with a concern about the safety of a person with a mental disorder. There are generally two options to address this concern:

- The person may receive voluntary treatment.
- The person can be held, on an emergency basis, for a limited period based on state law.

If a person is held for a civil commitment, there must be an investigation into whether the person is unsafe due to a mental disorder. Depending on the outcome of the investigation:

- If the person is determined to be safe, they are released.
- If the person is determined to be unsafe and is still refusing voluntary treatment, a court hearing will be held to determine whether the person meets state law requirements for civil commitment (e.g., whether the person is imminently unsafe due to a mental disorder).

There are two possible outcomes from the hearing:

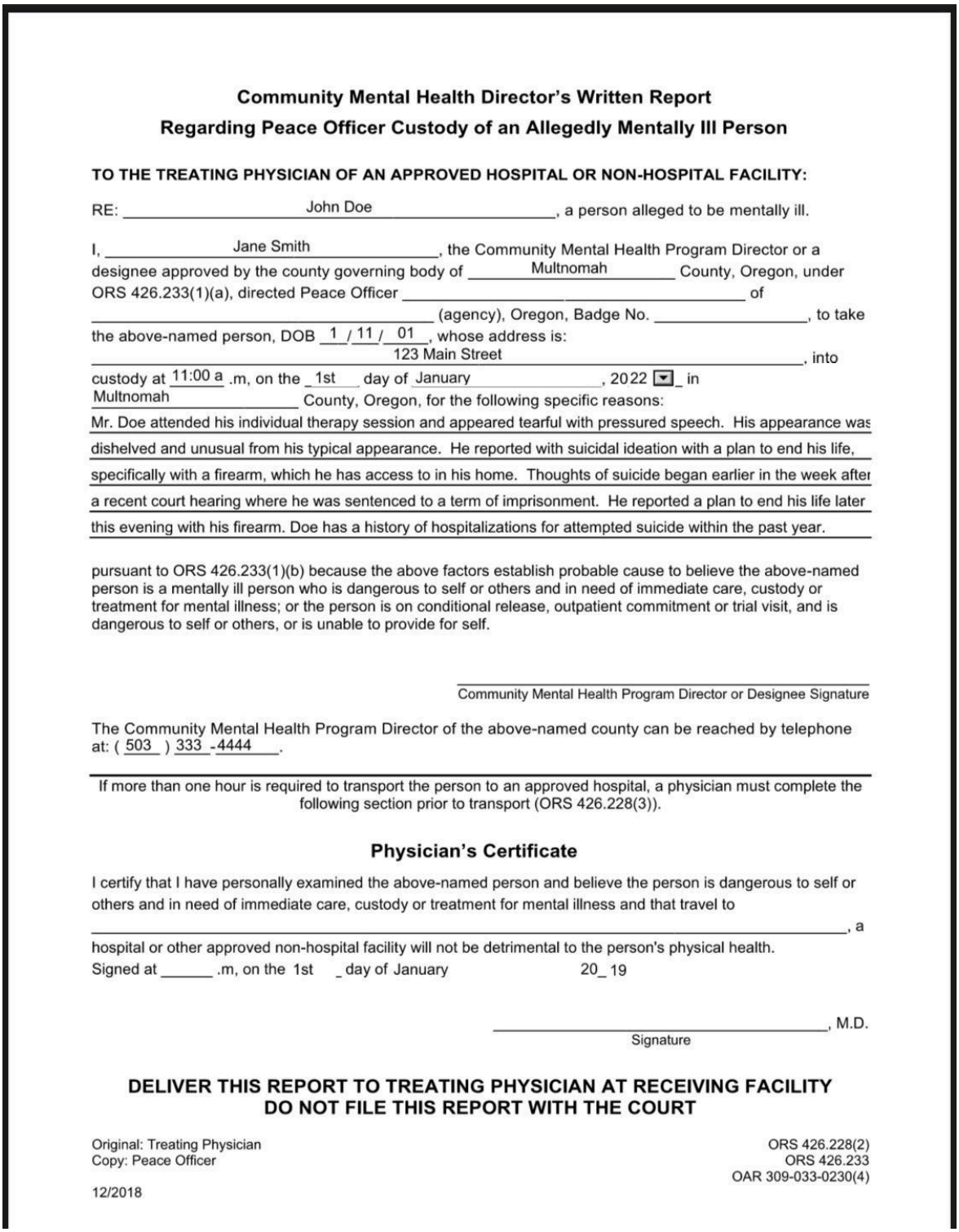
- The court finds that the person does not meet the legal criteria for commitment (they do not have a mental disorder, or they are not unsafe at the required level), and the person is released.
- The court determines the person meets the criteria (e.g., they have a mental disorder making them immediately unsafe), and the person is involuntarily committed for up to 180 days to be treated in a hospital, a community-based program, or some combination of these until the person is stabilized and legally discharged.

Emergency Hold

The civil commitment process often starts with an **emergency hold**, which allows a care provider to order that a person be kept under medical supervision. This type of restriction may also be called a *hospital hold* or just a *hold*. The hold keeps a person safe while providing time for their mental health to be assessed and for the next steps to be considered.

Often, however, a preliminary step is getting the person *to* a provider who can assess the person's mental health. If a person is unwilling to go voluntarily, the law generally allows the person to be picked up by police (taken into custody) and transported to a hospital. This type of police custody is authorized for the limited purpose of getting the person to a hospital and is only allowable for the amount of time necessary to do so. Custody must be based on reliable information that the person needs to be controlled for safety reasons—that is, they are believed to have a mental disorder, and they are dangerous to others or themselves.

Custody can be initiated in various ways and is regulated by state law. In Oregon, every county has a mental health director who designates qualified mental health professionals with the power to approve hospital transport (figure 9.2). Police can also take a person into custody and to a hospital on their authority as peace officers.



Community Mental Health Director's Written Report
Regarding Peace Officer Custody of an Allegedly Mentally Ill Person

TO THE TREATING PHYSICIAN OF AN APPROVED HOSPITAL OR NON-HOSPITAL FACILITY:

RE: John Doe, a person alleged to be mentally ill.

I, Jane Smith, the Community Mental Health Program Director or a designee approved by the county governing body of Multnomah County, Oregon, under ORS 426.233(1)(a), directed Peace Officer _____ of _____ (agency), Oregon, Badge No. _____, to take the above-named person, DOB 1/11/01, whose address is: 123 Main Street, into custody at 11:00 a .m, on the 1st day of January, 2022 in Multnomah County, Oregon, for the following specific reasons:

Mr. Doe attended his individual therapy session and appeared tearful with pressured speech. His appearance was dishelved and unusual from his typical appearance. He reported with suicidal ideation with a plan to end his life, specifically with a firearm, which he has access to in his home. Thoughts of suicide began earlier in the week after a recent court hearing where he was sentenced to a term of imprisonment. He reported a plan to end his life later this evening with his firearm. Doe has a history of hospitalizations for attempted suicide within the past year.

pursuant to ORS 426.233(1)(b) because the above factors establish probable cause to believe the above-named person is a mentally ill person who is dangerous to self or others and in need of immediate care, custody or treatment for mental illness; or the person is on conditional release, outpatient commitment or trial visit, and is dangerous to self or others, or is unable to provide for self.

_____
Community Mental Health Program Director or Designee Signature

The Community Mental Health Program Director of the above-named county can be reached by telephone at: (503) 333 -4444 .

If more than one hour is required to transport the person to an approved hospital, a physician must complete the following section prior to transport (ORS 426.228(3)).

Physician's Certificate

I certify that I have personally examined the above-named person and believe the person is dangerous to self or others and in need of immediate care, custody or treatment for mental illness and that travel to _____, a hospital or other approved non-hospital facility will not be detrimental to the person's physical health.

Signed at _____ .m, on the 1st day of January 20_19

_____, M.D.
Signature

DELIVER THIS REPORT TO TREATING PHYSICIAN AT RECEIVING FACILITY
DO NOT FILE THIS REPORT WITH THE COURT

Original: Treating Physician
Copy: Peace Officer

ORS 426.228(2)
ORS 426.233
OAR 309-033-0230(4)

12/2018

Figure 9.2. An example of a form used in Oregon to initiate a civil commitment with a hold. The form documents a community mental health director's authorization to take a person into custody for emergency mental health care based on specific details about immediate danger. Image description available. **Image description.**

Once a hold is initiated, its length is limited by state law. Most commonly, states permit involuntary treatment for just a few days before a judge must review the matter to ensure the hold is

legally justified. In Oregon, for example, as shown in the flowchart in figure 9.1, a person may be held up to 5 business days on an emergency or hospital hold before the case must be reviewed by a judge.

A medical hold is only one route to initiating civil commitment. Most states allow other people, following certain rules and procedures, to initiate the process of civil commitment via paperwork submitted to a court. In Oregon, the law allows certain designated officials or any two people acting together (such as family or friends of the person) to initiate the commitment process.

Court Involvement

Regardless of how a civil commitment is initiated, the paperwork submitted to a court is what starts the legal process of civilly committing a person. In Oregon, the official paperwork submitted to a court is called a **Notice of Mental Illness (NMI)**. The NMI is what triggers the court's involvement in a legal commitment.

The next steps in the commitment process are a pre-commitment investigation and a civil commitment hearing. A **pre-commitment investigation** includes an evaluation by mental health professionals to determine what, if any, mental disorder the person is experiencing and how that mental disorder is currently impacting the person facing commitment. Designated investigators, usually state or county mental health professionals, gather evidence that may be presented in a later commitment hearing. The person facing commitment will also have an attorney at this point, and that attorney may conduct a fact-finding process as well. Investigators may speak with family members or other witnesses. The investigation is intended to establish whether the person's current circumstances warrant civil commitment: Does the person have a mental disorder, and does that mental disorder make them dangerous? The question of "dangerousness" is central to the court's ability to commit a person, and it is not an easy question to answer. Dangerousness is discussed in more detail later in this chapter.

Diversion from Commitment

Even when the first steps toward civil commitment have been taken—a hospital hold is in place, or a petition has been filed, or a hearing has commenced—the person may not ultimately be committed. A pre-commitment investigation, or simply time, may reveal that the person is safe or that the person does not have a mental disorder warranting commitment (e.g., they were intoxicated rather than mentally ill).

Alternatively, during the pre-commitment period, a person may be "diverted" into voluntary treatment—avoiding involuntary commitment by consenting to necessary care. Diversion in this context is used in the same sense that this text has previously discussed criminal diversions (see Chapter 4). Diversion allows a person to access services without the burden or stigma of a formal system determination against them. In other words, a person can get the benefit of treatment without a judge having to decide they are dangerous. When possible, Oregon law encourages diverting civil commitment subjects into voluntary intensive treatment for a 14-day period rather than finalizing commitment (Or. Rev. Stat. § 426.237).

Diversion to voluntary treatment may be preferred over involuntary commitment for many reasons. Voluntary treatment is potentially more effective and less expensive than commitment. Voluntary treatment may be more available; in many states, there is a critical shortage of beds and facilities for people who are committed involuntarily. It may also be more attractive to the impacted person than a lengthy and restrictive commitment, which can last for many months.

Finally, although civil commitment does not create a *criminal* record, it does create a record with consequences. A person who has been civilly committed will face limitations of their right to possess firearms, for example (18 U.S.C. § 922[d][4], 2022). They may also be more readily committed in the future, should similar circumstances arise. Oregon law, for example, provides a special pathway for commitment when a person has had two previous commitments and is exhibiting the same symptoms that preceded the earlier commitments (Or. Rev. Stat. § 426.005). A person who engages in voluntary treatment, even in a last-minute diversion from commitment, does not face these consequences.

Findings Required for Commitment

If a person who is the subject of commitment proceedings is not diverted into voluntary treatment or otherwise released from the process, the court will hold a **commitment hearing**. The commitment hearing usually occurs fairly quickly—ideally in a matter of days from the initial hold. The hearing is conducted by a judge or hearings officer who will assess the evidence to determine whether the information satisfies the requirements for a civil commitment. The hearing is an adversary process, where the person facing commitment may have an attorney to present their position, and the state also employs an attorney to advocate in favor of commitment. Witnesses, including pre-commitment investigators and mental health evaluators, will be allowed to testify or submit reports, and attorneys can ask them questions.

The evidence and questions at the commitment hearing are directed to the issues on which the court must make findings, typically, whether the person is:

- affected by a mental disorder, and if so,
- whether that renders them dangerous (or gravely disabled) so as to justify commitment.

The presence of a mental disorder is often not the primary issue. Professional evaluators will offer expert opinions as to whether a person has a mental disorder, or the person may well agree that they have a mental disorder. The second question, whether the person is a danger to themselves or others, is the much more difficult and contentious question. The way that a particular state or its courts define "dangerous" is critical to the court's findings on this issue, and of course, states define this term in varying ways. For commitment to be ordered, a person's risk has to fit within the definition of "dangerous" in that particular state.

Typically, "dangerous" has its commonly understood meaning—likely to cause harm—so that a person who is making serious threats against themselves or another person, or who seems poised to hurt themselves or another person, may be deemed "dangerous." Courts have also interpreted "dangerous" to mean immediately or imminently dangerous—meaning dangerous *now*, not in the future.

Many states also have a commitment category for "grave disability." **Grave disability** is a specialized term that usually means the person is unable to provide for their basic needs (food, shelter) such that they will experience harm in the very short term. For example, a person experiencing delusions or paranoia about food may be unable to eat. If the person develops malnutrition due to these symptoms of their mental illness, they may be considered gravely disabled by their mental illness. Some states have a "grave disability" standard for commitment without using those precise words. For example, Oregon allows the commitment of a person who is "unable to provide for basic personal needs" (Or. Rev. Stat. § 426.005; SAMHSA, 2019).

Commitment and Treatment

If, at the conclusion of a commitment hearing, evidence shows that the person meets that state's criteria for commitment, then the judge will order an involuntary commitment. A commitment usually lasts for several months, but it can be shortened if the person regains stability. The maximum time for a commitment in Oregon is 180 days, after which another hearing is required to continue involuntary treatment. This period is fairly typical among state laws.

The care provided to a person under a civil commitment may involve hospitalization or an outpatient treatment program. In some circumstances, psychiatric medications can be part of the treatment that is required for the committed person. The person may agree to accept necessary medications, or, with additional procedures, they may be medicated on an involuntary basis. A person can be medicated on an involuntary basis when there is "good cause" to do so. Good cause might be established when medication is necessary to deal with an emergency. More frequently, good cause is based on the person's lack of capacity to make a reasonable decision about taking medication, requiring medical providers to decide for the person. In Oregon, involuntary medication is a multi-step process with at least two doctors involved, and there is a separate opportunity for legal review as well (Yost et al., 2012).

As shown in the flowchart in figure 9.1, Oregon provides opportunities for a person to improve and progress, even while they are civilly committed. The person may start treatment in a hospital setting and progress to a less-restrictive community setting. If a person makes significant progress and no longer meets the criteria for commitment, the person can transition to "voluntary" status, in which case they can choose to leave the hospital (Or. Rev. Stat. § 426.300). Most states have similar, though not identical, options for resolving commitments.

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9.3 The Role of Civil Commitment

Over time, our society has come to recognize that people with mental disorders—like other people—enjoy individual rights and personal liberties. People do not automatically forfeit their rights to

freedom and autonomy when they experience illness or disability. Rather, rights must be compromised only in extreme circumstances, for important reasons, and with adequate protections in place.

As you will recall from the history of mental disorders and the development of laws related to mental disorders discussed in **Chapter 1** and **Chapter 3** of this text, the existence of rights for people with mental disorders was not always self-evident. The laws related to civil commitment help ensure that people who are experiencing mental illness and disability are not confined or forced into involuntary treatment improperly merely because of their diagnosis or because they need help. Civil commitment has rightfully taken its spot as a "last resort" option in the mental health continuum of care.

Commitment as a Threat to Freedom

The prospect of commitment raises important questions about the competing goals of safety and individual liberty:

- When is it appropriate to restrict the freedom of a person for something that is merely threatened but has not yet happened? On the other hand, when is it appropriate to allow a situation to unfold where people may be hurt?
- More specifically to the topic of this text, are we pleased to have a mechanism to help a person *avoid* engaging in potential criminal activity? Or are we troubled by treating a person, in some ways, like they *have* committed a crime—when they have not?

Scholars, medical and legal professionals, and disability and mental health communities have struggled with these questions. Opinions differ on how best to strike a balance and identify what takes priority: a person's need to receive care and treatment for a serious mental disorder that threatens health and safety, or the person's right to decline treatment and move about the world as desired, even if that desire is influenced or compromised by a mental disorder (figure 9.3).

Figure 9.3. An indoor cat sits on a bed (left) and an outdoor cat is on the move (right). Both freedom and confinement have benefits, even for our beloved pets. For people, of course, the issues and contrast are much more weighty and complex.

As stated by one prominent scholar considering the issue of civil commitment, "Patients should not die with their rights on. But they should not live with their rights off, either" (Hoffman, 2021). In other words, it is troubling to think of someone sacrificing their life or health for an abstract "right" to liberty, yet it is also troubling to consider that a life preserved via involuntary care may lack

the freedom that most of us consider essential to a good life. Do we allow a sick or disabled person to "die with their rights on," or do we intervene, perhaps maintaining safety and life, but at the expense of freedom, forcing this person to "live with their rights off"?

These are not simply theoretical or legal questions. To be forced into hospitalization at a point of serious illness and extreme vulnerability is traumatic and damaging (figure 9.4). In the words of one writer offering her first-person account of civil commitment: "Unless you have experienced it, I don't think you can fully comprehend what it means to lose autonomy over your own body or to have to 'earn the privilege' of 30 minutes of fresh air and sunshine" (Sangree, 2022).

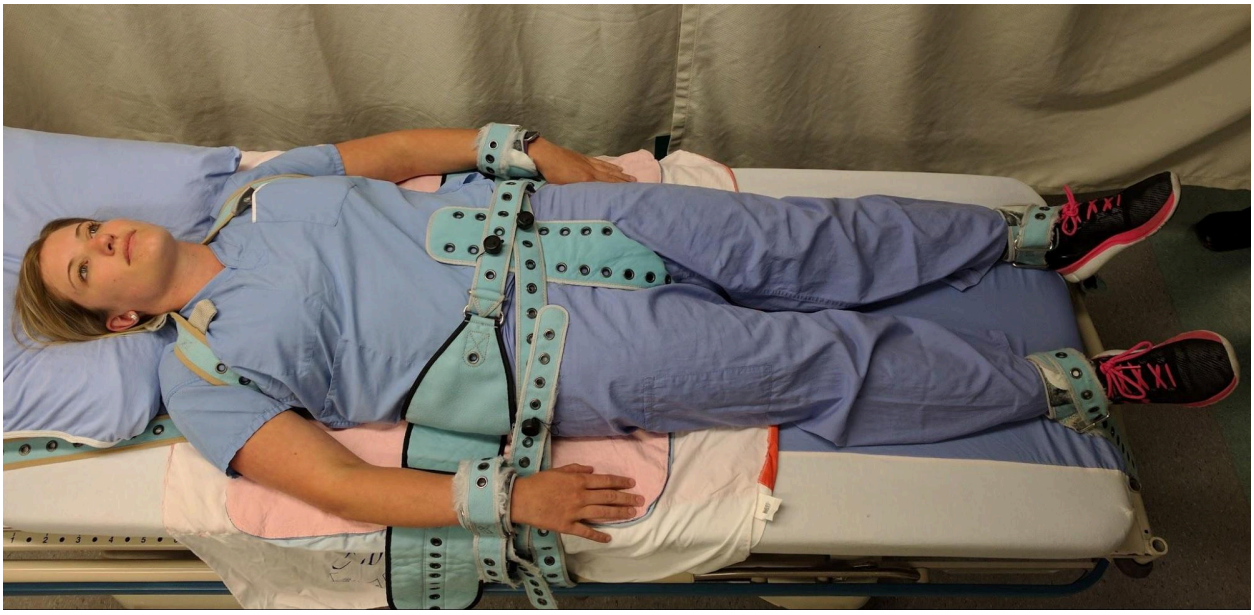

Figure 9.4. A person lies in Pinel restraints, a tool used in medical settings when patients are behaving dangerously. Restraints are a last resort, but seeing them in use, especially in a medical setting, feels shocking and emphasizes the serious loss of autonomy that can occur in a medical hold.

A further challenge in determining the right "balance" between competing concerns of freedom and safety is the impact of inappropriate factors, such as racism, sexism, and ableism, on these determinations. For example, studies looking at civil commitment populations have found clear racial bias in involuntary commitment trends: "Patients of color [are] significantly more likely than white patients to be subjected to involuntary psychiatric hospitalization, and Black patients and patients who identified as other race or multiracial [are] particularly vulnerable, even after adjustment for confounding variables" (Shea et al., 2022). When freedom and autonomy are generally valued less for a particular group—as has been the case for Black people, women, and those with mental disorders in the United States—the concerns around involuntarily committing members of these groups in their "best interest" should be heightened.

Commitment as a Safety Measure

While limits on civil commitment are critically important for the protection of those with mental disorders, it is also true that many observers and participants in this system experience legitimate frustration at the seeming unavailability of this tool when it is needed. Legal and mental health professionals, as well as first responders, may naturally want to prevent harm or stop problems

from materializing. A county attorney advocating for civil commitment, for example, has only this route to intervene *prior* to a person experiencing a severe deterioration in health and safety. If the person comes back to the courthouse as a criminal defendant after civil commitment was denied, that can be seen as a system failure. If the goal is to avoid criminalizing mental disorders, then shouldn't civil commitment be used more often?

Community and family members may share similar feelings of frustration (or fear, or sadness) as they try to prevent a loved one from becoming very sick or from acting in ways that might cause harm or send them into the criminal justice system. Disability advocates may express concern on both sides of this issue. There is concern about government overreach in civil commitment, but also concern for the loss of dignity a person may experience before reaching a court-recognized level of deterioration. Before being eligible for commitment, a person may experience a great deal of loss from destroyed relationships, jobs, support systems, and other critical pieces of a stable life. Should we allow it to go that far? Should the standard for stepping in with mandated help be lower?

This issue is closely connected to the problem of criminalization discussed in **Chapter 4**. Ideally, people choose and have access to treatment in the community, but sometimes they can't effectively access treatment. The criminal justice system can quickly become an alternative source of care, absorbing people who did not qualify for involuntary treatment in a civil process and so become criminally involved, arrested, charged, and confined. As we have learned, vastly more people receive mental health treatment in the criminal justice system than anywhere else. Objections to this state of affairs range from financial (it's expensive) to practical (jail is not an ideal place to provide mental health care) to ethical (it is simply wrong to criminalize mental disorders). Again, this raises the question: Should civil commitment be an easier hurdle? Is the difficulty of obtaining commitment a source of the criminalization problem?

Courts have wrestled with all of these questions, and they face the conundrum of how speedily and confidently to require involuntary treatment for people with mental disorders. Decisions by courts responding to these questions provide us with some additional guidance around civil commitments. However, the issues and questions presented in this section are not easily or finally resolved.

As you watch the 6-minute video linked in figure 9.5, think about the commitment process reviewed there and the requirements to qualify for civil commitment. As you consider the perspectives of Eric's mother, frustrated that her son was not committed, and Lorene, who faced civil commitment herself, what do you think is the proper role of civil commitment? What important perspectives are missing from this video clip?

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=KHkWfEYspJE

Figure 9.5. This local news outlet's story is about the status of civil commitment practices in Oregon. If you are interested in more details about the stories introduced in this shorter clip, you may want to follow up by watching the longer piece: **Uncommitted Report Produced by KGW News [Streaming Video]**. **Transcript.**

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Figure 9.3 (Left). Photograph of cat in window by Mariya_M is licensed under the Pixabay License.

Figure 9.3 (Right). Photograph of cat outdoors by Neryx is licensed under the Pixabay License.

Figure 9.4. "PinelRestaint.jpg" by James Heilman, MD is licensed under CC BY-SA 4.0.

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Figure 9.5. What it takes for a patient to be committed involuntarily by KGW News is licensed under the Standard YouTube License.

9.4 Legal Limits on Civil Commitment

One of the more important cases that speaks to the issue of civil commitment, and more broadly to the humanity and rights of people with mental disorders, is *O'Connor v. Donaldson*, decided by the U.S. Supreme Court in 1975. Kenneth Donaldson (figure 9.6) was committed to a state psychiatric hospital in Florida by his father in 1957. Donaldson was committed based on his diagnosis of schizophrenia and stayed in the Florida psychiatric hospital for over 15 years. During this time, Donaldson did not display dangerous behavior and received minimal treatment for his mental disorder. While he was hospitalized, Donaldson tried repeatedly but unsuccessfully to gain release into the care of friends who had offered to help him live in the community (*O'Connor v. Donaldson*, 1975).

Finally, Donaldson filed a lawsuit for his release against Florida authorities, including his attending physician at the hospital, Dr. O'Connor. Donaldson based his lawsuit on a federal civil rights statute. The statute Donaldson used (42 U.S.C. § 1983, referred to as **Section 1983**) allows individuals to sue state officials who have violated a person's federal constitutional rights. Section 1983 was originally passed as part of the Civil Rights Act of 1871, also known as the Ku Klux Klan Act, because it was intended to allow Black Southerners to sue state officials (often police) who were infringing on federal rights, such as the right to vote. Section 1983 allowed these lawsuits to be heard in federal rather than state courts. Federal courts were expected to be more sympathetic to civil rights, and hopefully less overrun by Klan members, than state courts.

Section 1983 allowed Donaldson to ask for help in federal court. He asserted that the state officials in Florida (the employees at the state hospital) had taken away his constitutional right to liberty. Section 1983, although created in the days of Reconstruction, is still the most important way for a person to challenge a state government official of any type that has violated the person's federal rights.

Donaldson's federal lawsuit eventually made its way to the Supreme Court on appeal. In its decision, the Supreme Court made landmark statements that signaled a change in how people with mental disorders would be seen with respect to individual freedoms.

Justice Potter Stewart wrote for a unanimous court:

> A finding of "mental illness" alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.
>
> May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution.
>
> May the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.
>
> In short, a State cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends (*O'Connor v. Donaldson*, 422 U.S. at 575-76) (internal citations omitted).

It is the last paragraph of the quotation above that is most commonly cited as the holding, or ultimate decision, of the *O'Connor* case. However, the preceding paragraphs, with their grand and somewhat poetic language, are significant as well, entertaining arguments in favor of restricting a person like Donaldson—and finding them inadequate. The *O'Connor* court was, in contrast to all of history, proclaiming that the rights of this marginalized group of humans could not simply be erased in favor of a desire to "help" them or due to a preference to avoid them. The court's findings acknowledged the condescension and stigma that played a prominent role in the treatment of people with mental disorders. The court then clarified that this intolerance does not justify confinement. Rather, there must be something "more," as the court said, to justify confinement.

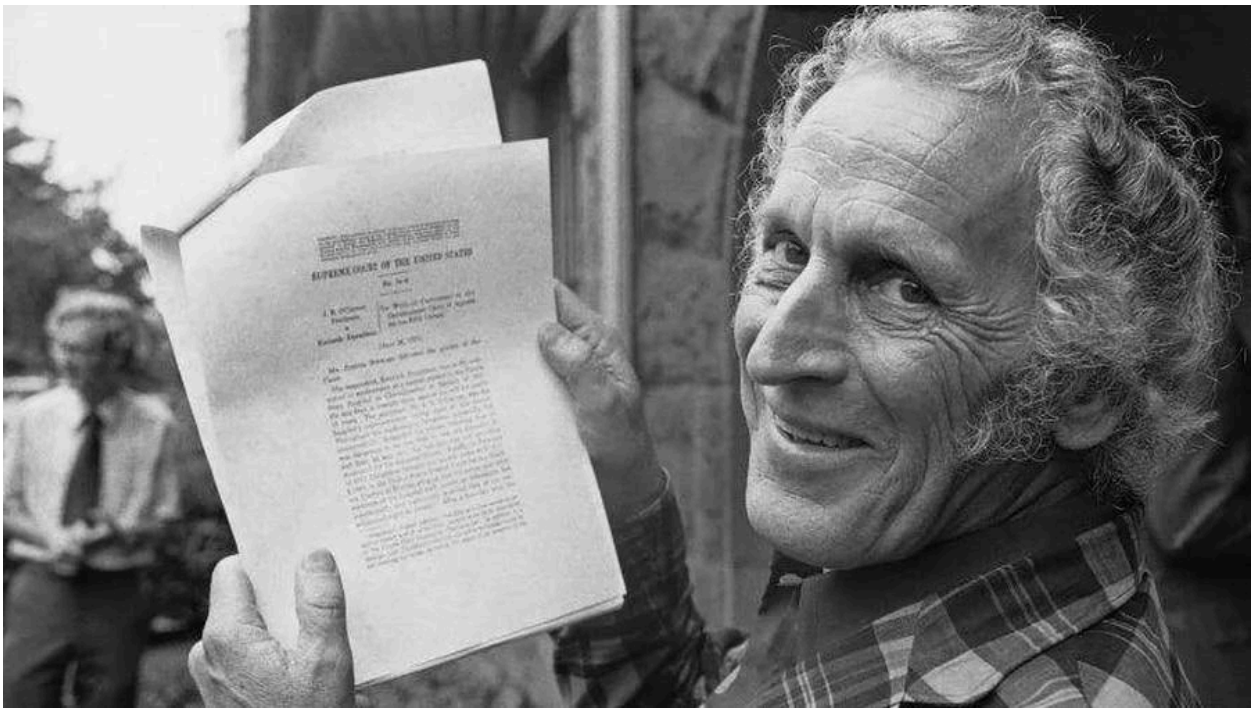

Figure 9.6. Kenneth Donaldson holds a copy of the Supreme Court decision ruling that he, and people like him, can not be confined due to the presence of mental illness alone. Donaldson's case was an enormous legal victory for people with mental disorders.

The Requirement of Danger

Because the Supreme Court specifically forbade confining a "nondangerous" person who is "capable of surviving" in the community, the *O'Connor* case is cited for the proposition that civil commitment—a restriction on liberty—must be limited to people who are *dangerous*, whether to others or themselves, such that they are incapable of surviving safely if free. Legislatures have included this dangerousness requirement in their statutes, and courts have tended to interpret *danger* to mean **imminent danger**—or dangerous right now, at the time of the hearing (SAMHSA, 2019). For example, even if evidence indicates the person has ceased taking prescribed medication, and they are going to decompensate and become dangerous in a few weeks, that is not likely sufficient for commitment in most jurisdictions. Is this requirement of *danger*, *right now*, too strict? Those who advocate for more liberal standards of commitment—desiring to offer involuntary treatment to a wider swath of patients—claim that *O'Connor v. Donaldson* does not exactly require dangerousness, nor immediacy of danger. In fact, as seen in the language quoted in this section, *O'Connor* forbids confinement of "nondangerous" people without "more," and the court never defines that "more." Could it be that "more" includes a serious need for treatment? Or something else?

The argument that danger is not required by *O'Connor* is appealing to those who want civil commitment to be more available. This perspective suggests that people need help before they become dangerous, and that help should be provided, even if the person lacks the clear-mindedness to choose that help. For example, involuntary commitment could be used to treat a person who suffers from a lack of insight as part of their mental disorder and does not appreciate that they need treatment or medications. This person could, it is imagined, be helped at the first signs of deterioration rather than waiting until they are deeply psychotic and requiring a lengthy period of

restorative treatment, possibly after hurting someone (Bloom, 2006). Would this not be more efficient and more humane?

Setting aside the results for individuals, the general prospect of requiring danger to be present before mental health treatment can be provided has bigger-picture consequences. There is a powerful argument that the "dangerous" standard does not protect people with mental disorders but rather hurts them. The "dangerous" standard may force society to allow people with mental disorders to become dangerous—fulfilling the negative thinking and stigma around people with mental disorders—before providing desperately needed help. This creation of danger, when alternatives exist, needlessly strengthens the negative public perception of mental illness and disability by effectively tying these conditions to dangerousness (Gordon, 2016).

The "gravely disabled" standard (or its variations), used in many states and discussed earlier in this chapter, has been an attempt to broaden the net for civil commitments outside of "dangerousness." The idea behind these broader standards is to allow the commitment of people who are experiencing severe deterioration and struggling to care for themselves before danger is truly upon them. However, the gravely disabled or basic needs standards have often been viewed as still requiring, ultimately, dangerousness to self. In fact, many of the states that use this standard specifically include an element of "danger" (by inaction) in the requirement. Some statutes (including Oregon's) specify that the grave disability results in serious harm (Bloom et al., 2017). It is unclear to what extent "grave disability" without resulting "danger" would be permitted as a basis for commitment under *O'Connor*—but perhaps a future Supreme Court case will tell us (SAMHSA, 2019).

Clear and Convincing Proof

Knowing that a person must be proven "dangerous" in order to commit them, the question arises as to how much proof of dangerousness is required. In 1979, just a few years after *O'Connor v. Donaldson*, the Supreme Court decided the case of *Addington v. Texas*, which addressed this question of level of proof.

Like Kenneth Donaldson, Frank Addington had a diagnosis of schizophrenia, but unlike Donaldson, Addington was probably dangerous. Addington had been threatening his mother, and according to doctors, he experienced delusions and had behaved in a dangerous manner repeatedly. Based on this information, Addington was committed to the Austin State Hospital—formerly known as the Texas State Lunatic Asylum—for an indefinite period (*Addington v. Texas*, 1979) (figure 9.7).

Figure 9.7 The former Texas State Lunatic Asylum in Austin, Texas. The building is now part of the Austin State Hospital, where Frank Addington was committed.

Addington challenged his commitment in court, and the case went up on appeal. The issue was how much, or what level of, evidence should be required to support Addington's commitment to the hospital. Opposing his commitment, Addington argued that the requirement should be a lot of evidence, or as much as would be required to convict a person of a crime. Predictably, the state argued that less evidence was required, as this was a civil rather than criminal case (*Addington v. Texas*, 1979).

Typically, civil cases have a lower **burden of proof**, meaning the amount or level of evidence required to prevail, than do criminal cases. Civil cases are generally lawsuits between private parties, such as cases involving contracts or money disputes. These cases are typically won with a **preponderance of the evidence** (often characterized as just enough to tip the scales, or 51%). Criminal cases, in contrast, require proof **beyond a reasonable doubt** to convict a person. Proof beyond a reasonable doubt is understood to mean overwhelming evidence that leaves no real doubt in the minds of decision-makers. Proof beyond a reasonable doubt is not 100%, but it is somewhere close to that level (figure 9.8).

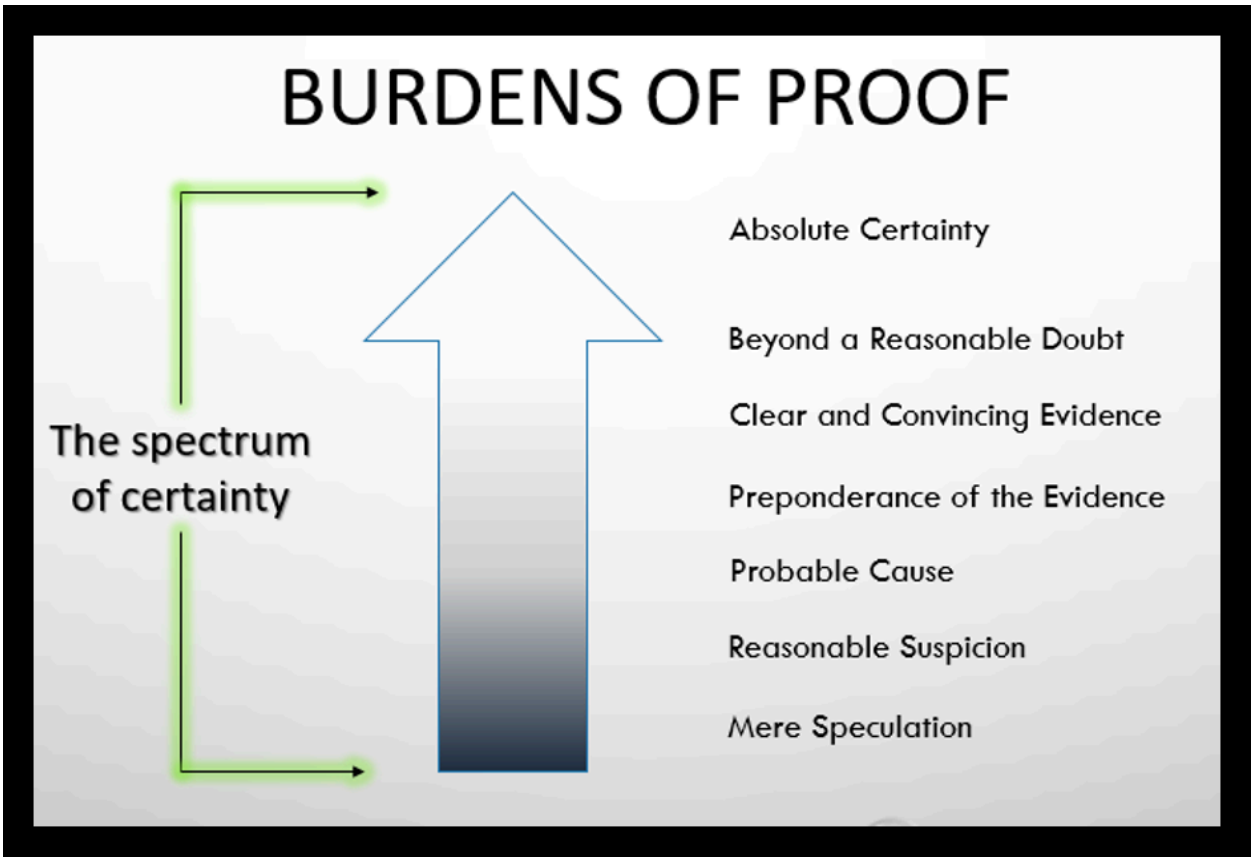

Figure 9.8. The range of legal burdens of proof is shown as a "spectrum of certainty." Lowest on this list is a mere speculation. Certainty increases from there to preponderance of the evidence in the middle and absolute certainty at the top, which is beyond any of the levels required in court. The "burden" of proof gets heavier as the need for certainty rises.

Although Addington argued that the state should be required to establish his suitability for involuntary commitment with proof "beyond a reasonable doubt" (the criminal standard), the Texas Supreme Court sided with the state and decided that a preponderance of the evidence (the civil standard) was sufficient for a civil commitment case. However, the U.S. Supreme Court ultimately disagreed with both parties, settling on a less common middle-ground standard: **clear and convincing evidence**.

As shown in the illustration in figure 9.8, the clear and convincing standard of proof is more demanding than the preponderance standard, but less stringent than proof beyond a reasonable doubt. The Supreme Court wrote that this in-between standard of clear and convincing evidence fit the circumstances of civil commitment, which is more weighty than a typical civil lawsuit, but not quite at the level of a criminal case. A court must weigh the "individual's interest in not being involuntarily confined" against the "state's interest in committing the emotionally disturbed [person]." The Supreme Court emphasized that commitment is "a significant deprivation of liberty," and found it "indisputable" that commitment will "engender adverse social consequences to the individual," namely "stigma" (*Addington v. Texas*, 441 U.S. at 425-26).

Although the *Addington* court would not agree to require proof beyond a reasonable doubt, distinguishing civil commitment from criminal cases, the Supreme Court explained the need for at least the clear-and-convincing standard in the interest of fairness:

> We conclude that the individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence (*Addington v. Texas*, 441 U.S. at 427).

Under the *Addington* ruling, if a court considering civil commitment found that witnesses and other evidence indicated a person was just slightly more likely to be dangerous than not dangerous, that person could not be committed (figure 9.9). The commitment judge would have to find that the person was *far* more likely to be dangerous than not dangerous—clearly and convincingly so. This is a significant burden not lightly undertaken and not easily met, especially in a matter as complex as presented by many mental disorders.

Figure 9.9. The scales are commonly used as a symbol of justice. In the even scales pictured, the evidence on each side would be roughly equivalent. If the scales were slightly tipped, that might indicate a preponderance of the evidence. Clear and convincing evidence would render the sides substantially unbalanced—clearly pointing to the weight of evidence on one side of the case.

Like the *O'Connor* decision, the *Addington* decision serves as a limit on the use of civil commitment and a reminder of the seriousness of this measure. While it is not a criminal conviction, commitment does require very substantial (clear and convincing) proof of a very serious concern (danger) on a specific timeline (often "imminent") before civil commitment can be used. In light of the historical disregard for the rights of people with mental disorders, this is reassuring. However, considering the need for protection and treatment of this vulnerable group, it is also potentially concerning.

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Figure 9.7. **Austin state hospital.jpg** by **Larry D. Moore** is licensed under **CC BY 4.0**.

Figure 9.8. Burdens of Proof from **Alaska Criminal Law – 2022 Edition by Robert Henderson** is licensed under a **Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License**.

Figure 9.9. **US Department of Justice Scales Of Justice.svg** by **Liquid** is in the public domain.

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9.5 Commitments in Criminal Proceedings

In contrast to the purely civil commitments discussed in the preceding section, several forms of involuntary treatment occur in the context of criminal proceedings. These commitments are closely connected to an underlying criminal case, but the commitment is not a sentence or a punishment (although it may be perceived that way).

A person who is facing criminal charges may be committed for treatment in the following cases:

1. When they are incompetent to resolve their criminal charges (either temporarily or permanently); or
2. When they are found not responsible for criminal acts due to insanity, or in another phrasing, they are guilty except for insanity.

These situations pause or end the underlying criminal proceedings and give rise to the proceedings described in this section.

A less common type of commitment occurs *after* conviction and incarceration when a person convicted of a sex offense remains dangerous and faces continued confinement and treatment to manage that danger. Post-conviction commitments are discussed in the final section of this chapter.

Commitment to Restore Competence

State psychiatric hospitals across the country, including those in Oregon, are overflowing with committed patients. These are not patients who have been civilly committed due to danger—a group that, as discussed, is now relatively small. Rather, these patients were arrested and brought into the criminal system and then were committed to the hospital. Most often, these commitments are for the purpose of competency restoration, a process discussed in **Chapter 6**. A person who is incompetent, or unable to aid and assist, in their criminal defense must be restored to competence before resumption of their criminal case. In Oregon, this commitment and restoration process takes place pursuant to Oregon Revised Statute §161.370, and the commitments are commonly called "3-7-0" commitments.

Oregon is not alone in being overwhelmed with criminally incompetent patients, but it is a good example of the problem. The Oregon State Hospital's daily average population of "aid and assist" patients has skyrocketed in recent years:

- In 2000, the hospital had a daily average of 74 aid and assist patients—just 9% of the total hospital population.
- In 2019, the hospital reported an average daily population of 260 aid and assist patients, over 40% of the hospital's patients.
- In the spring of 2022, there were over 400 daily aid and assist patients, with waiting lists of people in jail needing to enter the hospital for restoration (Oregon Health Authority, 2019).

Although patients average fewer days in the hospital now than before, even a faster process cannot keep up with the demand for beds. As a result, there is a concern that people too mentally ill to resolve their criminal cases must remain in jail for lengthy periods, awaiting their (also lengthy) hospital commitment to undergo a process that will allow them to return to jail. Jail-based restoration, an option that eliminates the need for hospitalization, is being explored in some jurisdictions but thus far has not been done in Oregon. See **Chapter 6** for more information on this option.

Advocates have pushed for faster hospital admissions for people facing competency issues, alleging that it is a violation of defendants' civil rights to delay needed treatment. Complaints have pointed out the negative health consequences and equity issues associated with keeping very mentally ill people in jail with no treatment. In Oregon, a 2002 federal court order resulting from the lawsuit *Oregon Advocacy Center v. Mink* required that the state psychiatric hospital take no more than 7 days to admit patients who are unable to aid and assist in their criminal defense (Oregon Health Authority, n.d.). Other states have been similarly directed by courts facing this problem. However, compliance has been spotty over the years, with efforts hampered by shortages of mental health care professionals and a lack of beds in state hospitals.

Even while federal courts have demanded hospitals prioritize this set of patients, system observers and stakeholders have noted that other groups are suffering at the expense of this one. Only so many beds are available in a state hospital. Should some of them be reserved for the civil commitment patients you have just learned about—those who have committed no criminal offense? What about patients who have been found guilty except for insanity of serious crimes? Beds must be available to hold patients who have nowhere else to be safely held.

The reasons for the daunting number of competence commitments are numerous and complex. Among them is the lack of community mental health treatment access for people in need before criminal system involvement. Untreated, people with mental disorders are entering the criminal justice system in large numbers, as described in **Chapter 4** of this text. Patients who are not competent to resolve their cases are a portion of that group.

Meanwhile, shortages of mental health professionals create barriers at all levels of care, including in hospitals and alternative community settings. This access issue, even at higher levels of care, exists in Oregon and other states, slowing patient progress through the system (Kaiser Family Foundation, 2023; Zhu et al., 2022). As an example, in 2022, the Oregon State Hospital's ongoing struggles with staff shortages required the closure of units and reduction of admissions (Loman, 2022).

Furthermore, despite efforts to move patients through the process quickly, restoration of competence is often a slow process. For example, there are limits on the treatment that can be provided to advance competence; it may be clear that psychiatric medications (figure 9.10) would benefit a patient, but if those are declined, there are limits on doctors' ability to administer them involuntarily to make a person competent to stand trial (*Sell v. United States*, 2003).

Figure 9.10. A picture of various forms of medication. Certain medications, including some psychiatric medications, are invasive (such as injectable medications) or have side effects that make them unattractive to patients. Forced administration of medications is an additional imposition on bodily autonomy that is not legal absent certain conditions and procedures.

Fortunately, perhaps, competency restoration efforts are not endless. In the face of hospital backlogs, courts have moved toward stricter limits on the time allowed to attempt competency restoration. For example, under previous rules in Oregon, restoration attempts could go on for years in a hospital setting. In August 2022, however, a federal court in Oregon set new, much shorter, time allowances for patient restoration at the Oregon State Hospital. Under these new rules, lower-level offenders being restored have to be released after no more than 90 days, and those who are charged with nonviolent felonies have to be released in 6 months (Oregon Health Authority, n.d.). Although this adjustment might reduce overcrowding at the hospital, new questions arise: where do these patients go upon release, and are they and their communities adequately served? In Oregon, negotiations and challenges around these limits are ongoing as of this writing, and similar conversations are occurring in other states.

Extremely Dangerous and Resistant to Treatment

Some patients, despite attempts at restoration, are found "never able" to aid and assist. That is, they are deemed permanently or indefinitely incompetent to resolve their criminal cases. At some point, prosecutors may be forced to dismiss charges (at least temporarily) against the person who is not or cannot be made competent to resolve those charges. This can be a terribly unsatisfying solution for the justice system and certainly for victims. It is a difficult situation for the accused person as well, who is left in a sort of limbo, unable to resolve their case with finality.

The Massachusetts case of Jose Veguilla, introduced in Chapter 6, is just such a case. Veguilla, his family, and his victim's brokenhearted loved ones have watched his case churn in an endless cycle of evaluations and hearings that will never result in a finding of competence. "[E]very few months,

the court convenes to discuss his case. A judge receives the update that Veguilla still has severe dementia and cannot proceed. And they agree to have the same hearing several months later. The hearing in January [2023] lasted less than 60 seconds" (Thompson, 2023, para. 44).

Oregon's solution to cases like Veguilla's was a statute, enacted several years ago, providing for the involuntary commitment of people who are deemed "Extremely Dangerous and Resistant to Treatment" (Or. Rev. Stat. § 426.701-702). This statute is specifically targeted and used to manage people who have committed a most serious offense (e.g., murder) and who have an entrenched mental disorder that is not amenable or responsive to psychiatric treatment. In practice, this often involves people who are charged with a very violent offense but who simply cannot reach competence to resolve that charge.

The Oregon law first requires that the person be found "extremely dangerous," criteria based on the offense they committed and the likelihood of repeated harm. The person must also be "resistant to treatment" (Or. Rev. Stat. § 426.701). If restoration to competence was attempted and failed—and the person continues to exhibit those same challenges—that information would indicate resistance to treatment. If a person meets these qualifications, the Oregon law allows commitment to involuntary treatment for two years, with an option for recommitment. If the person stops qualifying for recommitment and becomes competent to proceed to trial, the prosecutor on the underlying case may reinstate criminal charges against the person (Or. Rev. Stat. § 426.702).

Oregon patients committed under the Extremely Dangerous and Resistant to Treatment statute continue to receive treatment for their underlying mental disorders—and, despite barriers, they are sometimes able to move out of the hospital and into less restrictive housing and treatment options. Patients committed under the statute are supervised by the Oregon Psychiatric Security Review Board, discussed in more detail in the next section.

Commitment After Insanity Defense

Competing for bed space at state hospitals are patients who have been committed for psychiatric treatment after successfully asserting the insanity defense in criminal court. These are patients who have been found not guilty by reason of insanity, or, as it is called in Oregon, guilty except for insanity (GEI). As you have learned, a successful insanity defense excuses a person from criminal responsibility for an offense based on the impact of a mental disorder. See **Chapter 6** for a detailed discussion of the insanity defense. The excused person is not simply released as they would be with other "not guilty" verdicts; they are ordered into a term of treatment designated by law. This type of involuntary treatment after a criminal matter is sometimes referred to as a **criminal commitment**—as distinguished from the civil commitments discussed at the beginning of this chapter, which are unrelated to criminal charges.

Most people who are excused from criminal responsibility due to insanity are committed to a public psychiatric hospital, such as the Oregon State Hospital, for treatment and to ensure community safety (figure 9.11). The details of hospital treatment programs are beyond the scope of this text, but there are many opportunities and therapies available for different types of patients in various facilities. Programs will differ by jurisdiction. Feel free to click the link to learn more about the treatment programs at the **Oregon State Hospital [Website]**.

Figure 9.11. The western facade of the modern Oregon State Hospital in 2011.

Legal oversight of a person's criminal commitment is generally managed by some combination of medical providers and legal personnel in the criminal justice system. In the federal system, for example, a criminally committed person is supervised by a probation officer, sometimes for life. A few states, including Oregon, have specialized systems to supervise people under criminal commitments. The **Oregon Psychiatric Security Review Board (PSRB)** is a somewhat unique oversight board composed of professionals from multiple relevant disciplines. The PSRB is charged with ensuring proper management and community safety for all Guilty Except for Insanity (GEI) patients, as well as the Extremely Dangerous and Resistant to Treatment patients discussed in the previous section. Board members include a psychiatrist, a psychologist, a criminal lawyer, a parole and probation officer, and a community member—each bringing different expertise and perspectives to their supervision duties.

To perform its duties, the PSRB holds public hearings where the supervised person is in attendance, represented by an attorney. The state, interested in public safety, is also represented by an attorney at PSRB hearings. Hearings may involve testimony from witnesses—primarily treatment providers—who advise the board of the person's mental health status and treatment progress. Sometimes, hearings are an opportunity for the person and their treatment providers to request that a person be allowed **conditional release** from the hospital, meaning that the person is permitted to live in the community, often in a group setting, to participate in treatment under a set of rules and safeguards. If those conditions of release are violated, the person may be returned to the hospital. If you are interested, you may read more about Oregon's **PSRB here [Website]**.

Typically, people who have been criminally committed after an insanity verdict are ordered to remain under the supervision provided in their state for either an indefinite period or for the maximum length of time allowed by their underlying offense. However, if at some point it is determined that the person no longer meets the criteria for a criminal commitment—they no longer have a qualifying mental disorder or it no longer makes them dangerous to others—then the person must be released from supervision. Again, the standards for continued commitment and supervision in these circumstances will vary according to the law

of the jurisdiction. However, note that the criminal commitment standard is different from that used to civilly commit a person, as discussed earlier in this chapter. Civil commitment can be based on a person's danger to *themselves*. A criminal commitment typically requires that a person be seriously dangerous to other people.

Regardless of how patients are managed or supervised in a particular state, their treatment can be a source of stress and concern to crime victims (figure 9.12) who may feel that justice was not served when the person with a mental disorder was "excused" from responsibility. There can also be an understandable sense of resentment toward patients who are able to access mental health care after committing serious offenses when other people who have not found their way into the criminal system may have very limited access to mental health care.

Figure 9.12. A bench carved with a dedication to crime victims reads: "Justice isn't served until crime victims are." This statement reflects an ongoing concern that victims are not always well-served, supported, or cared for by the criminal justice process. This may feel especially true when offenders are not convicted due to mental disorders.

SPOTLIGHT: The Criminal Commitment of Andrea Yates

When a person with a serious mental disorder commits a terrible act that they certainly would not have done had they been well, the tragedy seems magnified, and the story of Andrea Yates fits that category. Yates's story is a difficult one to read and absorb. It is an example of an act that would be a terrible crime, except for the presence of mental illness in the offender. Is this a case where you believe the insanity defense was appropriately applied? Was commitment to a hospital the right outcome in this case?

Andrea Yates (figure 9.13) began as a happy young wife. She and her husband wed in April 1993 and soon announced that they planned to have as many children as they could during Andrea's reproductive years. It was after the birth of their fourth child that Andrea first showed signs of severe mental illness.

Figure 9.13. Andrea Yates is shown in a Houston Police Department photograph in 2001, after the killing of her children.

On June 16, 1999, Russell Yates found his wife shaking and chewing her fingers. She attempted suicide the following day and was prescribed antidepressants. Just weeks later, she again held a knife to her own throat and begged her husband to let her die. After this second suicide attempt, Andrea was hospitalized, diagnosed with postpartum psychosis, and prescribed several different medications that included antipsychotics. Andrea's psychiatrist urged Andrea and Russell not to have any more children, but she was pregnant with the couple's fifth child within 2 months of her diagnosis.

In November 2000, the fifth child was born. Andrea seemed stable for a few months until her father died in March 2001. This is when her psychosis returned in full force, leading Andrea to regularly mutilate herself. She became fully immersed in the Bible, her religious beliefs now

becoming fixations. Between March and June of that year, she was hospitalized twice. After Andrea's release in June 2001, her doctor told Andrea's husband to monitor Andrea around the clock. Unfortunately, there was a 1-hour block of time on the morning of June 20 when Andrea was alone with her five children, during which time Andrea drowned each child, one by one. She then called 911 and her husband.

Andrea suffered from psychotic delusions. In her mind, she believed she was saving her children. She later reported to her prison psychiatrist that she believed her children were not righteous because she, herself, was evil. She believed that their souls could never be saved because of who she was, and killing them while they were young would be their only salvation.

Andrea's first trial took place in 2002 and resulted in a guilty verdict with a sentence of life imprisonment. It was later discovered that a psychiatrist who had testified for the prosecution had given false testimony during the trial, and the conviction was overturned. A second trial in 2006 resulted in a not guilty by reason of insanity verdict. Andrea was committed to a psychiatric hospital where she remains to this day, refusing each year to seek release at her annual hearings.

Licenses and Attributions for Commitments in Criminal Proceedings

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Figure 9.12. Crime victims bench, Jesup.jpg by Michael Rivera is licensed under CC BY-SA 4.0.

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Figure 9.13. Andrea Yates by Houston Police Department, Texas, is included under fair use.

9.6 Post-Conviction Commitments

A final form of criminal system commitment that deserves a mention here is the post-conviction commitment. Post-conviction commitments are based on criminal conduct, unlike the civil commitments discussed earlier in the chapter. In a post-conviction commitment, a person has been charged with and convicted of a criminal offense. They were not excused based on insanity, and if they had competence issues, those were resolved. The person has served their time in prison and has completed their criminal case in all respects.

Now, after the person has completed their criminal sentence, they become subject to an involuntary commitment based on their continuing dangerous status. In practice, this type of commitment is directed at convicted sex offenders who are found to continue to pose a threat to the public upon their release from prison.

There are benefits and concerns associated with committing a person under these circumstances when the person has already served time based on the criminal offense. Constitutional challenges have called this type of commitment fundamentally unfair, or a form of double jeopardy—that is, punishing a person twice for the same offense. However, the Supreme Court has upheld this practice. This type of commitment is not intended as punishment (which would be illegal); rather, it serves the purpose of treating and managing the mental disorder (specifically a sexual disorder such as pedophilia) that drove the person's underlying offenses. Note that this type of mental disorder, specifically associated with a tendency to commit criminal offenses, cannot—as discussed in Chapter 6—form the basis of an insanity defense.

Understandably, victims or concerned observers may believe that the confinement of this group of people is well worth any potential challenges to fairness when an increase in community safety is achieved. The stigma against sex offenders is intense, and many people have little interest in protecting the civil rights of this particular group. However, it's important to note that these laws are not applied in an entirely fair manner. Like many processes in our criminal justice system, the impact on people of color is excessive,

indicating that biases may contribute to the imposition of these lengthy commitments. According to one researcher considering the application of post-conviction commitments of sex offenders, "Black sex offenders were twice as likely as white sex offenders to be civilly committed. In addition, men with male victims were two to three times more likely to be civilly committed than men with only female victims" (UCLA School of Law, Williams Institute, 2020).

Oregon does not have a statute for this type of post-conviction commitment, but many other states do, including our neighbor Washington. In Washington, sex offenders who complete their criminal sentences but are deemed by mental health evaluators to be a continuing threat can be civilly committed based on that threat. These offenders are committed to a secure facility, called a Special Commitment Center, on Washington's McNeil Island, which is dedicated to this purpose (figure 9.14).

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=oBUJREw_aqE

Figure 9.14. This **8-minute video [Streaming Video]** offers views and a discussion of Washington's McNeil Island Special Commitment Center. **Transcript.**

The McNeil Island facility houses 200 sex offenders who have already served their prison time and are now committed for treatment. Some may never leave the facility. As you watch the clip provided in figure 9.14, consider the issues at stake. How would you balance community safety and constitutional concerns about freedom and punishments? Is Washington striking the right balance?

Licenses and Attributions for Post-Conviction Commitments

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Figure 9.14. **McNeil Island** by **VICE News** is licensed under the **Standard YouTube License**.

9.7 Chapter Summary

- Several forms of commitment, or court-ordered involuntary mental health treatment, exist to serve various purposes in or adjacent to the criminal justice system.
- Civil commitment provides a non-criminal process for a court to order a person to receive treatment for a mental disorder, including possible confinement to a treatment facility.
- Civil commitment requires a complex set of processes with multiple layers of review to ensure that a person's rights are not violated. A person cannot be committed simply because they experience a mental disorder;

rather, there must be clear and convincing evidence that they pose a danger due to a mental disorder.

- Several forms of commitment relate directly to criminal proceedings. These include commitment for competency restoration and commitment to a hospital or other facility for treatment upon a successful assertion of the insanity defense.
- Another criminal system commitment specific to Oregon is the Extremely Dangerous and Resistant to Treatment commitment for people who have remained unable to aid and assist in their own defense for an extended period and have a low likelihood of gaining competence in the short term.
- Some states, including Washington, have provisions in law that allow for the post-conviction commitment of sex offenders who remain dangerous to the community even after serving a sentence on the underlying offense.

KEY TERM DEFINITIONS

- **Beyond a reasonable doubt:** The legal standard of proof in criminal cases. Proof at this level includes overwhelming evidence that leaves no significant doubt in the minds of decision-makers.
- **Burden of proof:** The amount or level of evidence required to prevail in a particular legal case. The burden of proof in a criminal case is "beyond a reasonable doubt," and in most civil cases it is "by a preponderance of the evidence."
- **Civil commitment:** A court order requiring involuntary treatment, and sometimes confinement, for a person who has become unsafe due to a mental disorder.
- **Clear and convincing evidence:** A legal standard of proof that is more demanding than the "preponderance of the evidence" standard, but less stringent than proof "beyond a reasonable doubt." This standard is used in civil commitment cases, in which serious liberty interests are at stake.
- **Commitment hearing:** A hearing during which a judge or hearings officer considers the evidence and decides whether it is sufficient to support a civil commitment.
- **Conditional release:** Release of a person from an institutional setting (like a prison or hospital) into the community, often in a group setting, with requirements to abide by a set of rules and safeguards. If those conditions of release are violated, the person may be returned to confinement.
- **Criminal commitment:** Term used to describe commitments (involuntary treatment and/or confinement) by operation of law in the context of a criminal case. A commitment is not a conviction or a punishment.
- **Emergency hold (hospital hold or hold):** A process allowing a designated professional to order that a person be kept under supervision so their mental health can be assessed and stabilized. A hold can be a first step in involuntary commitment proceedings.
- **Grave disability:** Legal term meaning that a person is unable to provide for their basic needs and is subject to immediate harm. Grave disability can be a basis for civil commitment in some states.

- **Imminent danger:** A threat of harm that is immediate rather than in the future.
- **Notice of Mental Illness (NMI)**: In Oregon, the paperwork that triggers a court's involvement in a civil commitment. Each state, as well as the federal system, has developed its own procedures for initiating and completing civil commitments.
- **Oregon Psychiatric Security Review Board (PSRB):** In Oregon, a multidisciplinary oversight board charged with ensuring community safety with respect to state Guilty Except for Insanity (GEI) patients. Each jurisdiction that allows the insanity defense has its own method of overseeing this population.
- **Pre-commitment investigation**: A fact-finding process to determine what, if any, mental disorder a person is experiencing and how that mental disorder is currently impacting the person facing commitment.
- **Preponderance of the evidence:** The legal standard of proof in civil cases. Evidence at this level makes something more likely than not to be true and may be characterized as "just enough" to tip the scales, or 51%.
- **Section 1983:** A common name for the federal law 42 U.S.C. § 1983, originally enacted in 1871 and known as the Ku Klux Klan Act. Section 1983 allows individuals to bring lawsuits in federal court to address violations of their federal civil rights by state officials.

DISCUSSION QUESTIONS

- How is a civil commitment under modern statutes different from the routine institutionalization of people with mental disorders that occurred up through the mid to late 1900s?
- Explain the "imminent danger" standard that is often required for civil commitment. Why does this standard exist? Should this be the requirement, or would you choose a different standard for civil commitment?
- Why is a person who asserts the insanity defense subject to a criminal commitment? How does such a commitment fulfill the goals of the criminal justice system? How might it not fulfill those goals?
- What is the basis for the post-prison commitment of sex offenders in states like Washington? What are the pros and cons of this type of commitment? Would you prefer to see restriction or expansion of these commitments?

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9.8 References

18 U.S.C. § 922(d)(4) (2022). https://www.govinfo.gov/content/pkg/USCODE-2022-title18/html/USCODE-2022-title18-partI-chap44-sec922.htm

42 U.S.C. § 1983 (2022). https://www.govinfo.gov/app/details/USCODE-2022-title42/USCODE-2022-title42-chap21-subchapI-sec1983

Addington v. Texas, 441 U.S. 418 (1979). https://supreme.justia.com/cases/federal/us/441/418/

Bloom, J. D. (2006, December). Civil commitment is disappearing in Oregon. *Journal of the American Academy of Psychiatry and the Law Online*, *34*(4), 534–537. https://jaapl.org/content/34/4/534

Bloom, J. D., Britton, J., & Berry, W. (2017, March). The Oregon Court of Appeals and the state civil commitment statute. *Journal of the American Academy of Psychiatry and the Law Online*, *45*(1), 52–61. https://jaapl.org/content/45/1/52

Civil Action for Deprivation of Rights, 42 U.S.C. § 1983 (2022). https://www.govinfo.gov/content/pkg/USCODE-2022-title42/html/USCODE-2022-title42-chap21.htm

Gordon, S. (2016). The danger zone: How the dangerousness standard in civil commitment proceedings harms people with serious mental illness. *Case Western Reserve Law Review*, *66*(3), 657. https://scholarlycommons.law.case.edu/caselrev/vol66/iss3/3

Hoffman, B. (2021, January 23). Living with your rights off. *Psychiatric Annals*, *7*(5), 79–87. https://doi.org/10.3928/0048-5713-19770501-08

Kaiser Family Foundation. (2023, March 20). *Mental health and substance use state fact sheets.* https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/

Loman, A. (2022, July 12). Oregon State Hospital temporarily closes unit in response to staffing crisis. *Salem Reporter*. https://www.salemreporter.com/2022/07/12/oregon-state-hospital-temporarily-closes-unit-in-response-to-staffing-crisis/

O'Connor v. Donaldson, 422 U.S. 563 (1975). https://supreme.justia.com/cases/federal/us/422/563/

Or. Admin. R. 309-033-0200 *et seq.* (2024). https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1027

Oregon Advocacy Center v. Mink, No. 02-339-PA (D. Or. May 15, 2002) (judgment and order) https://static1.squarespace.com/static/6387d767fc8a755e41aa5844/t/646d8c0aba05f968b954356c/1684900876076/Disability-Rights-Oregon-v.-Mink-Mazur-Hart-PANNER-final-order-2002.pdf

Oregon Health Authority. (n.d.). *Oregon State Hospital Mink-Bowman order compliance.* https://www.oregon.gov/oha/OSH/Pages/mink-bowman.aspx

Oregon Health Authority. (2019). *Oregon State Hospital – Aid and assist*. https://www.oregon.gov/oha/Documents/Aid-and-Assist-Fact-Sheet.pdf

Or. Rev. Stat. §§ 426.005 *et seq.* (2023). https://www.oregonlegislature.gov/bills_laws/ors/ors426.html

Or. Rev. Stat. §§ 427.005 *et seq.* (2023). https://www.oregonlegislature.gov/bills_laws/ors/ors427.html

Sangree, R. (2022, December 23). I was hospitalized against my will. I know firsthand the harm it can cause. *The Guardian*. https://www.theguardian.com/society/2022/dec/23/involuntary-hospitalization-policy-new-york-city-eric-adams

Sell v. United States, 539 U.S. 166 (2003). https://supreme.justia.com/cases/federal/us/539/166/

Shea, T., Dotson, S., Tyree, G., Ogbu-Nwobodo, L., Beck, S., & Shtasel, D. (2022, August 12). Racial and ethnic inequities in inpatient psychiatric civil commitment. *The American Psychiatric Association, Psychiatric Services*, *73*(12), 1322–1329. https://doi.org/10.1176/appi.ps.202100342

Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). *Civil commitment and the mental health care continuum: Historical trends and principles for law and practice*. Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/civil-commitment-mental-health-care-continuum.pdf

Thompson, C. (2023, June 28). *The never-ending murder case: How mental competency laws can trap people with dementia.* The Marshall Project. https://www.themarshallproject.org/2023/06/28/massachusetts-murder-courts-dementia

UCLA School of Law, Williams Institute. (2020, October 22). *More than 6,300 people are detained in civil commitment programs in the US* [Press release]. Williams Institute. https://williamsinstitute.law.ucla.edu/press/svp-civil-commit-press-release/

Watson, E. (2024, April 23). Nearly all of Oregon State Hospital's beds go to criminal patients, all but ending civil commitment in Oregon. *KGW8*. https://www.kgw.com/article/news/investigations/uncommitted/oregon-effectively-criminalized-severe-mental-illness/283-93567f83-75ee-4179-9b7d-fb4d77dd880c

Yost, K., Anderson, J., Englander, B., & Lebens, M. (2012). *Involuntary medication hearing handbook* (1st ed.) [Pamphlet]. https://easacommunity.org/files/Involuntary-Medication-Hearing-Handbook-First-Edition.pdf

Zhu, J., Howington, D., Hallett, E., Simeon, E., Amba, V., Deshmukh, A., & McConnell, K. J. (2022, February). *Behavioral health workforce report to the Oregon Health Authority and State Legislature*. Center For Health Systems Effectiveness at Oregon Health & Science University. https://www.oregon.gov/oha/ERD/SiteAssets/Pages/Government-Relations/Behavioral%20Health%20Workforce%20Wage%20Study%20Report-Final%20020122.pdf

CHAPTER
10

Opportunities, Rewards and Challenges in the Behavioral Health and Criminal Justice Fields

10.1 Chapter Learning Objectives and Overview

LEARNING OBJECTIVES

The following learning objectives tell you what is most important in this chapter. Use these statements as a guide to make sure you get the most out of this chapter.

1. Describe and compare career options in the overlapping areas of criminal justice and behavioral health.
2. Discuss the rewards and challenges associated with work in the helping professions.

3. Explain the importance of workplace satisfaction in counteracting workplace fatigue, identifying specific ways to increase well-being.

KEY TERMS

Look for these important terms in the text in bold. Understanding these terms will help you meet the learning objectives of this chapter. You can find definitions for these terms at the end of the chapter.

- **Burnout**
- **Certified alcohol and drug counselor (CADC)**
- **Compassion fatigue**
- **Compassion satisfaction**
- **Correctional officer**
- **Criminal defense attorney**
- **Depersonalization**
- **Forensic psychologist**
- **Mental health counselor**
- **Probation officer**
- **Prosecutor**
- **Psychiatric-mental health nurse practitioner (PMHNP)**
- **Psychiatrist**
- **Secondary traumatic stress**
- **Self-care**
- **Social worker**
- **Vicarious resilience**
- **Vicarious traumatization**
- **Victim advocate**

Chapter Overview

Throughout this textbook, we have discussed the important work done by the criminal justice and behavioral health professionals who serve our focus population: justice-involved people with mental disorders. This chapter takes a closer look at a number of these professional roles, including the requirements for entry and some basics about the work involved. Short videos are linked throughout to give you a chance to hear directly from people who do this work. Perhaps one of the in-demand roles discussed in this chapter will inspire you as you are investigating career options for yourself (figure 10.1).

Figure 10.1. If the challenges discussed in this textbook are issues you want to help tackle, consider looking for a career at the overlap of criminal justice and behavioral health.

The careers mentioned in this chapter are impactful and rewarding, which is generally why people choose them. Professionals in these roles want to help others and improve their communities. However, these helping careers also come with challenges, including the potential for the helper to be harmed in the course of their work. This chapter focuses specifically on the potential for mental and emotional harm that can result from regular engagement with people who have been, or currently are, hurt, victimized, or otherwise suffering. Awareness of these job-related risks, and taking proactive steps to counteract them, is important for sustaining effectiveness and satisfaction in your chosen work.

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10.2 Criminal Justice Careers

Criminal justice careers can include work in law enforcement, legal services, or corrections (figure 10.2). Most criminal justice careers involve working for a government entity, although there are also non-profit and private opportunities, such as working for a victim advocacy organization or a private law firm that does criminal defense work. The choice among these careers depends on which aspect of the criminal justice field you find most appealing or rewarding, as well as what role suits your goals in terms of educational investment, day-to-day job activities, and lifestyle. Consider, as you read about these roles, what interactions each type of professional may have with our focus population and how that interaction can impact the professional as well as the justice-involved person.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=Ru9dyuV7KcU

Figure 10.2. This optional video offers a very general overview of careers in public safety, law, and corrections. Transcript.

Some entry requirements for criminal justice jobs are mentioned in the descriptions in this section, but if a particular type of work interests you, you will want to research further to best position yourself to access job opportunities. Most professions discussed here require a criminal background check. The Oregon Department of Corrections, as an example, requires that applicants be "law-abiding . . . with no felony convictions" and "of good moral fitness [with] no acts or conduct which would cause a reasonable person to have substantial doubts about the individual's honesty, fairness, respect for the rights of others, or for the laws of the state and/or the nation." Applicants for law enforcement and corrections jobs must also be able to pass medical and psychological screenings and be eligible to possess firearms (Oregon Department of Corrections, n.d-b).

Law Enforcement and Beyond

Law enforcement personnel work to serve and protect the community. Law enforcement officers perform a variety of public safety duties, such as traffic stops, criminal investigations, and crisis response. Officers carry weapons—an enormous responsibility—and they have significant behind-the-scenes obligations, such as filing reports (Occupational Outlook Handbook [OOH], 2024h). Law enforcement officers at the local level work for cities, counties, or states in sheriffs' offices or police departments. Many police bureaus have specialized units that focus on particular tasks or needs, such as the behavioral health and crisis response teams discussed in Chapter 5. Officers working in these roles access additional training and gain valuable experience in managing particular types of encounters. Some law enforcement officers have very specific roles, such as bailiffs, who maintain order in courtrooms (OOH, 2024h). Overall, more than 80% of police officers are male. Women make up only 16% of officers. About 18% of all officers are Latinx, and 13% are Black. Only

7% of police officers identify as LGBTQIA+ (Zippia, 2024c).

Optionally, watch the short video in this section (figure 10.3) for a quick overview of the action-packed job of a Washington County Sheriff's Deputy. Keep an eye out for mention of the county's Mental Health Response Team at minute 2:14, which touches on law enforcement diversion.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=hhejBu71x4k

Figure 10.3. Washington County, Oregon, touts some important roles of that county's sheriff's office, including the operation of the Mental Health Response team that works to divert people away from the criminal justice system. **Transcript.**

Law enforcement also occurs at the federal level—operating on behalf of the U.S. government. Officers working for federal law enforcement agencies such as the Federal Bureau of Investigation (FBI) and the Department of Homeland Security will frequently encounter people who experience mental disorders, requiring adequate crisis response and other appropriate training as discussed earlier in this text (GAO Highlights, 2018).

There is a wide range of educational and experience requirements for law enforcement officers, depending on the hiring agency and the specific role. Some local police departments require only a high school diploma or GED. Others require a college degree or, in some cases, a graduate degree or other specialized training (OOH, 2024h). Special agents with the FBI, for example, typically must have a certain level of experience and/or an advanced degree.

There are also numerous law enforcement roles beyond that of a sworn officer. Law enforcement agencies employ various clerks, technicians, and supporting staff who are critical to the work of law enforcement. Forensic science technicians, for example, might do crime-scene work, such as photography, and/or lab work, such as testing (OOH, 2024b). Some law enforcement agencies also have roles for people who work with and serve victims of crime in various ways (figure 10.4). Victim advocates are discussed later in this section.

Figure 10.4. An FBI employee interacts with another person and a working dog.

Although they are not part of law enforcement, it is worth mentioning here the important—and growing—group of professionals who respond to mental health crises and other calls related to mental disorders in place of police. Fire Departments, as well as some of the other police-alternative responders discussed in **Chapter 5** of this text, are vital community safety workers often tasked with resolving problems related to mental disorders, including substance use disorders. The value of these responses is clear when they avoid the risks and problems associated with armed police responses. Noting the growing movement toward reducing police responses to non-criminal situations, one fire professional observed: "What appears to be emerging in many communities is a model with a fire department unit responsible for responding to behavioral health emergencies instead of a police officer. Many fire department units consist of a specialized team, including those trained in crisis intervention, maybe a sociologist, a psychologist or another trained mental health expert" (Ludwig, 2021). Alternatives to law-enforcement first responses can also be entirely separate from police and fire agencies. For example, the model police-alternative program CAHOOTS, in Eugene, Oregon (and spotlighted in **Chapter 5**), operates independently of both police and fire. Regardless, these alternative responders must be prepared to work closely with police to ensure effective community responses.

Likewise, people who work in public safety telecommunications, including 911 call-takers and emergency dispatch workers, are front-line responders who play a critical role in interacting with the public, making rapid decisions about call responses, and communicating with first responders. If you would like, you can learn more about this important work, which requires a calm nature under pressure, a high school diploma, and certification, at **this short video describing public safety telecommunicators [Streaming Video]**.

Legal Services

The law is a very broad field that encompasses far more than criminal justice, but numerous roles within legal services relate to the issues addressed in this text.

Lawyers working in or adjacent to the criminal justice system may represent the government as **prosecutors** (state or federal) in charging and trying people who are accused of crimes, or they may serve as **criminal defense attorneys**, representing people who have been charged. Defense attorneys can be court-appointed public defenders representing accused people who cannot afford to hire a private attorney, or they may be privately-retained attorneys paid by or on behalf of the person they represent. There are also lawyers who handle legal cases adjacent to the criminal system (such as civil commitment cases or victim representations), lawyers who appeal criminal convictions, and non-criminal lawyers who work to protect the civil rights of people who are harmed by the criminal justice system. For example, many important rights of police detainees or prisoners (e.g., limits on police searches or the right to receive mental health treatment in custody) have been established in the course of civil lawsuits. Both prosecutors and defense attorneys are more likely to be male (55% of prosecutors and 52% of defense attorneys) and white (75%). Only about 5% of these lawyers are Black, even though Black people make up about 12% of the U.S. population (Zippia, 2024e; U.S. Census Bureau, 2022).

Lawyers are required to have a bachelor's degree and attend law school. Lawyers must then gain admission to the bar, which oversees practicing lawyers, in any state in which they wish to practice law. Lawyers, like many of the professionals discussed in this chapter, often work for many years to gain skills and expertise in a particular specialty (OOH, 2024d).

Other key legal professionals in the criminal justice field include investigators, who often do work like gathering witness statements and other information for both prosecutors and defense attorneys, and paralegals, who can perform legal tasks under lawyer supervision. A paralegal may have an associate's degree or a bachelor's degree (OOH, 2024f). Oregon recently became one of just a few states that will begin licensing paralegals to independently perform some legal representation of clients in limited cases, such as family and landlord-tenant matters. As of this writing, criminal law is not yet an area where licensed paralegals can provide these services (Oregon Paralegal Association, 2024).

Most judges have a law degree and experience as lawyers before taking the bench (OOH, 2024c). Ideally, judges also have the temperament and wisdom needed to make good decisions on legal matters that impact individuals and the larger community. Judges may preside over trial-level courts where they will hear civil and criminal cases, or they may sit on appellate courts where they make decisions about legal matters that will apply to future cases as well as the ones they are deciding. While judges remain overwhelmingly white and male, efforts to increase racial and gender diversity at this higher level of the legal world offer the promise of increased fairness for people in and connected to the criminal justice system (figure 10.5) (American Bar Association, 2022).

Figure 10.5. The four women who, in 2024, serve as justices of the U.S. Supreme Court are pictured here. From left to right, they are Amy Coney Barrett, Sonia Sotomayor, Ketanji Brown Jackson, and Elena Kagan.

The nation's highest court, the U.S. Supreme Court, has an enormous impact on criminal justice throughout the nation, as it has the final say in interpreting the Constitution and the protections that it provides to individuals. Of the 116 people who have been appointed to the highest court since it was created, only eight were not white men. The first Black justice, Thurgood Marshall, was appointed in 1967, and the first woman, Sandra Day O'Connor, was appointed in 1981. Ketanji Brown Jackson was the first Black woman on the court, appointed in 2022. Sonia Sotomayor, appointed in 2009, is the first (and only) Latina justice—as well as the only justice to have a reported disability, with type 1 diabetes (Campisi & Griggs, 2022).

Corrections Roles

As in law enforcement and legal services, there are many different jobs within the large field of corrections. Professionals working within correctional facilities like jails and prisons include criminal justice staff who oversee the safety, security, and accountability of incarcerated people, as well as behavioral health staff, such as treatment providers, who are discussed more in the next section (National Institute for Occupational Safety and Health [NIOSH], n.d.). Correctional officers are more likely to be male (more than 60%) and white (more than 50%), but about 18% of these officers are Latino and about 16% are Black (Zippia, 2024b).

Correctional officers in prisons and jails have oversight of inmate populations and work to reduce or prevent security risks, doing jobs such as enforcing rules, conducting searches, and transporting incarcerated people between facilities and courtrooms (figure 10.6) (OOH, 2024a). With respect to incarcerated people with mental disorders, corrections officers may have special duties and obligations towards this group who are dependent on facility-provided care. It is critical for correctional officers to have training about mental disorders, including risks of self-harm and suicide, so they can respond to inmate needs and safety concerns both compassionately and effectively. Correctional officer jobs usually have minimum age requirements and at least high-school-level educational requirements. Some jobs may demand additional education or experience (OOH, 2024a).

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=Ie0XJoykVJQ

Figure 10.6. If you are curious about corrections careers in a prison environment, take a look at this optional recruiting video created by Oregon's Snake River Correctional Institution, in which officers describe the work environment and training opportunities, as well as the variety of different roles that need to be filled in the corrections environment. **Transcript.**

The field of corrections includes many professional roles supporting people who are being supervised outside of custody. **Probation officers** supervise people who are living in the community in lieu of incarceration after a conviction. Probation is meant to ensure that the person is not a danger to the community and to promote rehabilitation (OOH, 2024i). Parole or post-prison supervision officers work with people who have been in prison serving a sentence but have been released to complete their supervised time in the community. Like probation, post-prison supervision involves providing resources as well as oversight and enforcement of release conditions, with the aim of reducing a person's risk of reoffending (OOH, 2024i). Pretrial services officers also play a supervisory role, but for unconvicted people who have been permitted to leave or remain out of custody pending a criminal trial. The pretrial officer ensures that the person follows the conditions of release and appears at required court proceedings (OOH, 2024j).

Some community supervision departments have officers or divisions with specialized caseloads that address the particular needs of people with mental disorders. The required video linked in figure 10.7 revisits the parole and probation Mental Health Unit in Multnomah County, Oregon, which was first introduced as an Intercept 5 intervention in **Chapter 4**. As the officers explain how they support a population that experiences mental health issues and disabilities, consider what skills and personal qualities likely help these professionals succeed in their roles.

This interactive content is not available in this version of the text. It can be accessed online here:
https://youtu.be/NjMXSUwq4GY

Figure 10.7. This short video offers a glimpse into the work of the parole and probation Mental Health Unit in Multnomah County, Oregon. **Transcript.**

Community supervision generally involves the officer engaging in personal contact with the supervised person, as well as with their families and other people in their lives. Regular calls, visits, and check-ins are part of the process and provide opportunities for the supervising officer to note mental health concerns, oversee drug testing, and offer other support as needed (OOH, 2024j). As discussed in **Chapter 8** of this text, several specific community interventions have been shown to increase success (e.g., reduce reoffending) in the community for people with mental disorders.

Another role discussed in **Chapter 8** of this text, a case manager, also falls into the category of community correctional jobs. Case managers may be known as correctional treatment specialists or correctional counselors. These professionals advise people under supervision and help develop case plans for them, referring the individual to resources to meet their needs. This type of support can be provided while a client is incarcerated or in the community. A correctional treatment specialist at a prison, for example, may conduct an evaluation to determine an incarcerated person's needs and then follow up with other professionals at other agencies, as well as the incarcerated person, to create a release plan aimed at reducing risks. These plans might include education programs, substance use treatment, or other approaches to reduce the risk of recidivism (OOH, 2024j).

Community supervision professionals such as parole and probation officers or case managers are typically required to have a bachelor's degree. They may also have to pass certain tests, including psychological examinations (OOH, 2024i). Parole and probation officers are just slightly more likely to be women than men, and about 66% are white, 15% are Latino, and 13% are Black (Zippia, 2024d).

Victim Support and Advocacy

A **victim advocate**, or victim support person, provides direct services to victims of crime. Crime victims may have experienced trauma due to their victimization, and crime victims are already significantly more likely than other people to experience a disability or mental disorder, as these populations are especially vulnerable to victimization (Platzman Weinstock, 2018). Victim services staff in some roles may serve the dual purpose of supporting people who have been harmed and ensuring that victims can serve as witnesses to secure the conviction of the people who harmed them. Victim advocates may perform a variety of tasks, including helping the person they are serving navigate and understand the criminal justice system and assisting them to cope with the physical and mental harms associated with crime victimization. An advocate can work for a police department, a medical facility, a prosecutor's office, a court, or a non-profit organization (Indeed Editorial Team, 2024). The majority (nearly 90%) of victim advocates are women, about 11% are Black, and 11% identify as LGBTQ+ (Zippia, 2024f).

To some extent, the nature of an advocate's employer will dictate the advocate's role. For example, an advocate working with law enforcement will likely be sharing information they obtain with police, while an advocate at a women's shelter may be working more directly in service of the person impacted by domestic violence. A victim advocate usually needs to have a college degree. There are also certifications available to establish that the person has achieved certain levels of training and experience in the field (Indeed Editorial Team, 2023). Advocacy certification may be important (as it is in Oregon) to protect the confidentiality of communications between a working advocate and the person they are supporting (Oregon Coalition Against Domestic & Sexual Violence, 2024).

If victim services are of interest to you, watch the optional videos linked in this section. The first video (figure 10.8) shares the perspective of a domestic violence victim advocate in Vancouver, Washington, and the second (figure 10.9) offers information about victim advocacy at the U.S. Department of Homeland Security. In both cases, helping a person manage the trauma of victimization is a key component of this role.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=znCA-uY4wME

Figure 10.8. A member of the domestic violence prosecution team in Vancouver, Washington, the victim advocate in this video discusses the importance of community impact in her career choice. **Transcript.**

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=-5PpbKWkP4s

Figure 10.9. This video describes how a victim services professional works with a person who has survived traumatic victimization. **Transcript.**

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Figure 10.5. "**Justices Barrett, Sotomayor, Jackson, and Kagan**" by **Supreme Court of the United States**, is in the **Public Domain**.

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Figure 10.9. Victim Assistance Program: Sarolyn (2021) by wwwICEgov is licensed under the Standard YouTube License.

10.3 Behavioral Health Careers

There are many career paths for people interested in behavioral health as that connects with the criminal justice system. Careers in behavioral health have a range of educational and certification or licensing requirements, and, like criminal justice careers, roles can be found to fit a variety of priorities and interests. Many of the roles described in this section can be performed within correctional environments—jails or prisons—as well as in secure psychiatric settings, such as hospitals, or in the community. The Oregon Department of Corrections, for example, is regularly looking to hire professionals specializing in behavioral health, developmental disabilities, and mental health care, emphasizing the Department's constitutional obligation to provide continuous care consistent with community standards (Oregon Department of Corrections, n.d-a). Overall, behavioral health professionals are more likely to be female (69%) and white (67%), with people of color represented as follows: Hispanic (12%), Black (11%), Asian (3%), and Native American (0.4%) (Zippia, 2024a).

Mental Health Professionals

Most behavioral health jobs require some type of certification as a way of establishing that the person who holds the certification possesses and is maintaining certain knowledge, skills, and abilities (Indeed Editorial Team, 2023). Certifications vary by state, and these requirements are in addition to any education and experience requirements for particular jobs, although certifications may also require baseline levels of education and experience. For example, the QMHP (Qualified Mental Health Professional) and QMHA (Qualified Mental Health Associate) are two certifications issued by the Mental Health and Addictions Certification Board of Oregon (MHACBO) that allow a person to work at public facilities in Oregon such as jails or health organizations. The QMHA can be obtained without a bachelor's degree, while the QMHP usually requires a bachelor's degree and some graduate work. Two other Oregon certifications, the certified drug and alcohol counselor (CADC) and certified recovery mentor (CRM) are both discussed more in the next section. Although they may have slightly different names and requirements, similar certifications exist in other states, and there is some transferability among the states. If you are interested in the many types of mental health professional positions available in Oregon and would like to explore what certifications they may require, take a look at the MHACBO job listings [Website], or find the equivalent site in the state of interest to you as a way to get acquainted with the requirements there. This is a good starting place for considering education and work pathways that will lead you where you want to be.

Substance Use Counselors

Mental health professionals who specialize in substance use issues will obtain certification specific to that area of work. Again, certifications and their requirements vary by state. Many states have some variation on Oregon's version of certification for substance-use professionals, the **certified alcohol and drug counselor (CADC)**. States with similar requirements often allow reciprocity—meaning that people who move between states may be able to transfer their certification to the new state (Mental Health and Addiction Certification Board of Oregon, 2023). CADCs can be certified at different levels (I, II, or III) depending on their education and experience. The CADC I requires some coursework, along with a set minimum number of hours of supervised experience; the CADC II requires at least an associate's degree; and the CADC III requires a graduate degree. Each level of certification involves an increased minimum of hours of supervised work, as well as passage of certification exams (MHACBO, 2023).

If you are interested in a little more information about obtaining the CADC certification in Oregon, take a look at the **Portland Community College program in Addiction Counseling [Website]**, which offers multiple pathways to the CADC certification. Additionally, consider watching the optional video linked in this section (figure 10.10) to hear from an experienced drug and alcohol counselor who works at the Oregon State Hospital. The counselor describes the importance of the programs where he works and what he believes makes him successful in this role.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=IAjhBnyRp4U

Figure 10.10. This optional video describes the work of a drug and alcohol counselor who has obtained the NCAC-I (National Certified Addiction Counselor) certification, a voluntary national certification indicating a high level of experience in this field (Association for Addiction Professionals, 2024). **Transcript.**

Peer Support Workers

The important and unique role of peer support in the context of incarceration and reentry was discussed in **Chapter 7** and **Chapter 8** of this text. Like other behavioral health professionals, peer support workers, or peers, can be certified with various titles to indicate their levels of training and experience in the work that they do, including their lived experience. Peers have the key qualification of lived experience in the relevant area(s) in which they serve: as a mental health treatment consumer, as a person in recovery from a substance use disorder, or as a person with criminal justice system involvement. As with other certifications, peer certifications vary by state and are sometimes transferable to other states (MHACBO, 2023).

In Oregon, the Oregon Health Authority (OHA) oversees the training and certification required for people to serve as professional peers. If you are interested in more information about that process, take a look at the **information provided by OHA about certification of these professionals [Website]**. NAMI (the National Alliance on Mental Illness) is one OHA-approved provider of peer training. NAMI regularly offers training to people with lived mental health experience, and some of the trainings are aimed at specific groups (e.g., veterans or people who identify as LGBTQIA+) so their particular challenges and expertise can be highlighted. All of NAMI's peer training is offered at no cost and includes an emphasis on trauma-

informed care and cultural humility (National Alliance on Mental Health, n.d.).

Often, the types of professionals mentioned in this section will work in teams where each member offers their expertise. In the video linked in this section, you will hear from several behavioral health professionals and an incarcerated person participating in a co-occurring disorders program at the Columbia River Correctional Institution in Oregon (figure 10.11). The program serves people who will soon be released from custody and is a great example of the impactful professional opportunities available at the crossroads of behavioral health and criminal justice. The video includes professionals with the QMHA and QMHP certifications, one of whom is a formerly incarcerated peer professional now working at the same facility where he was incarcerated. As you watch, consider the challenges and rewards associated with working in a program like the one described.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=f2iNv9zejlo

Figure 10.11. This required video shares the perspective of a participant and several differently-certified professionals working in a prison behavioral health program that treats both substance use disorders and mental health disorders with evidence-based approaches. **Transcript.**

If the role of a peer professional is interesting to you, consider also watching an optional video that shares the experience of a peer mental health recovery specialist at the Oregon State Hospital (figure 10.12). Peers can have a significant impact when working with people who are housed in a controlled environment, in part because of the peer's ability to identify with the difficult circumstances inherent in this environment.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=ZdTckVr0hwY

Figure 10.12. This optional video describes the experience and work of a professional peer serving people receiving psychiatric care at the Oregon State Hospital. **Transcript.**

Mental Health Counselors and Social Workers

A **mental health counselor** is a professional providing treatment to someone with a mental disorder. This title is typically reserved for a state-licensed person who has at least a master's degree, along with a few years of supervised practice. Requirements for licensure vary by state. Mental health counselors may be known by slightly different titles depending on the state where they are licensed (Cherry, 2022b; OOH, 2024m). In addition to state licensure that allows a person to act as a mental health counselor, there are national certifications that indicate various levels of training and expertise. Specialized certification, such as certification to engage in addiction counseling, is available as well (National Board for Certified Counselors, 2024).

Like other mental health professionals, mental health counselors who want to work with justice-involved populations can do so in many different environments, including correctional facilities, hospitals, and community clinics. Mental health

counselors can diagnose mental disorders, as well as treat these disorders via therapy, goal-setting, problem-solving, and more (Cherry, 2022b).

A **social worker** is another professional who, in general terms, works to help people cope with various issues and problems in their lives. In this role, social workers may provide advocacy, counseling, case management, or other support to people with mental disorders who are involved in the justice system. Social workers specializing in mental health or substance abuse can both assess and treat people with these problems, engaging in therapy, skill-building, and rehabilitation services (Cherry, 2023). Social workers in these roles would have a master's degree in social work, along with a period of supervised practice and a license in social work according to the law of the state where they practice (OOH, 2024l). There are also social work-related professional roles that do not require licensing.

The optional video linked in this section (figure 10.13) relates the educational and career path of a social worker at the Oregon State Hospital. The speaker is certified as a CSWA, or clinical social work associate. This certification is for a person who is in the supervised practice stage of their career and on the path to gaining a license as a social worker who can practice independently (State of Oregon, Board of Licensed Social Workers, n.d.).

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=oBmFs8dmF5E

Figure 10.13. This optional video offers insight into the role of a social worker at the Oregon State Hospital, including the rewarding prospect of helping people leave the hospital to succeed in the community. **Transcript.**

Psychologists

Psychologists who are interested in working with justice-involved clients might take one of a few different pathways. Clinical or counseling psychologists are focused on the diagnosis and treatment of clients, while **forensic psychologists** more typically work with lawyers and the courts to help clarify the psychological aspects of a legal case by completing assessments and offering expert opinions (OOH, 2024b). In the overlap with the justice system, psychologists may work to support people with mental disorders and help them solve their problems. Also, they are frequently engaged to review information about a person, interview them, and offer an opinion or evaluation to a court, to the person's attorney, or to others on the person's treatment team to answer particular questions. For example, a psychologist may be called upon to perform an assessment to determine if a person is competent to stand trial or qualifies for the insanity defense (as discussed in **Chapter 6**). Psychological evaluations are critical to determinations such as whether a person may be civilly committed, as discussed in **Chapter 9**. Psychologists also perform evaluations that inform treatment and explain the risk of future danger (e.g., sex offender evaluations, stalking evaluations, or evaluations to look for things like signs of brain injury). Psychologists may be called upon to testify on their findings in court, or their findings may be used for treatment, or both (Cherry, 2022a).

Psychologists must be licensed to practice in the state where they work, and they typically have a doctoral degree, either a Ph.D. or Psy.D (OOH, 2024k). Forensic psychology has increased in popularity in recent years, and although there are master's-level programs available, practitioners advise that, as a practical matter, jobs in this field typically require a doctorate rather than just a master's degree. So if forensic psychology is your

interest (and it is interesting) be ready to go the distance in your schooling (Cherry, 2022a).

Watch the 5-minute video in figure 10.14 to hear from a licensed psychologist working in the restrictive setting of a psychiatric hospital. What stands out to you in this person's description of their work? Is this work that would appeal to you?

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=6g8NoIAIDrg

Figure 10.14. This optional video describes the role of a clinical psychologist who works at the Oregon State Hospital, where a primary focus is on helping people progress in managing their mental health. **Transcript.**

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Figure 10.14. **Clinical Psychologist: Careers in Mental Health** by **oshmp** is licensed under the **Standard YouTube License**.

10.4 Medical Careers

Many medical careers exist that involve caring for justice-involved people with mental disorders. Doctors, nurses, and other medical professionals who want to serve this population can be employed in jails and prisons, as well as psychiatric hospitals and community settings. Medical careers require significant education, from a minimum of a bachelor's degree for a registered nurse to a medical degree followed by years of residency and specialization programs for a physician (OOH, 2024g). Whether this work is of interest to you or not, it is important to be aware of these roles, as the people in them serve on and often lead care teams alongside the other professionals discussed in this chapter.

A **psychiatrist** is a physician who specializes in the diagnosis and treatment of mental disorders (figure 10.15). In addition to providing therapy, a psychiatrist can prescribe and oversee the use of medications, such as antipsychotic medications

or mood stabilizing medications, that treat mental disorders (discussed in Chapter 2 of this text). The ability to prescribe medications is a primary difference between psychiatrists and psychologists.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=l9URvIhGEzk

Figure 10.15. This optional video describes the role of a forensic psychiatrist working in a hospital. Forensic psychiatrists specialize in the area of psychiatry that deals with legal issues and criminally involved patients. Transcript.

Nurse practitioners have advanced nursing degrees—at least a master's degree in nursing but often a doctoral degree—and a license that qualifies them to diagnose and care for patients. Like physicians, nurse practitioners can prescribe and oversee the use of medications. They may work in a variety of settings, including hospitals, community-based mental health programs, residential settings, or controlled environments, such as prisons, jails, or psychiatric hospitals. Nurse practitioners may work with more general populations (e.g., providing primary care for adults) or they may be trained and certified in a specialty, such as psychiatric or mental health care. A **psychiatric-mental health nurse practitioner (PMHNP)** is specially trained and licensed to provide psychiatric care, including diagnosing mental disorders and prescribing psychiatric medications (e.g., antipsychotic medications or mood stabilizing medications to treat disorders like schizophrenia or bipolar) as part of their patient-care role (Oregon Health & Science University, 2023). Nurse practitioners will consult with physicians as necessary, but they can and do practice independently (OOH, 2024e).

Two optional videos describing the role of a nurse practitioner are linked here. The first video shares the experience of a nurse practitioner who enjoys her work in a prison setting (figure 10.16). The second offers the perspective of a psychiatric-mental health nurse practitioner who works in a psychiatric hospital (figure 10.17).

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=TyHO0HYG8z0

Figure 10.16. The nurse practitioner in this optional video shares the importance of her meaningful contribution as a care provider in a women's prison. Transcript.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=Iv_4Q6wTssA

Figure 10.17. This optional video describes the important work of a psychiatric nurse practitioner at the Oregon State Hospital. Transcript.

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Figure 10.16. "Within the Walls: Nurse Practitioner – Women's Prison" by Ohio DRC is licensed under the Standard YouTube License.

Figure 10.17. Psychiatric Nurse: Careers in Mental Health by oshmp is licensed under the Standard YouTube License.

10.5 Career Rewards and Challenges

Working in the criminal justice system or in a behavioral health field—or a combination of the two—can be extremely interesting and rewarding. As you have heard in the many videos shared in this chapter, or as you may already know from your own interests and experiences, people who work in service or "helping" careers tend to do so because the work holds meaning for them. They want to improve others' lives and make an impact in their communities.

Compassion Satisfaction

The emotional reward that comes from helping others through work is sometimes referred to as **compassion satisfaction** (figure 10.18). The concept of compassion satisfaction puts a name to a feeling you likely already know, and it recognizes that people derive pleasure from helping others and contributing to their communities alongside like-minded colleagues (The Center for Victims of Torture, 2021).

Figure 10.18. This illustration contains a quotation attributed to the Dalai Lama: "If you want others to be happy, practice compassion. If you want to be happy, practice compassion."

People in helping careers can work to grow their compassion satisfaction (which is a protective factor against the negative aspects of these jobs) by being aware of this concept and welcoming it. Specifically, a worker in a helping role should be "mindful of the experiences that can generate [compassion satisfaction], such as opportunities to 'make a difference,' difference-making being a key predictor of compassion satisfaction" (Stoewen, 2021). To maximize our satisfaction from work, we should intentionally savor "the

hope, joys, and rewards, and the sense of meaning and purpose within our work; and the relationships that we take pleasure in, with coworkers, clients, and patients. . . . Whether held close to the heart as quiet acknowledgments or shared openly with others, deepening these experiences can grow one's compassion satisfaction" (Stoewen, 2021). In other words, know that having and working hard at an impactful career can and should bring you fulfillment; recognize and enjoy it.

Workplace Trauma

While helping careers do bring great rewards, they can also bring challenges. One of these is the experience of trauma. Trauma has been discussed throughout this text as it relates to diagnoses (**in Chapter 2**) and as it relates to justice-involved people, who have often experienced a great deal of trauma. Individual trauma arising from personal experience is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as follows: "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2014). Note that other forms of trauma exist as well; communities can be traumatized, and trauma can become part of a group's culture and be passed from parent to child as intergenerational trauma (SAMHSA, 2014). The people most at risk of intergenerational trauma are those who have experienced serious forms of abuse, oppression, or racial inequities. Examples are Holocaust survivors or displaced Native Americans (Dixon, 2021). These aspects of trauma are separate from the individual workplace trauma discussed here, but they can be part of a person's entire experience that impacts how they respond to life events. If you are interested, you can learn more about **intergenerational trauma here [Website]**.

Some of the jobs discussed in this text come with the risk of directly traumatic and stressful events. Direct trauma involves an event that directly happens to or is witnessed by the person. For example, a first responder who goes to the scene of a horrific car crash may experience direct trauma from what they witness at the scene; likewise, a person in the car crash may have direct trauma from that experience. In contrast, someone who hears about the crash on the news or sees images in reports may have indirect trauma from that intake of information (Tend, n.d.). Direct and indirect trauma tend to have different impacts on the people who experience them, but both can be harmful.

Post-Traumatic Stress from Workplace Trauma

Post-traumatic stress disorder (PTSD), a diagnosis discussed in **Chapter 2**, stems from directly traumatic events. PTSD is generally not common, but it is far more prevalent in first responders, such as law enforcement officers, than in the general public because these workers are more likely than other people to experience direct trauma in the form of violent encounters and/or witnessing horrific events and scenes (Violanti, 2018). For example, police officers see abused children, dead bodies, and severe assaults, and they may themselves be involved in life-threatening situations, including shootings. These are all direct traumas that can give rise to the distressing symptoms of PTSD (figure 10.19) (Violanti, 2018). PTSD may be diagnosed in up to 19% of police officers (Douglas Otto & Gatens, 2022). PTSD is also startlingly common in the high-stress world of correctional officers, where up to a quarter of officers are thought to have some indications of the disorder

(Dawson, 2019). Interestingly, abusive behavior conducted by officers themselves is also associated with higher rates of officer PTSD. This evidence not only suggests a (possibly underestimated) route to officer trauma but also provides yet another incentive to reduce officer violence in community and corrections environments (DeVylder et al., 2019).

Figure 10.19. Police officers and other front-line criminal justice professionals are regularly exposed to direct trauma events, increasing the risk for problems like post-traumatic stress disorder.

A special concern with the experience of direct trauma and development of PTSD in criminal justice professionals is that PTSD can result in behavioral problems like substance abuse, aggression, and self-harm, as well as impairment of rapid decision-making capability (e.g., what tactics to use in a particular tense situation). There are clear risks to self and others that these problems could present in armed professionals tasked with resolving complex problems and crises in the community, as well as in prisons or jails (Violanti, 2018). Police officers, tragically, have higher suicide rates than other professionals, and one of the contributing factors to this risk is repeated exposure to trauma (figure 10.20) (National Consortium on Preventing Law Enforcement Suicide, 2023).

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=sFDq2xOLILQ

Figure 10.20. The optional, but recommended, 5-minute video linked here shares the story of a former Chicago police officer who experienced trauma in her job and describes how that impacted her and why she did not seek treatment. Note that the video discusses the frequency of officer suicide. **Transcript.**

See the Spotlight in this chapter on Compassion Satisfaction and Fatigue in Law Enforcement for more information on the topic of officer trauma.

Effects of Indirect Trauma at Work

Just as direct trauma can give rise to certain problems, indirect trauma in the workplace—especially when exposure is repeated—can have negative effects on the people in the careers discussed here. Workers in the fields of law enforcement, corrections, and behavioral health may routinely hear about or examine evidence of others' trauma, violence, or victimization. Workers may also engage with and emotionally invest in people with extremely challenging and sometimes entrenched life circumstances. These events are all normal parts of the helping careers, but they can be upsetting and frustrating. Over time, these events and the responses they evoke can have a cumulative negative effect on the professionals who experience them. The side effects of absorbing others' pain are sometimes referred to as a "cost of caring." The empathy and compassion that make workers good at their helping roles and allow them to derive such satisfaction from their work can also make them vulnerable to being harmed by their jobs (Mathieu, 2019).

Some terms commonly used to discuss the impacts of indirect trauma in the workplace are *vicarious traumatization*, *compassion fatigue*, and *secondary traumatic stress*. These terms describe related but distinct concepts.

- **Vicarious traumatization** can occur when a person in a helping career (e.g., victim services, law enforcement) is continuously exposed to victims of trauma and violence. This repeated exposure to others' trauma changes the worldview of the worker in a negative way (Office for Victims of Crime, n.d.). People experiencing vicarious traumatization notice that their fundamental beliefs have changed so that they see the world differently than they did before (Mathieu, 2019).
- **Compassion fatigue** occurs when a person in a helping profession is physically and emotionally depleted by caring for others who are in significant distress, leading to a lack of compassion and empathy. Compassion fatigue occurs when helpers are unable to properly refuel and recover (Office for Victims of Crime [OVC], n.d.; Mathieu, 2019).
- **Secondary traumatic stress** is a term used to describe situations where workers in high-stress fields (e.g., child abuse investigators, prosecutors, therapists, shelter workers) who experience indirect trauma are impacted in a way more commonly associated with direct trauma, that is, exhibiting symptoms similar to post-traumatic stress disorder (e.g., depression, despair, hypervigilance) (Tend, n.d.).

As examples of how these problems can occur, imagine a person who works as a child abuse prosecutor and regularly hears and reads accounts of severe, unthinkable abuse of children. The person feels very disturbed by all of this information, to the point that it interferes with their sex life and their ability to trust that their own children are safe. That is an example of *vicarious traumatization*; the person's feelings about the world are shifting in a negative way. The person might also have some of the symptoms experienced by people who are directly impacted by trauma, such as feeling hopeless or having trouble concentrating (figure 10.21). This might be termed *secondary traumatic stress*. If the person also stops being able to talk with and sympathize with a coworker or a friend who is having a hard time, they may additionally be experiencing *compassion fatigue* (Mathieu, 2019).

Figure 10.21. People in the helping professions—criminal justice, behavioral health, medical, and others—may experience direct and/or indirect trauma that can lead to negative outcomes.

As a practical matter, the terms *secondary trauma* and s*econdary traumatic stress* are often used interchangeably with the terms *vicarious traumatization* and *compassion fatigue*, and they all refer to the negative impacts of indirect trauma. These are terms to be aware of, but the key concept for purposes of this text is that indirect trauma at work can be harmful, and that can play out in different ways (Tend, n.d.).

Workplace Burnout

Yet another term used to describe a serious workplace problem is **burnout**. Burnout is a state of physical and mental exhaustion in which a worker is not experiencing satisfaction and fulfillment from their job (figure 10.22). A person experiencing burnout may feel depressed, cynical, and bored (OVC, n.d.). They may also feel detached or emotionally distant, with a loss of empathy for the people they are supposed to help, a process that is sometimes called **depersonalization** (discussed more in the video linked in figure 10.24) (SAMHSA, 2022). Burnout may overlap with compassion fatigue and vicarious traumatization, but it is different in significant ways. A person with burnout has not necessarily lost the ability to feel compassion, nor has their worldview changed. It's a very job-specific problem that can often be remedied by a job change or perhaps by a break from the job in question (Mathieu, 2019).

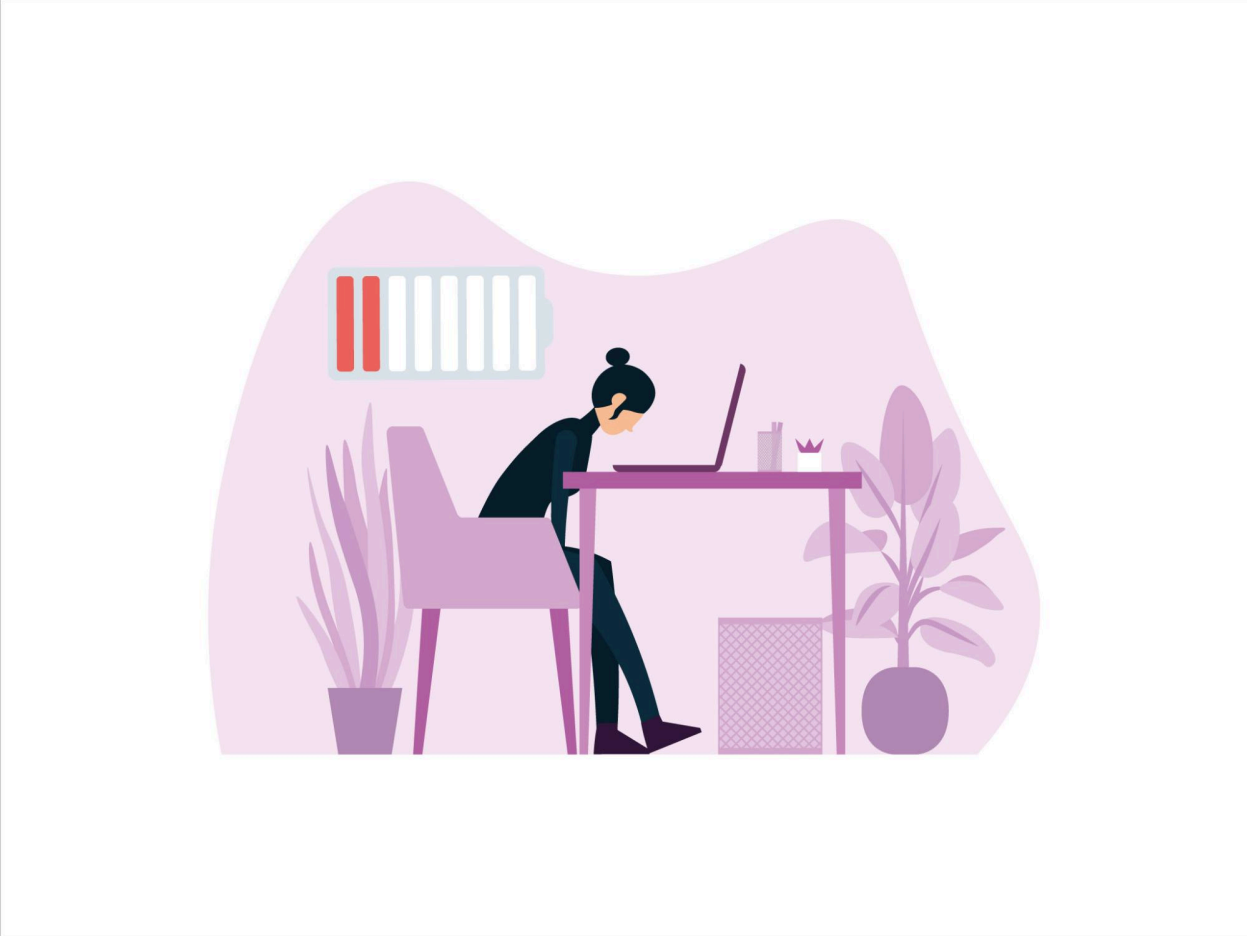

Figure 10.22, The concept of burnout can be illustrated as a depletion of one's "battery," with the battery symbolizing resources that make a job meaningful. Burnout may be combined with other issues, but it is a job-specific problem.

The concepts introduced here are complicated and important. The two videos linked in this section are required viewing and offered to expand upon and explain the ideas in this section. The first video (figure 10.23) offers a clear explanation of the concepts of compassion fatigue, vicarious traumatization, and burnout—as well as a mention of *compassion resilience*, another term related to compassion satisfaction discussed earlier in this chapter. As you watch, listen for and consider how and why criminal justice professionals may be particularly vulnerable to experiences of trauma, in different ways perhaps than behavioral health professionals. The second video (figure 10.24) provides additional discussion about the specific problem of burnout and how to address this problem. Although this video is not a criminal justice or behavioral health career-specific perspective, consider how the information offered would relate to the careers we discuss in this text.

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=aS7Rk5RFF20

Figure 10.23. This required 7-minute video explains several of the concepts discussed in this section, provided by Dr. Lisa Callahan, a scholar and expert in the fields of criminal justice and mental health. **Transcript.**

This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=VMbhM59K5FQ

Figure 10.24. This required 7-minute video explains the concept of burnout, including how burnout manifests, the terminology associated with burnout (including the term *depersonalization*), and how to address and resolve burnout. **Dr. Laurie Santos [Website]** is a Yale psychology professor who is an expert in the science of happiness. **Transcript.**

If you are interested in exploring these topics further, consider starting with this optional (but excellent) **TED Talk "Beyond the Cliff" by author and founder of the Trauma Stewardship Institute Laura van Dernoot Lipsky [Streaming Video]**. In the video, van Dernoot Lipsky discusses the cumulative toll people may experience from absorbing suffering around them, whether that is from personal caregiving, experiencing workplace trauma, or contending with worldwide crises such as global climate change.

SPOTLIGHT: Compassion Satisfaction and Fatigue in Law Enforcement

Police officers have a complex and varied job. In addition to performing routine duties and interacting with the public, they respond to the scenes of heinous crimes and bring order to chaos. Myriad situations require them to provide emotional support to people impacted by crime or survivors of catastrophic events. When victims experience chaotic and horrendous incidents, police officers often represent the most reliable and prominent sources of order, information, and support at the scene.

Compassion satisfaction refers to the gratification that officers derive from helping those who suffer. Officers and other frontline professionals who experience compassion satisfaction feel a greater sense of success and increased motivation because they can appreciate the value that their services add to the community and the lives of individuals. Additionally, police officers with high levels of compassion satisfaction tend to be more committed to their duties and have greater levels of self-perceived well-being. Fortunately, many police officers report high levels of compassion satisfaction.

Officers also may experience adverse effects over time. The term *compassion fatigue* is often used to describe the costs that accrue in frontline personnel as a result of caring for those who suffer. It is estimated that compassion fatigue may affect around a quarter of police officers in the United States. Compassion fatigue in police officers develops due to prolonged exposure to traumatized people, and it can result in an officer becoming emotionally detached or numb in the face of others' suffering. Within the context of police work, compassion fatigue relates to officers' powerful desire to help or save others and to perform their duties in a manner that makes such individuals feel better and safe. However, officers' realistic ability to do this in many cases is limited. For example, officers serving in child exploitation units may experience symptoms of compassion fatigue as a result of providing abused children with long-term support during investigations (figure 10.25).

Figure 10.25. Police officers can experience both compassion satisfaction and compassion fatigue as a result of the important and challenging work they do.

Significantly, compassion fatigue—if left untreated—can worsen and have an incapacitating impact on frontline professionals' well-being, decision-making ability in critical situations, and overall job performance. Compassion fatigue may adversely impact officers' relationships with family and friends because its effects cannot be left at work. For example, what officers experience in the line of duty regarding others' suffering may lead to emotional numbness or isolation. These "underground" emotions may reemerge in multiple problematic ways, including isolation from family, alcohol abuse, and difficulty controlling frustration and anger during interactions with others. Compassion fatigue is understood to be a precursor to post-traumatic stress disorder, and some of the symptoms are similar (Bosma & Henning, 2022).

Perhaps unsurprisingly, compassion satisfaction is negatively associated with compassion fatigue—that is, an increase in one appears to correlate with a decrease in the other. It may be that compassion fatigue symptoms (e.g., feeling overwhelmed, hypervigilant, irritable) preclude officers from experiencing compassion satisfaction. Officers with high levels of compassion satisfaction may better appreciate the importance of their services despite their exposure to overwhelming experiences. Using various techniques to strengthen compassion satisfaction may thus reduce the experience of compassion fatigue.

Several approaches foster police officer wellness and help build work-related satisfaction:

- **Practicing self-care.** Officers should be taught, as part of their police training, methods of effective self-care, such as controlled breathing, mindfulness, and journaling.
- **Appreciating the positives.** Departments should develop programs that identify and celebrate achievements and moments of gratitude. Police officers may view these positives as routine parts of their work, but they benefit from taking time to reflect upon and feel grateful for the services they provide for their communities.
- **Training around trauma.** Police organizations should emphasize training for law enforcement professionals that allows them to better respond to people who have been traumatized. Increasing police knowledge and enhancing responses helps officers achieve greater confidence and a sense of effectiveness, leading to professional satisfaction.
- **Peer Support.** Officers often need help but hesitate to request or accept it. Peer support programs may be one solution. An officer may be more comfortable approaching a peer who understands the context and has experienced the same stressors (Community Policing Dispatch, 2023).

Building Resilience

Counteracting burnout and problems associated with indirect trauma is more likely when professionals are aware of risks and proactive in maintaining protective factors. Certainly, recognizing and using the power of compassion satisfaction to stay energized and positively connected to our work can counterbalance negatives in the workplace (Stoewen, 2021). When negatives do occur, **resilience** is key to minimizing their impacts. Resilience is the process of adapting well in the face of adversity or significant stress (figure 10.26) (OVD, n.d.).

Figure 10.26. A flower surviving, even thriving, despite harsh conditions shows resilience.

Resilience is not an innate quality; rather, resilience involves using internal and external resources and strategies to adapt to adverse events or conditions. A resilient person might regularly draw upon their personal sense of optimism (an internal resource) as well as a wise mentor (an

external resource) and use strategies such as maintaining work-life balance and engaging in self-care (discussed below) (Stoewen, 2021). Additionally, just as a person can absorb others' trauma, they can also experience **vicarious resilience**, which is when one benefits from the secondhand experience of others' success in overcoming adversity. Vicarious resilience is a positive and empowering—rather than negative—result of witnessing the experience of someone who has been through trauma and emerged a survivor. (OVC, n.d.; Killian, 2023). "[Resilience] is actually a learned competency; one that—with awareness, intentional pursuits, and lived experience—can be strengthened over time" (Stoewen, 2021). Highly resilient people "are able to remain stable and function well during stress and recover from stress. They can 'bounce back' from difficult experiences and move on despite the challenges" (Stoewen, 2021).

One key to building resilience—and maintaining the ability to care for others—is the practice of **self-care** (Stoewen, 2021). Self-care refers to deliberate actions and behaviors that enhance mindfulness and well-being. Take a look at the "Tiny Survival Guide" reproduced in figure 10.27. This resource was created by the Trauma Stewardship Institute and offers several strategies for self-care. Consider what strategies you might employ, now or in the future, to maintain your health.

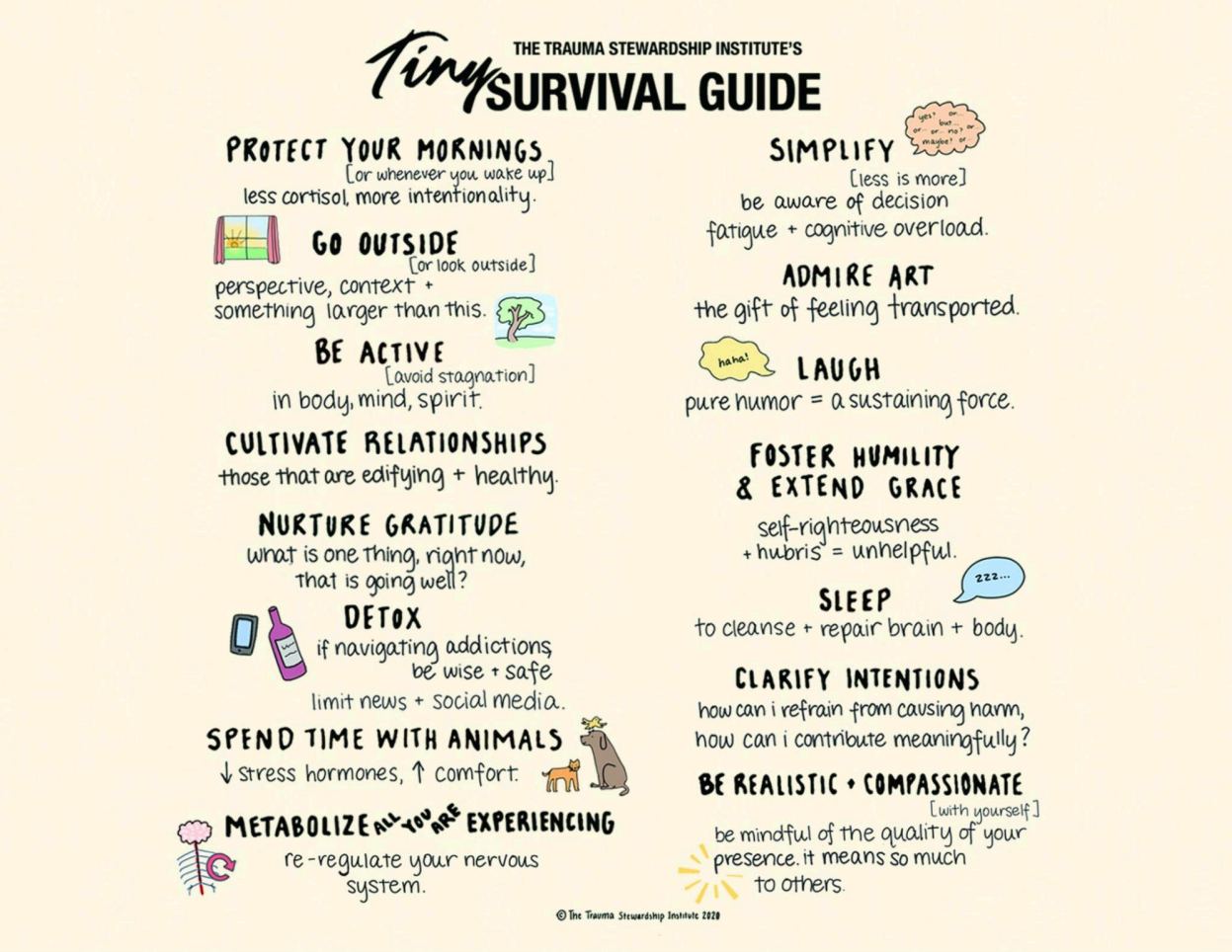

Figure 10.27. Tips for self-care from the Trauma Stewardship Institute. Image description available. **Image description.**

Although workers need to do what they can to remain healthy and cope with the realities of a career in "helping," it is also true that individual workers are limited in what they can do for themselves. Employers and organizations are, ultimately, determinative of the workplace environment. Organizations that rely upon the labor of people in helping professions need to support their workers in managing their exposure to trauma and provide ongoing education and support around these issues (Mathieu, 2019).

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Figure 10.18. "If you want others to be happy, practice compassion. If you want to be happy, practice compassion" by Nick Kenrick is licensed under CC BY-NC-SA 2.0.

Figure 10.19. "Compassion Fatigue Among Officers" by FBI LEB is in the Public Domain.

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Figure 10.22. "Woman Suffers Burnout At Work.jpg" by CIPHR, is licensed under CC BY 2.0.

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Figure 10.20. "A Psychologist and Former Officer on Mental Health and Suicide | We Are Witnesses" by The Marshall Project is licensed under the Standard YouTube License.

Figure 10.23. "Recognizing Compassion Fatigue, Vicarious Trauma, and Burnout in the Workplace" by Policy Research Associates, Inc is licensed under the Standard YouTube License.

Figure 10.24. "3 signs that you've hit clinical burnout and should seek help" by Big Think is licensed under the Standard YouTube License.

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Figure 10.26. "Sprout makes way through sand" is designed by FreePik.

Figure 10.27. "Tiny Survival Guide" © the Trauma Stewardship Institute is all rights reserved and included with permission.

10.6 Chapter Summary

- Numerous careers in the fields of criminal justice, behavioral health, and medicine involve working with and caring for justice-involved people who experience mental disorders.
- The careers discussed in this chapter span several fields and represent the spectrum of

educational and experience requirements. There are innumerable ways to be involved in a career that serves the people and systems discussed in this text.
- The work described in this text comes with great potential rewards for dedicated professionals who desire the opportunity to contribute to their communities.
- Careers in the service and helping professions carry risks as well as benefits, including exposure to direct and indirect traumatic experiences, which can give rise to many problems. Maximizing job benefits and building resilience are critical protective strategies for maintaining a satisfying and productive work life.
- Organizations that employ helping professionals must support their workers and create healthy, safe workplaces.

KEY TERM DEFINITIONS

- **Burnout:** A state of physical, emotional, and/or mental exhaustion where a worker is not experiencing satisfaction and fulfillment from their job.
- **Certified alcohol and drug counselor (CADC):** State certification for a professional who provides substance use counseling, also known as addiction counseling.
- **Compassion fatigue:** A state of physical and emotional depletion for a person in a helping profession, where caring for others in significant distress without the opportunity to adequately recover leads to a lack of compassion and empathy.
- **Compassion satisfaction:** The emotional reward that comes from helping others through work.
- **Correctional officer:** An officer who has oversight of the prison and jail inmate populations and works to reduce or prevent any security risks.
- **Criminal defense attorney:** A lawyer who defends people accused of crimes in criminal court, hired privately or by the government as a public defender.
- **Depersonalization**: The experience of becoming detached, emotionally distant, and losing empathy that is associated with workplace burnout.
- **Forensic psychologist:** A specialized psychologist who provides services within the legal system, such as completing psychological assessments and offering expert opinions on civil or criminal legal matters.
- **Mental health counselor:** A professional providing treatment to someone with a mental disorder or related symptoms.
- **Probation officer:** An officer who supervises people convicted of crimes who are placed on community supervision instead of or after a period of jail incarceration. Probation officers ensure that supervisees adhere to court-imposed conditions of release from custody.
- **Prosecutor**: A lawyer who represents the government in criminal matters against people accused of crimes.
- **Psychiatric-mental health nurse practitioner (PMHNP):** A nurse practitioner with special training and licensure to provide psychiatric care, including prescribing psychiatric medications (e.g., antipsychotic medications) as part of their patient-care role.

- **Psychiatrist:** A physician who specializes in the diagnosis and treatment of mental disorders. Psychiatrists can specialize as forensic psychiatrists to work in areas connected to the criminal justice system.
- **Secondary traumatic stress:** A phenomenon that occurs when service providers experience indirect, or secondary, trauma, yet experience symptoms similar to post-traumatic stress disorder, a condition associated with direct traumatic experiences.
- **Self-care:** Deliberate actions and behaviors taken to enhance mindfulness and well-being.
- **Social worker:** A professional who helps people manage problems in their lives. Work can involve an array of services, from advocacy to counseling to case management.
- **Vicarious resilience:** The positive and empowering impact of experiencing others' success in overcoming adversity.
- **Vicarious traumatization:** When one's worldview shifts after providing direct care to people who have experienced trauma.
- **Victim advocate:** A professional who provides direct services to victims of crime, often in community settings as a support person or in the context of court cases to ensure access to victims' rights, such as notification of hearings.

DISCUSSION QUESTIONS

- Are there roles in the criminal justice system or in behavioral health that appeal to you? What aspects of these jobs are appealing, and what concerns might you have about pursuing one of these careers?
- How do the roles that interest you involve interaction with people with mental disorders? Can you think of ways that those interactions may bring satisfaction and present challenges to the engaged professional?
- In your future (or current) career, what measures or actions will you take, or are you taking, to care for your mental health? How might/do these activities make you more effective at your job?
- How can trauma impact police officers? How can/should these issues be addressed?

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10.7 References

American Bar Association. (2022, August, 1). *New report on profession focuses on judicial demographics*. https://www.americanbar.org/news/abanews/aba-news-archives/2022/08/new-report-on-profession/

Association for Addiction Professionals. (2024). *National certified addiction counselor, Level 1 (NCAC 1)*. https://www.naadac.org/ncac-i

Berg, S. (2023, May 23). Terms every doctor should know about physician burnout. *American Medical Association, Physician Health.* https://www.ama-assn.org/practice-management/physician-health/terms-every-doctor-should-know-about-physician-burnout.

Bosma, L. J. & Henning, S. L. (2022, June 6). *Compassion fatigue among officers*. FBI Law Enforcement Bulletin [LEB]. https://leb.fbi.gov/articles/featured-articles/compassion-fatigue-among-officers

Campisi, J., & Griggs, B. (2022, March 24). *Of the 115 supreme court justices in US history, all but 7 have been white men*. News Channel 21, KTVZ. https://ktvz.com/politics/cnn-us-politics/2022/03/24/of-the-115-supreme-court-justices-in-us-history-all-but-7-have-been-white-men/

The Center for Victims of Torture. (2021). *Compassion satisfaction*. Professional Quality of Life. https://proqol.org/compassion-satisfaction

Cherry, K. (2022a). *Forensic psychology career profile*. https://www.verywellmind.com/forensic-psychology-careers-2795639

Cherry, K. (2022b). *Mental health counselor training, skills, and salary*. https://www.verywellmind.com/what-is-a-mental-health-counselor-4157925

Cherry, K. (2023, November 30). *What does a social worker do?* https://www.verywellmind.com/what-is-a-social-worker-2795656

Community Policing Dispatch [COPS Office]. (2023, February). *Peer support for officer wellness*. https://cops.usdoj.gov/html/dispatch/02-2023/OSW_peer_support.html

Dawson, J. (2019, April 8). *Fighting stress in the law enforcement community*. National Institute of Justice [NIJ]. https://nij.ojp.gov/topics/articles/fighting-stress-law-enforcement-community

DeVylder, J., Lalane, M. & Fedina, L. (2019). The association between abusive policing and PTSD symptoms among U.S. police officers. *Journal of the Society for Social Work and Research, (10)*2. https://www.journals.uchicago.edu/doi/epdf/10.1086/703356

Dixon, E. (2021, July 3). Breaking the chains of generational poverty. *Psychology Today*. https://www.psychologytoday.com/us/blog/the-flourishing-family/202107/breaking-the-chains-generational-trauma

Douglas Otto, H. & Gatens, A. (2022, May 24). *Understanding police officer stress: A review of the literature*. Illinois Criminal Justice Information Authority [ICJIA]. https://icjia.illinois.gov/researchhub/articles/understanding-police-officer-stress-a-review-of-the-literature

Government Accountability Office [GAO] Highlights. (2018, February). *DHS and DOJ are working to enhance reponses to incidents involving individuals with mental illness* [GAO-18-229]. https://www.gao.gov/assets/gao-18-229-highlights.pdf

Indeed Editorial Team. (2023, March 10). *10 behavioral health certifications to consider*. https://www.indeed.com/career-advice/career-development/behavioral-health-certifications

Indeed Editorial Team. (2024, April 18). *How to become a victims advocate (With Career path info)*. https://www.indeed.com/career-advice/finding-a-job/how-to-become-victims-advocate

Killian, K. D. (2023, September 20). Happiness correlates with self-care and vicarious resilience. *Psychology Today*. https://www.psy-

chologytoday.com/us/blog/intersections/202309/happiness-correlates-with-self-care-and-vicarious-resilience

Ludwig, G. (2021, August 26). *Mental health response teams: It's time to add them to our growing list of responsibilities*. FireRescue1. https://www.firerescue1.com/fire-products/fitness-mental-health-wellness/articles/mental-health-response-teams-its-time-to-add-them-to-our-growing-list-of-responsibilities-6H533CgwV6i4B4pa/

Mathieu, F. (2019). *What is compassion fatigue?* https://www.tendacademy.ca/what-is-compassion-fatigue/

Mental Health and Addiction Certification Board of Oregon [MHACBO]. (2023). *Certifications*. https://www.mhacbo.org/en/certifications/

National Alliance on Mental Health [NAMI]. (n.d.). *Peer Support Specialist training*. https://www.namimultnomah.org/peer-support-specialist-training

National Board for Certified Counselors. (2024). *National certified counselor (NCC)*. https://www.nbcc.org/certification/ncc

National Consortium on Preventing Law Enforcement Suicide. (2023). *National consortium on preventing law enforcement suicide, 2023 report and recommendations*. International Association of Chiefs of Police [IACP] and Education Development Center [EDC]. https://www.theiacp.org/sites/default/files/2023%20Report.pdf

The National Institute for Occupational Safety and Health [NIOSH]. (n.d.). *Correctional Workers Safety, Who are correctional officers?* Centers for Disease Control and Prevention. https://www.cdc.gov/niosh/corrections/about/index.html#cdc_environmental_basics_definition_about-who-are-correctional-officers

Occupational Outlook Handbook [OOH]. (2024a). *Correctional officers and bailiffs, What correctional officers and bailiffs do*. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/protective-service/correctional-officers.htm#tab-2

Occupational Outlook Handbook [OOH]. (2024b). *Forensic Science Technicians*. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/life-physical-and-social-science/forensic-science-technicians.htm

Occupational Outlook Handbook [OOH]. (2024c). *Judges and hearing officers*. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/legal/judges-and-hearing-officers.htm

Occupational Outlook Handbook [OOH]. (2024d). *Lawyers*. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/legal/lawyers.htm

Occupational Outlook Handbook [OOH]. (2024e). *Nurse anesthetists, nurse midwives, and nurse practitioners, What nurse anesthetists, nurse midwives, and nurse practitioners do*. U.S. Bureau of Labor Statistics https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm#tab-2

Occupational Outlook Handbook [OOH]. (2024f). *Paralegals and Legal Assistants*. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/legal/paralegals-and-legal-assistants.htm

Occupational Outlook Handbook [OOH]. (2024g). *Physicians and surgeons, How to become a physician or surgeon*. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-4

Occupational Outlook Handbook [OOH]. (2024h). *Police and Detectives*. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/protective-service/police-and-detectives.htm

Occupational Outlook Handbook [OOH]. (2024i). *Probation officers and correctional treatment specialists*. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/community-and-social-service/probation-officers-and-correctional-treatment-specialists.htm#tab-1

Occupational Outlook Handbook [OOH]. (2024j). *Probation officers and correctional treatment specialists. What probation officers and correctional treatment specialists do*. U.S. Bureau of Labor

Statistics. https://www.bls.gov/ooh/community-and-social-service/probation-officers-and-correctional-treatment-specialists.htm#tab-2

Occupational Outlook Handbook [OOH]. (2024k). *Psychologists, How to become one*. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm#tab-4

Occupational Outlook Handbook [OOH]. (2024l). *Social workers, How to become a social worker*. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/community-and-social-service/social-workers.htm#tab-4

Occupational Outlook Handbook [OOH]. (2024m). *Substance abuse, behavioral disorder, and mental health counselors. How to become a substance abuse, behavioral disorder, or mental health counselor*. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm#tab-4

Office for Victims of Crime [OVC]. (n.d.). *The vicarious trauma toolkit, What is vicarious trauma?* U.S. Department of Justice. https://ovc.ojp.gov/program/vtt/glossary-terms#glossary-of-terms

Oregon Coalition Against Domestic & Sexual Violence. (2024). *Advocate certification and training requirements*. https://www.ocadsv.org/resources/advocate-certification-and-training-requirements/

Oregon Department of Corrections. (n.d-a). *Careers, Learn about job opportunities at Oregon DOC, Work for health services*. https://www.oregon.gov/doc/careers/Pages/health-services-jobs.aspx

Oregon Department of Corrections. (n.d-b). *Minimum qualifications for a correctional officer. State of Oregon.* https://www.oregon.gov/doc/careers/Pages/correctional-officer-qualifications.aspx

Oregon Health & Science University, School of Nursing. (2023). *Psych Mental Health Nurse Practitioner*. https://www.ohsu.edu/school-of-nursing/psych-mental-health-nurse-practitioner

Oregon Paralegal Association. (2024, March 8). *Oregon begins licensing paralegals through the Oregon State Bar*. https://www.oregonparalegals.org/news/13326878

Platzman Weinstock, C. (2018, June 1). Risk of being a crime victim goes up with mental illness diagnosis. https://www.reuters.com/article/idUSKCN1IX5W1/

State of Oregon, Board of Licensed Social Workers. (n.d.). *Clinical social work associate information*. https://www.oregon.gov/blsw/pages/cswainformation.aspx

Stoewen, D. L. (2021, November). *Moving from compassion fatigue to compassion resilience, Part 5: Building personal resilience*. National Library of Medicine, Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8543697/

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014, July). SAMHSA's concept of trauma and guidance for the trauma-informed approach. https://store.samhsa.gov/sites/default/files/sma14-4884.pdf

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2022). *Addressing burnout in the behavioral health workforce through organizational strategies* [Publication No. PEP22-06-02-005]. https://store.samhsa.gov/sites/default/files/pep22-06-02-005.pdf

Tend. (n.d.). *Defining vicarious trauma and secondary traumatic stress*. https://www.tendacademy.ca/resources-2/defining-vicarious-trauma-and-secondary-traumatic-stress/

U.S. Census Bureau. (2022). *DP05, ACS 1-year estimates data profiles*. https://data.census.gov/table?q=DP05

Violanti, J. (2018, May). *PTSD among police officers: Impact on critical decision making*. Office of Community Oriented Policing Services [COPS Office]. https://cops.usdoj.gov/html/dispatch/05-2018/PTSD.html

Zippia. (2024a). *Behavioral health professional demographics and statistics in the*

US. https://www.zippia.com/behavioral-health-professional-jobs/demographics/

Zippia. (2024b). *Correction officers*. https://www.zippia.com/correction-officer-jobs/demographics/

Zippia. (2024c). *Police officer demographics and statistics in the US*. https://www.zippia.com/police-officer-jobs/demographics/

Zippia. (2024d). *Probation and parole officer demographics and statistics in the US*. https://www.zippia.com/probation-and-parole-officer-jobs/demographics/

Zippia. (2024e). *Prosecutor demographics and statistics in the US*. https://www.zippia.com/prosecutor-jobs/demographics/

Zippia. (2024f). *Victim advocate demographics and statistics in the US*. https://www.zippia.com/victim-advocate-jobs/demographics/#

Glossary

Ableism
Discrimination against, exclusion of, or devaluation of people with disabilities.

Adverse childhood experiences (ACEs)
Potentially traumatic events that occur in childhood (0 to 17 years), such as experiencing violence, abuse, or neglect.

Affirmative defense
A type of defense requiring production of evidence by the defendant, rather than the state. Examples include the defenses of self-defense or insanity.

Aid and assist
Another term for competence to stand trial. A person's ability to work with (or "aid and assist") their defense attorney is a key element of competence to proceed in a criminal case.

Alcohol use disorder
Substance use disorder that involves recurrent use of alcohol, despite significant impairment or problems associated with continued use.

Americans with Disabilities Act (ADA)
A civil rights law that prohibits discrimination against people on the basis of disability.

Anosognosia
A lack of awareness or insight into one's own mental disorder diagnosis and related needs.

Antipsychotic medications
Medications that treat psychosis, a debilitating aspect of mental illness that impacts a person's ability to distinguish what is real.

Anxiety disorders
A category of disorders characterized by excessive and persistent fear and related disturbances in behavior. There are multiple types of anxiety disorders.

APIC Framework
A set of guidelines for ensuring people in custody receive treatment that continues and is effective across transitions. The APIC framework includes four steps: Assessment, Planning, Identifying, and Coordinating treatment.

Assertive community treatment (ACT):
A community-based model of care where mental health services are provided in a person's home or in a community location. ACT has the goal of keeping people with serious mental disorders in the community and trying to decrease hospital admittance.

Assessment
A followup evaluation triggered by a screening that flags a potential problem or issue. An assessment is more in-depth than a screening, is performed by a mental health professional, and informs the facility about the services a person will need.

Asylum
Facilities that were originally intended as a refuge for confinement and care of those with mental disorders and served in Europe and America as precursors to mental hospitals and psychiatric facilities.

Behavioral health
A term used to include treatment of both mental health conditions and substance use disorders. Behavioral health providers may include psychologists, medical professionals, peers, therapists, social workers, and other medical and non-medical professionals who help manage and support behavioral health issues.

Beyond a reasonable doubt
The legal standard of proof in criminal cases. Proof at this level includes overwhelming evidence that leaves no significant doubt in the minds of decision makers.

Burden of proof
The amount or level of evidence required to prevail in a particular legal case. The burden of proof in a criminal case is "beyond a reasonable doubt," and in most civil cases it is "by a preponderance of the evidence."

Burnout
A state of physical, emotional, and/or mental exhaustion where a worker is not experiencing satisfaction and fulfillment from their job.

Case management
Supporting clients by planning, coordinating and connecting them to services (health care, mental health care, substance use treatment, and social services) to address their needs and goals.

Certified alcohol and drug counselor (CADC)
State certification for a professional who provides substance use counseling, also known as addiction counseling.

Civil commitment
A court order requiring involuntary treatment, and sometimes confinement, for a person who has become unsafe due to a mental disorder.

Civil Rights
Personal rights guaranteed and protected by the Constitution and federal laws enacted by Congress, such as the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990. Civil rights include protection from unlawful discrimination.

Civil Rights of Institutionalized Persons Act (CRIPA)
A federal law that allows the federal government to protect the civil rights of people who are in a facility such as a jail, prison, juvenile hall, or state hospital.

Clear and convincing evidence
A legal standard of proof more demanding than the "preponderance of the evidence" standard, but less stringent than proof "beyond a reasonable doubt." This standard is used in civil commitment cases, where serious liberty interests are at stake.

Co-occurring mental disorder
A mental disorder diagnosed in a person who also experiences (an)other mental disorder(s), most frequently referring to a mental disorder along with a substance use disorder.

Cognitive Behavioral Therapy (CBT)
A set of therapeutic techniques aimed at adjusting someone's mental processes (e.g., thinking or perceiving) to promote behavior change.

Cognitive disabilities
Mental disorders that impact the ability to do things like think, problem-solve, or pay attention.

Commitment hearing
A hearing where a judge or hearings officer considers the evidence and decides whether it is sufficient to support a civil commitment.

Community corrections
A system of oversight outside of jail (probation) or after serving time in prison (post-prison or parole) where the supervised person has conditions to fulfill in order to remain in the community.

Community Mental Health Act
A 1963 act that was intended to provide federal funding to shift mental health care from institutional to community settings.

Compassion fatigue
A state of physical and emotional depletion for a person in a helping profession, where caring for others in significant distress without opportunity to adequately recover leads to lack of compassion and empathy.

Competence
The ability of a criminal defendant to adequately participate in their own defense under the applicable legal standards.

Competency evaluation
An assessment that considers a person's mental capability in light of the legal standard for competence in their jurisdiction and then offers a professional opinion as to whether the person is legally competent.

Conditional release
Release of a person from an institutional setting (like a prison or hospital) into the community, often in a group setting, with requirements to abide by a set of rules and safeguards. If those conditions of release are violated, the person may be returned to confinement.

Continuity of care
Ability to access uninterrupted health and mental health services during a setting transition.

Correctional officer
Officer who has oversight of the prison and jail inmate populations and works to reduce or prevent any security risks.

Criminal commitment
Term used to describe commitments (involuntary treatment and/or confinement) by operation of law in the context of a criminal case. A commitment is not a conviction or a punishment.

Criminal defense attorney
Lawyer who defends people accused of crimes in criminal court, hired privately or by the government as a public defender.

Criminalization of mental disorders
Using the criminal justice system as a response to people who come to the attention of authorities primarily due to their mental disorders.

Criminogenic risk
A person's likelihood of criminally reoffending, assessed based on factors that directly relate to whether the person is likely to commit another crime (criminogenic risk factors).

Crisis intervention Team (CIT) training:
A program aimed at training criminal justice professionals to safely and effectively respond to individuals experiencing mental health crises. CIT emphasizes de-escalation techniques and referrals to mental health and social services.

Crisis response system:
A network of community supports (including someone to call, people to respond, and a place to go) for people experiencing behavioral health crises. A functioning crisis response system avoids criminal justice involvement in response to crises.

Culturally competent
A descriptor applied to behavioral health care that factors in and positively uses understanding of a person's background and life experiences to provide them with care that meets their needs.

De-escalation:
In policing, use of skills to slow events, decrease risk of physical confrontation, and increase opportunity for improvement of outcomes.

Deinstitutionalization
The dramatic downsizing and closure of large institutions, such as state hospitals, that housed people with mental disorders.

Deliberate indifference
A legal standard of proof required in some civil rights cases involving the criminal justice system, meaning that an official was aware of substantial risk of harm but chose not to take action to avoid that harm.

Depersonalization
Experience of becoming detached and emotionally distant, and losing empathy, that is associated with workplace burnout.

Dignity of risk
The ability and power to potentially fail that comes along with an opportunity for self-determination and growth.

Disability
Any condition or impairment of a person's body or mind that makes it more difficult for that person to engage or participate in activities.

Disability Rights Movement
A broad push toward securing equal rights and opportunities for people who experience disabilities.

Discrimination
Categorical exclusion or unfair treatment based on a person's status.

Diversion
Where a person is identified at some point (early or late) in the criminal justice system and provided with a pathway out of that system.

Due process
The idea of guaranteed fair treatment within the legal system based on established procedures.

Durham rule
A formulation of the insanity defense eliminating criminal responsibility where a person's wrong act was the "product" of a mental disorder.

Dusky standard
The federal legal standard for competence to stand trial, requiring that an accused person must have a rational and factual understanding of the proceedings and an ability to reasonably consult with their lawyer about the case.

Eighth Amendment
Amendment to the U.S. Constitution that prohibits cruel and unusual punishments, and regulates excessive fines and bail.

Electroconvulsive therapy (ECT)
A medical procedure that involves passing small electric currents through a patient's brain, creating changes in brain chemistry that have been highly effective in treating conditions such as severe depression.

Emergency hold (hospital hold)
A process allowing a doctor to order that a person be kept under medical supervision so their mental health can be assessed and stabilized. A hold can be a first step in involuntary commitment proceedings.

Eugenics
An American movement beginning the 1890s that encouraged practices such as forced sterilization to remove "unfavorable" characteristics in the gene pool. Eugenics became disfavored in the late 20th century.

Evidence-based
Descriptor of a treatment, practice or intervention that is proven, via research, to be effective for achieving desired outcomes.

Excuse defense
A defense asserted by a criminally accused person stating that the accused person has done something wrong but bears no criminal responsibility due to the circumstances of their action. Examples are duress (the person was forced to do something wrong) or insanity (the conduct was attributable to a mental disorder resulting in legal insanity).

Failure to accommodate
A legal claim based on discrimination that alleges a failure to provide a disabled person with the accommodations that they need to be on equal footing with non-disabled people.

Failure to train
A legal claim intended to hold an agency or supervisors liable for their employees' conduct by asserting that lack of training caused the employee to do the harmful act.

Fifth Amendment
Amendment to the U.S. Constitution that creates numerous important rights. Among those rights is the right to receive "due process" of law in any proceeding that could deprive a person of life, liberty, or property.

Forensic psychologist
A specialized psychologist who provides services within the legal system, such as completing psychological assessments and offering expert opinions on civil or criminal legal matters.

Forensic:
Relating to investigatory or court proceedings.

Fourteenth Amendment
Amendment to the U.S. Constitution that governs the rights of citizens in the states. The due process clause of the Fourteenth Amendment is understood to guarantee fairness in proceedings in the criminal justice systems in the states, just as the Fifth Amendment due process clause requires fairness in the federal system.

Grave disability
A legal status defined by state laws indicating that a person is unable to safely care for themself or is likely to harm themself. Grave disability can be a basis for civil commitment in some states.

Guilty except for insanity (GEI)
The terminology used in Oregon for a person who has successfully asserted the insanity defense and been excused from criminal responsibility. Other states use varying terms, often "not guilty by reason of insanity" or NGRI.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
A law that prohibits health entities from sharing protected patient medical records without authorization.

Imminent danger
Threat of harm that is immediate rather than in the future.

In-reach
A strategy where providers from community-based organizations meet with individuals prior to their release from custody to begin service planning and establish continuity of care.

Individuals with Disabilities Education Act (IDEA)
A law that established "special education" services for children who experience disabilities that impact their ability to learn and function in school. The IDEA requires that all students be provided with an appropriate and inclusive education.

Insanity defense
A defense asserted by a criminally accused person stating that they should be excused from criminal responsibility for their conduct due to their state of legal insanity at the time of the conduct.

Institutionalization
Confining people with disabilities or mental illness in facilities rather than supporting their integration into communities.

Intercept
A window in time during a person's interaction with the criminal justice system where that person might be provided an opportunity for diversion out of the system.

Irresistible impulse test
A formulation of the insanity defense eliminating criminal responsibility where a person's mental disorder prevented them from controlling their behavior or compelled them to do the bad act.

Justification defense
A defense asserted by a criminally accused person stating that the accused person's conduct was not wrong, or criminal, because their behavior was warranted, or justified, by the circumstances. An example is self-defense.

Legal standard
A law created by statute or a court decision that guides decisions and creates consistency in the legal system. For example, the legal standard of proof in criminal cases is "beyond a reasonable doubt," and the legal standard for competency was established in the Dusky case.

Lived experience
Personal knowledge gained through direct, first-hand involvement. In the context of this text, lived experience refers to experience with mental disorders, including substance use disorders, and/or criminal justice system involvement.

Lobotomy
A surgery where part of the brain is removed with a goal of managing or curing mental illness. Lobotomies were performed on patients up until the 1950s in America.

M'Naghten rule
A formulation of the insanity defense eliminating criminal responsibility where a person, due to a mental disorder, did not know the difference between right and wrong in the context of their behavior.

Medical model of disability
A disability is perceived as attributable to a person's impairment. This model contrasts with the social model of disability, which recognizes that the environment creates barriers—not the disability

Medication-assisted treatment (MAT)
Use of medication along with other therapies to treat substance use disorders. There are several medications that target alcohol use, as well as medications that treat opioid use disorder.

Medications for alcohol use disorder (MAUD):
A medication-based approach for treating alcohol use disorders, reducing alcohol use, and sustaining recovery. The most common FDA-approved medications used to treat alcohol use disorders are acamprosate, disulfiram, and naltrexone.

Medications for opioid use disorder (MOUD):
A medication-based approach for treating opioid use disorders, preventing overdose, and sustaining recovery. The FDA has approved three medications for opioid use disorders: buprenorphine, methadone, and naltrexone.

Mental disorders
A mental illness, substance use disorder, or disability that impacts a person's cognitive, emotional, or behavioral functioning.

Mental health counselor
A professional providing treatment to someone with a mental disorder.

Mental health court
A diversion or "problem-solving" court that substitutes treatment and other interventions for traditional criminal punishments (jail or fines) for qualifying offenders.

Mitigation
Explaining a defendant's conduct in a way that does not excuse but may soften judgment of the conduct, thereby providing a reason for a judge or jury to impose a reduced sentence. Facts in explanation might be considered mitigating factors or circumstances.

Mobile crisis team:
A team, often consisting of a mental health worker and a peer support provider, that responds to mental health crises in the community. Team members vary, and some operating under this name may include different types of professionals including law enforcement professionals.

Model Penal Code (MPC)
An example criminal code developed by experts to provide states with standard language on which to base their statutes. Many states have adapted MPC language for use in their state codes.

Moral treatment
A 19th century approach to treatment of those with mental disorders that specifically rejected the harsh treatments that had previously been common and instead fostered the idea that ill patients could become well if they were treated kindly.

Multidisciplinary team:
Team of providers with members from different professions or specialities. ACT and mobile crisis teams, for example, are multidisciplinary.

National Alliance on Mental Illness (NAMI)
A nationwide advocacy organization for people experiencing mental illness and their families.

National Institute of Mental Health (NIMH)
Leading U.S. agency for research on mental health issues, founded in 1949 pursuant to the National Mental Health Act, as part of the National Institutes of Health (NIH). The NIH is composed of 27 research institutes and centers and is part of the U.S. Department of Health and Human Services.

National Mental Health Act
A 1946 act that authorized research and care for mental health and significantly expanded America's commitment to use science to understand and treat mental illness.

No wrong door approach
The idea that anyone can receive services at a provider, whether they walk in or are brought by a crisis team or law enforcement; and once there they will be assessed for whatever care they need at whatever level, large or small.

Non-qualifying mental disorder
Diagnoses that, while potentially very impactful, do not make a person eligible for the insanity defense under state law, generally because they are diagnosed based on rule-breaking behaviors. Examples include sexual disorders, substance use disorders, and personality disorders.

Notice of Mental Illness (NMI)
In Oregon, the paperwork that triggers a court's involvement in a civil commitment. Each state, as well as the federal system, has developed its own procedures for initiating and completing civil commitments.

Nurse practitioner
A nurse with an advanced degree and licensing to provide patient care, including diagnosis and prescription of medications, in a variety of settings.

Opioid drugs
A class of drugs that includes legal and illegal substances, such as heroin, fentanyl, and prescription pain relievers like oxycodone, morphine and others.

Opioid use disorder
A substance use disorder involving opioid drugs, such as heroin, fentanyl, or prescription opioids (e.g., OxyContin).

Oregon Psychiatric Security Review Board (PSRB)
In Oregon, a multidisciplinary oversight board charged with ensuring proper management and community safety with respect to all GEI patients. Each jurisdiction that allows the insanity defense has their own methods of overseeing this population.

Paralegal
A professional who generally assists lawyers with various administrative tasks, as well as legal tasks under supervision.

Parole or post-prison supervision officer
Officer who supervises people who have been released from prison to a period of supervision in the community, providing oversight and enforcement of release conditions, as well as resources to reduce risk of reoffense.

Patient navigation
The use of trained healthcare workers to reduce barriers to care for individuals returning from criminal justice settings. Patient navigators help individuals navigate complex healthcare and social services systems to improve access to care and treatment.

Peer Support Workers or Peers
People with lived experience, including with mental disorders and/or criminal justice system involvement, who have been successful in the recovery process and are trained to help others experiencing similar situations. Peers can have various titles: peer support workers, peer specialists, peer recovery coaches, peer advocates, or peer recovery support specialists.

Pre-commitment investigation
An evaluation by mental health professionals to determine what, if any, mental disorder a person is experiencing and how that mental disorder is currently impacting the person facing commitment.

Preponderance of the evidence
The legal standard of proof in civil cases. Evidence at this level makes something more likely than not to be true and may be characterized as "just enough" to tip the scales, or 51%.

Pretrial services
Programs that allow a person to be supervised in the community while awaiting resolution of criminal charges.

Pretrial services officer
Officer who supervises people allowed to leave or remain out of custody pending a criminal trial, ensuring supervisees follow court-imposed release conditions and appear at required proceedings.

Probation officer
Officer who supervises people convicted of crimes who are placed on community supervision, instead of or after a period of jail incarceration. Probation officers ensure that supervisees adhere to court-imposed conditions of release from custody.

Problem-solving courts
Courts that attempt to support sustainable behavior changes (and avoid incarceration) by responding to offending conduct with treatment and other interventions. Examples are drug courts and mental health courts.

Prosecutor
Lawyer who represents the government in criminal matters against people accused of crimes.

Psychiatric disability
A mental disorder that causes disability, or limits one or more major life activities.

Psychiatric-mental health nurse practitioner (PMHNP)
A nurse practitioner with special training and licensure to provide psychiatric care, including prescribing psychiatric medications (e.g. antipsychotic medications) as part of their patient-care role.

Psychiatrist
A physician who specializes in the diagnosis and treatment of mental disorders.

Public petition for civil commitment
In Oregon, a specific procedure for initiating civil commitment proceedings that allows any two people acting together to initiate the commitment process.

Qualifying mental disorder
Diagnoses that are permitted to form the basis for an insanity defense, assuming other requirements of the defense are met. This includes mood disorders, psychotic disorders, and trauma-related disorders, among others.

Reasonable accommodation
An adjustment or modification that meets the needs of the disabled person requesting it but does not place an excessive burden on the person providing the accommodation.

Recidivism
Return to criminal offending, as measured by re-offense, re-arrest, re-conviction, or re-incarceration.

Recovery
Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Reentry
The process of leaving jail or prison, from preparation and planning during incarceration through release into the community.

Restoration of competence
Targeted treatment provided to a criminally charged person who is incompetent, or unable to aid and assist in their defense. Treatment is intended to enable the person to constitutionally proceed with resolution of their criminal case.

Risk-Need-Responsivity (RNR):
Model of providing services that informs who receives services based on risk, what services are provided based on need, and how services are provided to maximize responsivity.

School-to-prison pipeline

Patterns of school discipline that push students toward entry into the juvenile or adult justice systems. This is a particular risk and concern for students of color, disabled students, and students living in poverty.

Screening

A standardized set of questions designed to flag people who are at risk for a targeted problem, such as a mental or substance use disorder. A screening does not provide a diagnosis or guidance on the severity of any disorder; rather it informs that a person needs further assessment.

Secondary traumatic stress

A phenomenon that occurs when service providers experience indirect, or secondary, trauma, yet experience symptoms similar to post-traumatic stress disorder, a condition associated with direct traumatic experiences.

Section 1983

A common name for the federal law 42 U.S.C. § 1983, originally enacted in 1871 and known as the Ku Klux Klan Act. Section 1983 allows individuals to bring lawsuits in federal court to address violation of their federal civil rights by state officials.

Section 504 of the Rehabilitation Act

A federal law prohibiting discrimination against people with disabilities in certain federal government contexts.

Self-care

Deliberate actions and behaviors to enhance mindfulness and well-being.

Sequential Intercept Model (SIM)

A tool for discussing and assessing various diversion options for people with mental disorders at progressive points, or intercepts, in the criminal justice system. The SIM may highlight options that are available or missing in a particular community or at a particular intercept point.

Social model of disability

An understanding of disability as an aspect of a person's identity rather than as a source of barriers, recognizing that environments present barriers for people who experience disability.

Social worker

A professional who helps people manage problems in their lives. Work can involve an array of services, from advocacy to counseling to case management.

Solitary confinement

A form of discipline or separation used in incarceration where the person is also called isolation or administrative segregation, is where an incarcerated person is placed in a cell alone, with their human interactions strictly limited. Solitary confinement is generally used as a form of discipline for prison rule violations, or as a method to keep the isolated person or others safe.

State hospitals

Originally, state-funded institutions in the model of asylums intended to house people with mental disorders. Modern state hospitals are psychiatric facilities that provide care and treatment, usually on a short term basis.

Stigma
Persistent and unfounded negative attitudes towards people with conditions such as mental disorders. Some people object to this term on the grounds that it may perpetuate negative ideas, and they prefer use of the terms "prejudice and discrimination" to describe societal attitudes and actions that reinforce negative stereotypes and policies.

Substance Abuse and Mental Health Services Administration (SAMHSA)
An agency of the U.S. government that leads public health initiatives aimed at improving national mental health. SAMHSA offers extensive information and resources on mental disorders.

Substance use treatment
Treatment that helps a person manage and recover from a substance use disorder, typically including evidence-based therapies such as cognitive behavioral therapy and/or other therapeutic approaches, and increasingly including medication-based approaches. Substance use treatment represents a significant need in custodial environments.

Supported employment
Evidence-based intervention that provides job development and placement, job coaching and training, and problem-solving skills development to people with disabilities and behavioral health conditions.

Telehealth
Provision of health care, including mental health care, via means such as phone or video appointments, as well as electronic transfer of medical data.

Transinstitutionalization
A hypothesis suggesting that people in need of care during the deinstitutionalization movement were simply moved from one institution (hospitals) to another (prisons).

Trauma-informed (training, care or approach)
A system or action that realizes the widespread impact of trauma; recognizes its signs and symptoms; and responds by integrating this information into policy and practice, seeking to actively resist re-traumatization.

U.S. Department of Justice
The federal agency that enforces laws of the United States.

Vicarious resilience
The positive and empowering impact of experiencing others' success in overcoming adversity.

Vicarious traumatization
When one's worldview shifts after providing direct care to people who have experienced trauma.

Victim advocate
A professional who provides direct services to victims of crime, often in community settings as a support person, or in the context of court cases to ensure access to victim's rights, such as notification of hearings.

Warm hand-off
A transfer of care between support people or care providers (e.g. from correctional health to community-based services) that includes direct introductions, provision of required information, and if appropriate, transportation to the receiving service provider. Warm hand-offs are a technique to ensure continuity of care for people being released from custody.

Wrongful arrest
A legal claim asserting that an arrest of a person is unlawful and unreasonable. In the disability context, wrongful arrest may involve an arrest based on disability-related conduct that is treated as illegal conduct.

Image Descriptions

Image description for Figure 5.15

This image demonstrates the role of Assertive Community Treatment (ACT) services as part of a bigger picture of care options, serving as a bridge or conduit between longer-term more restrictive and shorter-term or less restrictive settings.

A large circle on the left represents ACT services. Arrows in and out of ACT services go to a box on the right, representing more restrictive settings: long-term inpatient hospitals, incarceration, and supervised residential settings. The arrows show that people may go from these long-term restrictive settings into ACT, or people may go from ACT into these long-term restrictive settings.

Two other boxes to the right of the ACT circle represent other settings that relate to the ACT service population: lower-intensity community based services (care management, outpatient therapy, medication management, psycho-social rehabilitation services, and peer support) and more intensive acute settings (emergency department, crisis services, and short-term inpatient hospital). An arrow from the ACT circle to the lower-intensity box shows that people from the ACT population may leave ACT for the lower-intensity community services. An arrow from the lower-intensity box to the acute box shows that people in lower-intensity may need to step up to acute settings. An arrow from the acute settings box to the ACT circle shows that people who have been stepped up to acute care may need to return to the intensive community option that is represented by the ACT circle.

Return to Figure 5.15

Image description for Figure 6.5

The flowchart for Competence to Stand Trial (CST) involves five stakeholders with interests in the competence process. These are hospital, jail, community, support and court, and they are represented by icons showing when each plays a role in the process.

The flowchart shows four stages in the competence process. The first is when competence is raised, which involves only the court. The second stage is the competence evaluation, involving all stakeholders except the court. The third stage has two options: if the person evaluated is not competent, they go to restoration, and if they are competent, they resume the criminal process. Each of these options at all three stages has arrows back to the left of the flowchart where the word diversion indicates that a person at any point can be diverted out of the criminal process. The first two stages are at Intercept two of the SIM. The second two stages are at Intercept three of the SIM.

The final stage of the flowchart has four options: disposition; not restorable; further restoration, or restored. These options indicate how the case will look after restoration in the third stage. If the person is not restorable, that may result in disposition by alternative means. If the person can be restored, further attempts are made. If the person is restored, the arrow takes them back to stage three, to resume the criminal process. In this final stage, only the further restoration option has an arrow back to the diversion box at the far left of the chart, indicating that diversion would not be available to a person who was unrestorable or who had resolved the case otherwise.

Throughout, the stakeholder icons show that the court is involved in the criminal processes, where the hospital, jail, community and other support may be involved in restoration efforts, indicating back and forth hand-off of the defendant as the process moves through each stage.

Return to Figure 6.5

Image description for Figure 6.9

A flow chart outlines the four versions of the insanity defense.

The Model Penal Code Rule

The Model Penal Code Rule would apply in either of these two situations:

- Because of mental disorder, defendant lacks substantial capacity to appreciate criminality of conduct.
- Because of mental disorder, defendant lacks substantial capacity to conform conduct to the law.

Irresistible Impulse Test

The Irresistible Impulse Test would apply when, because of mental disorder, defendant cannot control conduct.

Durham Rule

The Durham Rule would apply when defendant conduct is the product of mental disorder.

The M'Naghten Rule

The M'Naghten Rule would apply in either of these two situations:

- Because of mental disorder, defendant does not know the nature or quality of conduct.
- Because of mental disorder, defendant does not know conduct was wrong.

Return to Figure 6.9

Image description for Figure 7.2

Three steps in the incarceration process

The first step is being accused. A person is accused of a crime by county, state, or local law enforcement. A SWAT team in helmets and bulletproof vests is pictured. A person can also be accused by a federal agency, including the Bureau of Alcohol, Firearms, Tobacco and Explosives; the Drug Enforcement Administration; the U.S. Marshals Service; Homeland Security; the Secret Service; the Bureau of Indian Affairs; the Inspector General's Office; the Fish and Wildlife Service; or the Internal Revenue Service. Federal agents with guns and walkie talkies are pictured.

The second step is going to jail. Jails house people not convicted of a crime, awaiting sentencing, or serving shorter sentences (less than one year). Persons pending charges are incarcerated, meaning they don't have access to the community. Convicted people with longer terms are sent to prison after sentencing. A sparse jail cell is pictured with a bunk bed, chair, and locker.

The third step is imprisonment. People may be imprisoned in either a federal prison run by the Bureau of Prison, which houses people convicted of a crime by the U.S. Attorney's Office. They may also be housed in a state prison, where people convicted of a crime at the state level by a District Attorney's Office go. There is a picture of a federal prison with guard towers and a state prison, which is a collection of nondescript cement buildings.

Richard J. Donovan Correctional Facility by Don Ramey Logan is CC BY 4.0. Public domain photos by ATF.gov, Spc. Tanya Van Buskirk for the US Army, and BOP.gov. This infographic is designed by Kendra Harding and Michaela Willi Hooper, Open Oregon Educational Resources is CC BY 4.0.

Return to Figure 7.2

Image description for Figure 8.7

The infographic begins with three definitions.

- Criminogenic factors: Risks and needs that increase an individual's likelihood of re-offense.
- Criminogenic risk: The likelihood that an individual will engage in future illegal behavior in the form of new crime or failure to comply with probation/parole conditions.
- Criminogenic needs: Dynamic or changeable factors that increase an individual's likelihood of re-offense but can be remedied or lessened through appropriate interventions or services.

The infographic contains 8 small diamonds with the eight Criminogenic risk factors. These are:

1. History of antisocial behavior,
2. Antisocial personality pattern
3. Antisocial cognition
4. Antisocial associates
5. Family or marital problems
6. Work or school problems
7. Lack of healthy leisure or recreational pursuits
8. Substance use

The 8 diamonds encircle a larger diamond with the text, Criminogenic Risk and Need Factors. Each factor is associated with a static risk and changeable need that should be assessed and addressed through treatment and services. The large diamond has a dotted line around it with dotted lines connecting to the small risk factor diamonds. This illustrates that multiple risk factors can be addressed individually, but they interact and combine to represent an individual's assessed criminogenic risk, which informs treatment levels.

The bottom of the infographic contains a description of the Risk-Need- Responsivity (RNR) model. The Risk-Need- Responsivity (RNR) model is used to help identify the appropriate treatment for individuals to reduce the risk of re-offending.

- Risk principle – match the level of service to the individual's risk to re-offend.

- Need principle – assess each individual for known criminogenic needs and target treatment to the most salient needs.
- Responsivity principle – maximize the potential success of the intervention by providing cognitive behavioral treatment and tailoring the intervention to the learning style, motivation, and strengths of the individual.

Return to Figure 8.7

Image description for Figure 9.1

This flowchart demonstrates the progression of the civil commitment process based roughly on the process in Multnomah County, Oregon.

The image begins with a white circle in the upper left corner where the civil commitment process is triggered by "a concern about safety of a person with a mental disorder." From there, arrows point right, the option of an emergency hold or a notice of mental illness, or down, to a box labeled voluntary treatment. Arrows back to the voluntary treatment box from other steps in the process show that a decision to engage in voluntary treatment can stop the commitment process.

From the emergency hold box, an arrow goes to a box stating that the person can be held for up to five days, and a decision about whether to have a hearing is to be made in three days. From the five day box, an arrow points to a box labeled "investigation:is the person unsafe due to a mental disorder?"

If the answer to that question is YES, the arrow points to a box labeled: "hearing: is the person imminently unsafe due to a mental disorder?"

If the answer to that question is YES, the arrow points to a box labeled "Involuntary commitment: up to 180 days."

If the answer to the investigation or hearing boxes are NO, the arrows point to a label that the "person is released," with further arrows pointing to the option of voluntary treatment that is still available.

The box labeled "Involuntary commitment: up to 180 days" has arrows pointing downward through three stages: treatment options (hospital and/or community), stabilization, and legal discharge, signifying the end of the commitment process.

Return to Figure 9.1

Image description for Figure 9.2

This is an image of a form that would be used in the State of Oregon as one way to initiate a civil commitment. The form has a number of blanks that have been filled in with example names and information. This blank form was created in December, 2018.

The form is titled Community Mental Health Director's Written Report Regarding Peace Officer Custody of an Allegedly Mentally Ill Person.

The form is directed to a treating physician of a designated person alleged to be mentally ill.

The form contains the name of the Community Mental Health Program Director, the County, the relevant law (ORS 426.233(1)(a)), the Peace Officer who will take the person into custody, including the officer's agency and badge number.

The form identifies the person to be taken into custody by name (example John Doe), date of birth, and address, and identifies the place and time of custody. It specifies the reasons the person is to be taken into custody. As an example, the form is completed with the following information: Mr. Doe attended his individual therapy session and appeared tearful with pressured speech. He reported suicidal ideation with a plan to end his life, specifically with a firearm, which he has access to in his home. Thought of suicide began earlier in the week at a recent court hearing where he was sentenced to a term of imprisonment. He reported a plan to end his life later this evening with a firearm. Doe has a history of hospitalizations for attempted suicide within the past year.

The form cites the law allowing the person named to be taken into custody: pursuant to ORS 426.233(1)(b) because the above factors establish probable cause to believe the above-named person is a mentally ill person who is dangerous to self or others and in need of immediate care, custody or treatment for mental illness; or the person is on conditional release, outpatient commitment or trial visit, and is dangerous to self or others, or is unable to provide for self.

The form has a signature line and contact phone number for the Community Mental Health Program Director or Designee.

The form specifies that If more than one hour is required to transport the person to an approved hospital, a physician must complete an additional certification prior to transport pursuant to ORS 426.228(3). The certification states: I certify that I have personally examined the above-named person and believe the person is dangerous to self or others and in need of immediate care, custody or treatment for mental illness and that travel to [blank for location], a

hospital or other approved non-hospital facility will not be detrimental to the person's physical health. The certification has a blank for date, time, and physician signature. These are not completed on the example form.

The form specifies at the bottom that it is to be delivered to the treating physician at the receiving facility, not filed with the court.

Return to Figure 9.2

Image description for Figure 10.27

The Trauma Stewardship Institute's Tiny Survival Guide Image Description

- Protect your mornings (or whenever you go outside). Less cortisol, more intentionality.
- Go outside (or look outside). Perspective, context, and something larger than this.
- Be active (avoid stagnation) in mind, body, and spirit.
- Cultivate relationships. Those that are edifying and healthy.
- Nurture gratitude. What is one thing, right now, that is going well?
- Detox. If navigating addictions, be wise and safe. Limit news and social media.
- Spend time with animals to lower stress hormones and increase comfort.
- Metabolize all you are experiencing. Re-regulate your nervous system.
- Simplify (less is more). Be aware of decision fatigue and cognitive overload.
- Admire art. The gift of feeling transported.
- Laugh. Pure humor = a sustaining force.
- Foster humility and extend grace. Self-righteousness + hubris = unhelpful

- Sleep. To cleanse and repair the body.
- Clarify intentions. How can I refrain from causing harm? How can I contribute meaningfully?
- Be realistic and compassionate (with yourself). Be mindful of the quality of your presence. It means so much to others.

Return to Figure 10.27

Transcripts

Transcript for Figure 1.9, Eugenics: In the Shadow of Fairview

[Music.]

[John Kitzhaber, Oregon Governor]: Today, I am here to acknowledge a great wrong that was done to more than 2,600 Oregonians over a period of approximately 60 years: forced sterilization in accordance with a policy known as eugenics.

Between 1900 and 1925, Oregon was one of 33 states that enacted to provide forced sterilization. The Oregon law established a state board of eugenics. The board's job was to decide which people should undergo involuntary sterilization in the interest of promoting a higher quality of human beings in succeeding generations. That is a part of Oregon's history.

[Narrator] In 1923, Oregon enacted a eugenics law for the compulsory sterilization or even castration of people deemed feeble-minded, insane, epileptic, habitual criminals, moral degenerates, and sexual perverts.

[Philip Ferguson, Professor Emeritus at Chapman University]: Positive eugenics was the notion of having the best examples of humanity match up and to have children that carried on those paragons of virtue. And then the negative eugenics was keeping the misfits and the threats to social order, keeping them from reproducing.

[Kimberly Jensen, Professor of History and Gender Studies at Western Oregon University]: The eugenics law eventually included terms like antisocial behavior or sexual deviancy, so this was a very wide net. The use of eugenics as a so-called therapeutic tool really meant that there were some very horrible things that happened.

[Narrator]: Fairview Training Center was the state's institution for those with developmental and intellectual disabilities. For decades, residents were required to be sterilized before they could be released.

[Ruth Morris, Former Fairview Resident]: I lived in Fairview from '65 to '72. I was one of these people who got sterilized. My dad and I had to sign a paper that I did not understand until afterwards. I did not have a choice. Before people got to go out in the community from Fairview, they would have to have a sterilization, every one of us.

[Narrator]: At least 2,500 Oregonians were sterilized under the law. The legislature finally revoked it in 1983.

[Kitzhaber]: The time has come to apologize for public policies that labeled people as defective. To those who suffered, I say the people of Oregon are sorry.

[Morris]: I felt good that he apologized.

[Applause.]

[Music.]

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Transcript for Figure 1.15, Dignity Of Risk

[Max Barrows, Outreach Director of Green Mountain Self-Advocates]: One thing that is really big in self-advocacy and the work that I do and we discuss it a lot is the dignity of risk. The dignity of risk is the opportunity and the right to make mistakes. It's one thing to be told things through lecture but how else can you learn if you don't make mistakes. Life is about learning from the mistakes you make.

I appreciate and we appreciate protection from people but please don't protect us too much or at all from living our lives. We are going to have to encounter failures through decisions that we make. But the way to conquer that is to get up on your feet, brush yourself off, and learn from that because people grow by encountering failures and making mistakes in their life. It's really the number one way of learning of where lines are drawn and also it helps with learning about yourself.

The dignity of risk is one of many opportunities that people with disabilities deserve to have. It's one thing just to give them like only a select few but clearly, even saying in the Americans with Disabilities Act, people with disabilities deserve to live their lives with no limits of opportunity. It really opens the doors for people with disabilities to really discover what is out there and to take advantage of what is out there and not be limited to only certain things due to the overprotection that people with disabilities unfortunately have to live with.

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Transcript for Figure 2.6, What is PTSD?

[Narrator]: Most people go through some type of traumatic event in their lifetime. In some cases, the effects are short-term, but for many people, those experiences persist for years, causing Post-Traumatic Stress Disorder, also known as PTSD. Events such as a natural disaster, physical or sexual assault, a serious accident, a terrorist attack, war or combat, or the death of a loved one may be the source of developing PTSD.

PTSD symptoms often fall into four categories: intrusive thoughts or images related to the traumatic experience such as nightmares and vivid flashbacks; avoiding reminders of the trauma; negative thoughts and feelings like fear or anger; and reactive symptoms like irritability, and sleep difficulty.

However, not everyone has these symptoms to the same extent or intensity. Each person's experience of PTSD is unique to them. Fortunately, there are recovery options.

If you think that you or a loved one is experiencing PTSD, social support, empathy, and acceptance are key steps towards recovery. If they are open to it, encourage them to contact a mental health professional who will introduce them to treatment options after conducting an evaluation. The primary treatment may involve psychotherapy and/or medication.

Adequately and appropriately treating PTSD can help them regain a sense of control over their life. Even though PTSD is an intense disorder, it doesn't have to last forever. For more information about diagnosis and recovery, please visit **www.psychiatry.org**.

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Transcript for Figure 2.7, What is trauma? The author of "The Body Keeps the Score" explains | Bessel van der Kolk | Big Think

[Bessel van der Kolk]: The most important thing to know is that there's a difference between trauma and stress. As I like to say to people, life sucks a good amount of the time. We all have jobs and situations that are really unpleasant. But the moment that a situation is over, it's over.

The problem with trauma is that when it's over, your body continues to relive it.

My name is Bessel van der Kolk. I'm a psychiatrist, neuroscientist, and author of the book, "The Body Keeps the Score."

I got interested in trauma on my first day working at the Veterans Administration. 1978 was the year, and the Vietnam war was over by about six or seven years. The very first day that I met Vietnam veterans, I was just blown away. These were guys who were my age, who were clearly smart and competent and athletic. And they clearly were just a shadow of their former self. But their bodies were clearly affected by trauma and they had a very hard time connecting with new people after the war.

Around that time, a group of us started to define what trauma is. And in the definition of PTSD, we write, these people have been exposed to extraordinary events that's outside of normal human experience. Now, in retrospect, that shows us how ignorant and narrow-minded we were, because it turned out that this is not our usual experience at all.

People usually think about the military when they talk about trauma. But at least one out of eight kids in America witness physical violence within their parents. A larger number of kids get beaten very hard by their own caregivers. A very large number of people in general, but women in particular, have sexual experiences that were clearly unwanted and that left them confused and enraged.

So, unlike what we first thought, trauma is actually extremely common. There's a lot of debates of what the trauma is to this day. But basically, trauma is something that happens to you that makes you so upset that it overwhelms you. And there is nothing you can do to stave off the inevitable. You basically collapse in a state of confusion, maybe rage, because you are unable to function in the face of this particular threat. But the trauma is not the event that happens, the trauma is how you respond to it.

One of the largest mitigating factors against getting traumatized is who is there for you at that particular time. When, as a kid, you get bitten by a dog, it's really very scary and very nasty. But if your parents pick you up and say, oh, I see that you're really in bad shape, let me help you. The dog bite doesn't become a big issue because the foundation of your safety has not been destroyed. We are profoundly interdependent people, as long as our relationships are intact, by and large, we're pretty good with trauma. It's a

subjective experience and what may be traumatic for you may not be traumatic for me, depending on our personality and our prior experiences.

The problem with trauma is that it starts off with something that happens to us, but that's not where it stops, because it changes your brain. Much of the imprint of trauma is the very primitive survival part of your brain that I like to call the cockroach brain. As a part of you that just picks up what's dangerous and what's safe. And when you're traumatized, that little part of your brain, which is usually very quiet, continues to just send messages. I'm in danger. I'm not safe. That event itself is over, but you continue to react to things as if you're in danger. We are talking about survival. We are talking about staying alive. I say, some people go into fight-flight. Or on a more primitive level, people's brains shut down and they collapse. Yet, these automatic responses, they are not a product of your cognitive assessments, they're products of your animal brain trying to stay alive in the face of something that that part of your brain interprets as a life threat. And the problem then becomes that you are not able to engage, or to learn, or to see other people's point of view, or to coordinate your feelings with your thinking.

Traumatized people have a tremendous problem experiencing pleasure and joy. But the core issue is our hormones and our physiological impulses that have to do with survival. Your body keeps mobilizing itself to fight. You have all kinds of immunological abnormalities. Endocrine abnormalities. And that really devastates your physical health also.

Oftentimes, the physical problems are longer lasting than the mental problems. And the other thing that is terribly important is the impact of poverty, or the impact of racism, or the impact of unemployment. There are other societies that are much more trauma savvy than we are. Where there is not an enormous amount of income inequality, healthcare is universal, childcare is universal. A culture like that really looks at what are the antecedents for certain forms of pathology. So, the big issue is a political issue.

How do we rearrange our society to really know about trauma so that people who grow up under extreme adverse conditions can become full-fledged members of society? The sense of community and people being there for each other is a critical part of surviving and thriving.

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Transcript for Figure 2.9, What is Schizophrenia

[Matthew Diep, NAMI Mental Health Advocate]: Being able to talk openly about our mental health journeys feels like the biggest breath you ever took and that exhale that comes with that.

So what is schizophrenia? Schizophrenia is a serious mental illness that can interfere with the person's ability to think clearly, relate to others, manage their emotions, and make decisions. It is a complex, long term medical condition. Although schizophrenia can occur at any age the typical age of onset tends to

occur from the late teens to the early twenties for those assigned male at birth and the late twenties to the early thirties for those assigned female at birth.

Here are some of the key signs.

- Hallucinations. Hearing voices or seeing or smelling things that others cannot. These are very real to the person experiencing the hallucinations and they can be very threatening or scary for them.
- Delusions. False beliefs or ideas that don't change even when the person is presented with new ideas or facts that contradict those beliefs.
- Negative Symptoms. So these are things that may diminish a person's abilities. So, for example, feeling emotionally dull or speaking in a sort of disconnected, flat way. People with negative symptoms may show little interest in life or have a hard time sustaining relationships. And oftentimes this can be confused with depression.
- Disorganized thinking. This can look like struggling to remember things, organizing thoughts or completing tasks.

And whether you're experiencing these symptoms or maybe your experience is a little different it's important to seek help so that you can find the right supports and services that work for you.

Some harmful assumptions about people living with schizophrenia that aren't true are that they have multiple personalities, that they're a danger to everyone around them or that they can't live happy and fulfilling lives that work for them. In reality, people living with schizophrenia can find ways to support themselves and manage their symptoms and live very fulfilling lives. The symptoms of schizophrenia can be reduced with medication, psychosocial rehabilitation, which might look like community based care or peer support groups, therapy and family support.

People living with schizophrenia should seek treatment as soon as symptoms start to appear because early detection and treatment can reduce the severity of symptoms. Getting a diagnosis of schizophrenia can be really scary and intimidating. There's always hope. Whether you're here to learn more about yourself or to support a loved one, we encourage you to lead with love, compassion and patience and just know that we're here for you as you're on this journey.

So when I'm feeling ungrounded or I need something to support myself, oftentimes I'm dealing with a negative emotion or a thought that I can't get away from. And something I like to do is a breathing exercise where I breathe in an affirmation or a positive thought to help challenge that negative thought. And then on my exhale I'll think about that negative thought or that emotion leaving my body. Hopefully this is a tool that you can take home with you. To learn more, visit nami.org/schizophrenia. And remember you're not alone.

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Transcript for Figure 2.10, The Difference in Symptoms Between Schizoaffective Disorder and Schizophrenia

[Music.]

[Breanne Dargon, Clinical Director, BrightQuest San Diego]: Here at BrightQuest, we often see a lot of clients that have been diagnosed with schizophrenia or schizoaffective disorder and those two often can be confused.

With individuals that are diagnosed with schizophrenia, they often have symptoms such as hallucinations, delusions, negative symptoms, things like that. Those that are diagnosed with skis or affective disorder have those components paired with a serious mood component as well. So they might have periods where they are very, very low in their mood, they might have periods where they are very high, but it's combined with the symptoms of delusions, paranoia, negative symptoms.

What that means when I say positive symptoms is the addition of things. So that means they are experiencing hallucinations, they are experiencing delusions, so they are having extra things happening to them. The negative symptoms is not something that you would typically think of "Things I don't want." Negative symptoms actually means the subtraction of things so that might mean that they do not have the ability to show affect. They do not have the ability to have social interaction as well as somebody that does not have those symptoms would maybe

present with.

[Music.]

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Transcript for Figure 2.11, Profile: Phil Y., Living with Bipolar Disorder

[Interviewer]: Tigger or Eeyore. Who's at the wheel today?

[Phil Yoo]: My name is Phil Yoo and I'm living with bipolar disorder. It always comes a double-edged because the mania is kinda what brings on the depression. Being high that long makes you crash. With bipolar disorder, it's large, large life events that set off phases. So like, like breakups or blowout, blowout fights with a family member or something like that.

But with me it was a breakup. In that situation I ended up, I ended up going to the hospital because I was so depressed. And they recommended me to their, their inpatient facility. It's, it's tough to know where you, where you, end and the, and the illness begins.

[Interviewer]: What is an attribute to you, and what is an attribute to bipolar disorder?

[Phil]: There's, it's such a fuzzy line. I'm not sure that there is a difference. The medication definitely makes me feel a little duller. You're trading this side effect for that symptom. I may not be like at full mental acuity, but at least I'll be like nice and even. You know.

It's definitely challenging paying attention to all your cycles, paying attention to yourself, making all your doctor's visits, therapy, blood draws. But it's definitely possible to have a normal life with bipolar disorder. You just have to stick with your treatment plan and go forth.

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Transcript for Figure 2.12, Profile: Dan L., Living with Major Depression

[Dan Lukasik]: Nobody could do anything worse than what depression had done to me. When I turned about 40 I was the managing partner at my law firm. I was just sad all the time but things started to go really off the rails when my sleep became fragmented. I just couldn't get enough sleep and was told at that time that I had major depression and that I needed to go on medication.

People can't recover from depression by themselves. I mean, that's what's so wrong about stigma. At the end of my life, what's going to count is what I've done for other people. And for me, the biggest contribution I can make in that effort is to connect to other people with major depression and let them know they're not alone. You can be a professional person, you could be a working person and you can live with depression.

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Transcript for Figure 2.13, ECT: Disrupting the Stigma Around An Essential Treatment Option

[Alyssa, ECT patient]: I was diagnosed with catatonia. I was delirious, confused, regression, dementia – I didn't know what was going on. We had tried everything else – meds, therapy, chiropractic work, ketamine treatments – and nothing was working, so finally we ended up deciding to try ECT.

[Dr. Dan Maixner, Professor at University of Michigan and Director of the Electroconvulsive Therapy Program]: ECT is a procedure that was first developed in the 1930s and has been refined over many decades to reduce side effects and to improve outcomes. It's used for depression, bipolar illness, psychosis, and catatonia. We're inducing a very brief seizure under general anesthesia to affect brain changes that will help depression and other illnesses.

[Dr. Neera Ghaziuddin, Professor at University of Michigan and Electroconvulsive Therapy Program]: Stigma is a problem where ECT is concerned; however, there is a big mismatch between reality and the basis of the stigma. So the reality is that ECT is painless, it's quick, it's highly effective, and it can be life-saving in many instances.

[Julie, mother of ECT patient George]: ECT has changed George's life. He was unfunctioning completely, he would cry and hit himself in the head for hours and hours straight, and nothing you could do would help him. You just couldn't console him so it was a horrific time period for both of us because as a mother not being able to help your child who you are watching suffer and deteriorate before your eyes, it was horrible for both of us.

The ECT clinic is amazing. The people here are some of the most caring people you can ever meet. Coming to ECT has become almost like a safe place for George. He knows he's going to feel better and I believe that he knows he's being very well taken care of.

[Dr. Ghaziuddin]: If you were a patient coming in to do ECT, this is what your day would look like. The check-in: The nurse does the intake and IV is set up. They get wheeled into an OR where they receive ECT. They are taken care of by a team from anesthesiology and psychiatry. Your IV is already set up so in rapid succession receive light and very quick acting anesthesia. At that point the psychiatrist along with their team will induce a seizure. There is a set of paddles which are placed either on two sides of your head or they might be placed on one side of your head. Those are the two common placements, known as bilateral and unilateral. Your seizure takes about 30 seconds to a minute or two. Once that's over, you slowly over minutes wake up and I would say that it takes no more than about five to seven minutes. They're assisted during their recovery and the whole procedure is over within a few minutes and usually within two to three hours you're ready to go home.

[Alyssa]: So it's been about a year since I first started becoming ill. It took like nine sessions before an improvement was noticed and I've really noticed it after the last couple of sessions. ECT has improved my life so much.

[Dr. Maixner]: The most common side effects of ECT are headache or nausea. The issue that patients are most concerned about tend to revolve around memory side effects.

One big issue that patients worry about is short-term memory and what's going to happen after their treatment course but in fact the short-term memory side effect that does happen during the course tends to ease up and dissipate over a matter of days to a few weeks after the treatment course is completed.

[Alyssa]: My side effects are pretty minimal. On occasional headaches right after treatment and did have some disorientation more recently. The past couple treatments I've noticed my memory is getting longer. I'm more confident, more motivated, happier – I laugh a lot, that wasn't the case before.

[Dr. Ghaziuddin]: To be able to see somebody get better – a young person be able to go back to school or go back to their job to do whatever they need to do and function in a safe way – that's the part that I would say that it really is a game changer.

[Alyssa]: ECT has changed my life. It saved my life, honestly. I feel better than I've ever felt.

[Julie]: Prior to ECT, George had zero quality of life. Zero. He now is able to go to school and he's able to participate in social activities. We lost him for a while and ECT gave him back to us.

[Music.]

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Transcript for "ECT: Disrupting the Stigma Around An Essential Treatment Option" by Michigan Medicine is included under fair use.

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Transcript for Figure 2.14, What is Anosognosia?

[Lauren Kennedy]: Hi, everyone. So today I wanna talk to you a little bit about a concept called anosognosia. So anosognosia is the symptom of a severe mental illness, such as schizophrenia or schizoaffective disorder, that impairs a person's ability to understand, or to perceive their own diagnosis or treatment. In other words, this is when someone is unaware of their own mental condition, or when they have difficulty perceiving or understanding their condition accurately.

Now, this is different from simply being in denial about an illness, and it's more a lack of insight into an illness. Anosognosia is the single largest reason why people living with schizophrenia or bipolar disorder refuse medication or refuse to seek treatment. So it's obviously very hard to understand that you need to take medications, or that you need to seek treatment when you don't believe that there's anything wrong, or that you have an illness of any kind. So this is why it makes it so difficult, when individuals are experiencing anosognosia, to ensure proper treatment of their illness.

I myself have gone through periods of anosognosia where I, myself, don't really think that I have schizoaffective disorder, or that I don't have a mental illness. And so it's important to note that anosognosia varies, and it kind of ebbs and flows in individuals. Variations in awareness are typical in anosognosia, so it's not something that you can just overcome. Sometimes you can gain more insight into your illness and have better awareness of what you need to do in order to keep it under control. But then you can go again into periods of anosognosia where you don't think that you are ill.

So what do you do about anosognosia? A few things that have worked for me have been research around my illness. So going to the library, doing some research online, taking classes in university, or just taking classes in general, some are offered through local community programs and whatnot, that can just give you more information about your illness, and that can really help with insight. Peer support groups have also been really helpful for me in terms of building up insight. So just getting together with people who are going through similar situations, and people who can understand what I'm going through and kind of normalize it a little bit, have really helped to build insight around my diagnosis and around my illness.

Another thing that has been really helpful for me in the past is keeping a journal about my thoughts and feelings and symptoms. So when I'm experiencing intrusive thoughts or racing thoughts, I often keep a journal about those thoughts in order to just kind of check back and reflect on what I was experiencing, and to gain a bit more insight into what I was going through at that time. It also helps to just keep a daily log of other symptoms of my illness, and of things like sleep, and things like medication, and all that kind of stuff just helps to build insight around the illness a little bit more. So what it really helps to do is to identify patterns in your symptoms or in your illness. So if you're noticing that you stopped taking

medications and your symptoms are increasing or worsening, you can kind of help, or it can kind of help to identify that pattern of stopping medication leading to worse symptoms.

Another possible way to kind of mitigate anosognosia is to just talk about it more with family and friends. So the more open you are around your illness and around your diagnosis, I think the more it's going to help you in terms of self-acceptance and coming to terms with your own illness, which increases insight.

So just to wrap things up, a quick review of ways to deal with anosognosia are to do your research, to try out peer support groups, keeping a journal or a log of some sort, and talking more openly with your family and friends.

So hopefully you found this video helpful in terms of understanding more of what anosognosia means and what it entails. Thank you so much for watching. If you wanna follow along more with me, you can follow me on Instagram or Twitter. My handles are in the description below. Also, if you wanna help support the creation of future videos, you can become a patron on my Patreon page. The link is also in the description below. So thank you so much again for watching, and have a great day, bye.

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Transcript for "**What is Anosognosia?**" by **Living Well with Schizophrenia** is included under fair use.

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Transcript for Figure 2.18, What Is Conduct Disorder? | Child Psychology

[Dr. Kimberly Williams, Clinical Psychologist]: Conduct disorder in children is very serious.

It's a disorder of childhood and adolescence that is long term, that's chronic, where children have very aggressive impulses, where children are involved in difficulties with the law and really seem to have no regard for the rules or for authority.

When children have conduct disorder they are definitely at risk of carrying these difficulties into adulthood which also brings about a myriad of different problems.

Children with conduct disorder often have difficulties in schools, have difficulty with relationships and have difficulty with employment and lifelong long-term relationships.

It's important to recognize that if your child is not doing well in school, if your child has had difficulties where legal action was necessary, if your child is bullying, getting into fights and this is constant and ongoing, if your child does not get help these complexities will really exacerbate into other major difficulties.

Look for signs of your child's grades dropping, look for signs of repeated detentions, suspensions and brushes with the law.

Parents, please recognize that if your child has signs of conduct disorder the sooner you get help, the sooner your child can start to learn more adaptive behaviors.

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Transcript for Figure 3.9, This is Ableism

[Music.]

Ableism – the belief that it is normal to not have a disability and that normal is preferred. It's discrimination on the basis of disability.

What's the impact? Well, ableism –

I live in a world not built for me because of ableism.

I don't belong.

I am invisible.

I am underestimated.

I am not an equal citizen.

I experience barriers to higher education.

People assume that I have a bad life.

I get funny looks.

My privacy isn't respected.

I get kicked out.

I am not heard.

I have poor job prospects.

I do a lot of emotional labor.

I live in poverty because of ableism.

My human rights are not respected.

You might not recognize ableism unless you experience it. This is ableism – learn how to take action against ableism in your home, your community, and your sector by visiting inclusioncanada.ca/this-is-ableism/.

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Transcript for Figure 3.12, Crip Camp: A Disability Revolution

[Woman 1]: Wait, you want me to tell 'em what happened?

Well, two people got crabs, and they were spreading.

We were all very hyper about it.

I have to go shower some people.

[chuckles] I'll see you later.

[Man 1]: I wanted to be part of the world, but I didn't see anyone like me in it.

I hear about a summer camp for the handicapped, run by hippies.

Somebody said you probably will smoke dope with the counselors.

[chuckles] And I'm like, "Sign me up!"

Come to Camp Jened and find yourself.

There I was! I was at Woodstock.

[Man 2]: You wouldn't be picked to be on the team back home. But at Jened, you had to go up to bat. Even when we were that young, we helped empower each other. It was allowing us to recognize that the status quo is not what it needed to be.

[Woman 2]: The world always wants us dead. We live with that reality.

[Man 1]: At the time, so many kids just like me were being sent to institutions. It was just a continual struggle. Most disabled people, like myself, are unable to use public transportation.

[Man 1]: We needed a civil rights law of our own.

[Music playing.]

[Reporter]: A rehabilitation program has been vetoed by the president because it was cost prohibitive.

[Woman 3]: We decided we were gonna have a demonstration.

[Woman 4]: You get the call to action. "To the barricades!"

[Reporter]: A small army of the handicapped have occupied this building for the past 11 days.

[Man 1]: So many people from Camp Jened found their way into the building.

[Crowd chanting.]

[Woman 2]: The FBI cut off the phones. The deaf people went, "We know what to do." That's how we communicated to the people outside the building. The Black Panther Party would bring a hot meal. We were like this.

[Man over PA]: We are the strongest political force in this country. We will no longer allow the government to oppress disabled individuals. And I would appreciate it if you would stop shaking your head in agreement when I don't think you understand what we are talking about.

[Crowd cheering.]

[Man 1]: What we saw at that camp was that our lives could be better.

[Boy]: Go!

[Man 3]: Go!

[Music continues playing.]

[Woman 5]: If you don't demand what you believe in for yourself, you're not gonna get it.

[Protester 1, mimicking a reporter]: Would you like to see the handicapped people depicted as people?

[Protestor 2]: Excuse me?

[Laughter.]

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Transcript for "**CRIP CAMP: A DISABILITY REVOLUTION | Official Trailer | Netflix | Documentary**" by **Netflix** is included under fair use.

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Transcript for Figure 3.19, Exposing Parchman

[Music.]

[Narrator]: This is what we live in in Parchman.

[Shawn "Jay-Z" Carter]: People losing their lives and being covered up.

[Mother of incarcerated person]: The last time I talked to my son he said, "Mom, I'm not gonna be able to make it."

[Advocate 1]: People are living in a place that was built for them to suffer.

[Advocate 2]: A former Plantation that had a history of slavery.

[Music.]

[Mother]: My son did it wrong but he's a human.

[Relative]: He was my whole world.

[Mother]: I missed my [unintelligible].

[Speaker 1]: We filed the class action lawsuit.

[Speaker 2]: It's time for the world to help us correct these wrongs.

[Speaker 3]: If this was an animal shelter people would be going to jail.

[Mario "Yo Gotti" Mims]: Every action that we take is all to get justice for these families.

[Relative]: My son.

[Relative]: My brother.

[Relative]: My nephew.

[Relative]: My everything.

[Speaker 4]: We're not going to be silenced. Ever.

Exposing Parchmen. Premiere Saturday June 17th at 8 on A&E.

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Transcript for "**Exposing Parchman**" by **ROC Nation** is included under fair use.

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Transcript for Figure 3.24, Lois Curtis Documentary Trailer – 2023 Anniversary of Olmstead v. L.C. (Lois Curtis)

[Narrator]: 1995. Aspiring artist Lois Curtis was confined to a state-run institution in Atlanta, Georgia. Curtis was not alone. Thousands of people with disabilities were confined to State institutions.

The women argued their right to live in integrated communities fully funded and won.

[Keri Gray]: Lois Curtis to me represents our need and our fight for bodily autonomy.

What I respect about her Legacy is: her fight. She fought for her bodily autonomy and she won. And what I love about her is that she won not just for herself but for the many of us who have come after her.

[Vesper Moore]: For me as a brown disabled person, Lois Curtis's legacy, Olmstead, is symbolic of ideas of freedom and liberation that are important for disabled people, that are important for brown and black disabled people. That legacy and what that means is that we can live lives in the community just as any other person would.

[Keris Myrick]: As a black, disabled and psychiatric survivor, a person with a psychiatric disability, this means so much to me because so often things have been forced upon me without my choice, without my voice. And when I think about Lois and what she did using her voice being able to talk about the importance of choice, community inclusion, being a part of and developing a community that is for and by her with the supports that she needed, I know that I can speak up and do that as well.

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Transcript for "**Lois Curtis Documentary Trailer – 2023 Anniversary of Olmstead v. L.C. (Lois Curtis)**" by **Bazelon Center** is included under fair use.

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Transcript for Figure 4.5, NAMI Sharing Your Story With Law Enforcement Program

[Jennifer Paster, Deputy Chief Superintendent, Brookline Police Department]: I'd like to think that the job has changed and that it's allowed us to slow down a little bit. It's placed a focus on actually helping people in ways that are not just about locking them up and putting them away.

[Jolissa Hebard, NAMI speaker]: Hi, everyone. Thank you for being here. My name is Jolissa and I'm with NAMI. NAMI is the National Alliance on Mental Illness. We are the largest grassroots organization started by the friends and family of those with serious mental illnesses. So we are not clinicians, we're not doctors, we're not therapists. We are people with lived experience.

[Pietro D'Ingillo, law enforcement psychologist, Los Angeles County Sheriff's Department to police officers]: Our NAMI friends are here today because they want to see you succeed. One of the highlights of the whole week is the presentation from our friends from NAMI. So we have Jolissa and Christine. They've both been here before. They do a great job at explaining their stories.

[D'Ingillo]: When they experience that emotional connection with our NAMI presenters, it accentuates their experience and very importantly, it promotes the shift in attitude.

[Paster]: Sure, part of our job is law enforcement, but it's also about upholding people's constitutional rights and allowing people to live their best lives.

And sometimes that's not making an arrest. It's actually connecting somebody to services for mental health, for substance use.

[Jasminka Jurisaga, senior lead officer, Mental Evaluation Unit – Valley Bureau]: I mean, this is an opportunity that you don't get too often, where you are in an environment where everyone's safe and you can ask questions and actually listen to someone who's willing to share their story because they want you to know. They want the officer to know what they're going through or what they've been through.

[Jose Navarro, law enforcement psychologist, Los Angeles County Sheriff's Department]: It's a tough job. It's a job where… physiologically we're wired to run away from danger. They're using their willpower to go towards it, to rescue, to save, to protect. But to be able to get away from that mentality of, "I'm here to fix something," that in reality is not fixable. It's something that we need to manage in the moment.

[Paster]: If it's a younger officer, if they haven't been to a call where somebody is in crisis, I can guarantee that they will be and definitely before the end of their first year of service.

[Jurisaga]: I specifically remember a call that we went to and the family was calling on their adult son. He was younger, and we had determined almost immediately that he was going to go to the hospital. But I remember putting him in the back seat of the police car

and him screaming out the window like, "You were not even listening to me!" "You're treating me like an animal!"

I'd still rather be out in the field handling calls, but after going through this training and seeing how beneficial it was to be able to hear someone from NAMI share their story with the police… Absolutely. I'd do this training anytime.

[Paster]: I think a really important aspect of the NAMI training is that we get to see that people do recover, people do get better, and people go on to lead successful lives.

[Navarro]: If I have one word that Share Your Story from NAMI does for the people in the class is "hope." It provides hope, especially when at times folks come to the class not feeling it anymore because of – just the crisis. And so hope is definitely ignited.

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Transcript for Figure 4.6, Decriminalize mental illness

[Tonya Jones, Peer Support Specialist]: People look at mental illness as a crime. You are a menace to society, and that's not the case. They're not a problem. They're a human being. They're going through something. How can I help them?

[Sarah Radcliffe, Disability Rights Oregon]: My name is Sarah Radcliffe from Disability Rights Oregon. There are two crises happening simultaneously. One is lack of access to mental health care and the other is lack of access to affordable housing. People with mental health concerns or brain injuries who are living on the streets can become trapped in a cycle of incarceration and institutionalization. Say that I'm charged with a crime, disorderly conduct, trespass, even littering or public urination, and because of my disability I may not be able to understand the charges against me and to effectively work with my defense attorney.

That's what we call the ability to aid and assist in my own defense. So if I'm unable to aid and assist, the court will probably order an evaluation and I may wait in jail for weeks or months in order for that evaluation to happen. Then if I'm found unable to aid and assist, the court would send me to the state hospital to receive treatment in order to become able to aid and assist. And I may stay at the state hospital for a long time, months, even years. Then I'm discharged, sometimes back to living on the streets because I'm not connected to the services I may need. Housing, healthcare, transportation, food, government benefits.

[Jones]: I'm not getting released to any services. I'm homeless again. One more time, I get arrested, I get released, I'm homeless. So I'm back at square one. It just continues that cycle.

[Melissa Allison, Assistant District Attorney, Marion County]: If we're just taking them off the street for a couple days and then causing them to lose their benefits, lose their housing, and then really make matters worse for everyone, we're not really helping anybody in that process.

[Radcliffe]: And it's created a doubling in the past eight years of the number of patients who are at our state psychiatric hospital on aid and assist orders.

[Allison]: There is a great problem here where people are serving more time in custody just because of their mental illness.

[Jones]: Instead of understanding that this person is struggling with their mental illness, they're criminalized. That's a problem. That's the problem.

[Dorian, former state hospital patient]: It sucks to be out on the streets. I went from being at home living with my mom and my sisters to the streets overnight.

I've dealt homelessness since age 20, in and out of jail 45 times. Many of the charges were trespassing, things that mostly a homeless person would go to jail for. The first time I was in the psych hospital was for about four months. My first psych eval was that I was schizoaffective. I went to the state hospital three times. One time was for a year and five months.

[Radcliffe]: Treatment at the state hospital costs $240,000 per person per year. More than half of Oregon's mental health budget is being eaten up by the state psychiatric hospital.

[Dorian]: They spent all that money. They pretty much dumped me back on the street with no help at all. It's really hard. It's really hard. It doesn't feel that good.

[Radcliffe]: We're spending a lot of money on this process, which we all recognize doesn't work.

[Allison]: Take the humanitarian angle out of it and we're just looking at the fiscal impact. What else could our communities do? What can our communities be doing with this money to avoid these things happening in the first place and making our communities better?

[Music.]

[Jessica Kampfe, Public Defender, Marion County]: There really needs to be an intervention early on that takes the person out of that loop of pre-trial incarceration and hospitalization. We are fortunate in Marion County that we are building good resources to help people with mental illness.

[Ann-Marie Banfield, Marion County Health Department]: The Psychiatric Crisis Center began back in 1995. Our goal is to move people. Out of law enforcement and even acute care services, really to community stabilization.

[Jason Myers, Marion County Sheriff]: Oftentimes law enforcement are afraid if they leave somebody on the scene of a call, they'll either get hurt or they'll hurt somebody. Psychiatric Crisis Center is a great place outside of jail, outside of the ED where people can access services because it is manned 24 hours a day. We want to make sure the community is safe and that's a great alternative and I think that's why it's been so successful.

[Banfield]: We do that through the outreach team. We do that through our mobile crisis team.

[Myers]: Working together with law enforcement officers, we have developed case management systems.

[Banfield]: In 2015, we were also able to hire a half-time deputy district attorney to help us focus on the aid and assist cases.

[Allison]: I'm Melissa Allison. I do the aid and assist cases at the Marion County District Attorney's Office. When we get a case at the DA's office, we look for signs that this was mental illness driven. If so, can we just connect them with services and not charge a criminal case? And then I dismiss the case.

[Kampfe]: The numbers at the state hospital are now consistently going down, which is different than the statewide numbers, which are consistently going up.

[Myers]: The diversion has helped. Our jail bookings from our historic high in 2009 are down, which is good news. The criminal justice system is not the answer. Treatment-based services in the community is, and that's where we see the success.

[Josh Smithers, person helped through diversion]: I'm Josh and I'm 23 years old. If there hadn't been a diversion program, I think I would probably still be homeless and using drugs.

[Cliff Smithers, Josh's father]: His mother and I used to live on Wilbur. And so when the kids were really little, we'd have picnics here. I didn't have any idea my son would end up living here. When folks were telling me Joshie was living in the park, it broke my heart.

[Josh Smithers]: I lived in the park for about a year. My day-to-day was kind of searching for drugs, get high and get in trouble, to be honest. I was charged with two misdemeanors, a DUI and possession of methamphetamine. I was hospitalized for 95 days. Diversion is helpful because they got me out of jail. They really got me connected with my family, and that was a huge support that I needed.

[Cliff Smithers]: He's not using methamphetamine anymore, so it's really good to have him back at his real home and be able to just come visit.

[Music.]

[Dorian]: There are people that suffer from mental problems that are homeless, run into a lot of problems on the streets and with jails and institutions. They need someone to help them with housing and Social Security benefits, get them ID and get them medication, get them a job possibly. If you don't have those things, you're most likely going to end up in jail, a psych hospital, or prison.

[Myers]: You can't arrest your way out of that issue of behavioral health or homelessness or addiction. It just doesn't work. Where I've seen the work is with an intervention and treatment and wraparound services in the community. That's where lives are changed and the community's actually safer because the individual is treated and they're better for it.

[Jones]: When a person's basic needs are met, they're able to become more self-sufficient. Our criminal justice system really should find the money to make that happen.

[Radcliffe]: If you care about this issue, talk to your state and county elected leaders and visit DROregon.org.

Licenses and Attributions for Transcript for Figure 4.6, Decriminalize mental illness

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Transcript for Figure 4.15, A rare look inside a mental health court

[Music.]

[Narrator 1]: A mental health court is a treatment court that focuses on the offender and the offender's mental health.

[Narrator 2]: It is a team of people working hard behind the scenes to help each of our participants be successful in their life.

[Hon. Sally Tarnowski, mental health court judge]: I'm so happy to see you! Have a seat, Wow! How are you guys doing?

Oh, when they come into mental health court, we sit in a circle. I sit down in the well with them; they have the team around them in the courtroom; they have their other participants sitting with them. It is a much more nurturing and supportive environment for them than a regular courtroom.

[Mental Health Participant 1]: My kid's father got out of prison after eight years, and we were together when he went in; it was just like a whole – just a whole lot – of family issues, family emergencies going on. I felt bombarded with just distress, like emotional distress; and I made, I made choices that you know.

[Tarnowski]: A participant will come in and tell me the judge, in front of the prosecutor, in front of the probation officer, in front of a law enforcement person, that he or she used something over the weekend, used meth or used heroin, something that would be a violation of their probation and would get them in trouble; but which they know we are going to respond in a way that is going to support them and get them the help they need.

[Team member to Mental Health Participant 2]: This is the light that you have in the world and you've done so much good work that your light now shines through.

[Participant 2]: I need to write that down.

[Kim Davis, client advocate]: It's not about getting people to confess, you know I mean. You have to tell us what you've done and pretty soon they feel really invested in their truth-telling, that the truth really means something to them, and that the truth means that it's going to have like a treatment response to it.

[Barry Schull, case manager]: A lot of times when a person will enter the mental health court, they're homeless or they are in court-ordered treatment, part of the things that we focus on are stability in all of those different Areas, it's a long process.

[Carolyn Phelps, psychologist liaison to mental health court]: It is not a get-out-of-jail-free card. It is way harder than actually doing your time because of the accountability piece. You can't get away with not going to treatment.

[John Villa, probation officer]: My name is John Villa. I work for Arrowhead Regional Corrections for the mental health court of St. Louis County today, what we're doing is we're doing field visits on clients. It's a standard thing that we do in the mental health court, where you know not only do clients meet with the judge on Fridays and correspond with their case managers and everything, but part of my responsibility is to go out and see them in their residence to see how they're doing in the community. Because a lot of that information can then be relayed to the team and, plus, it keeps them connected. It's not just they come to the court, report to the court, and then it's done. It's so it shows them that we're out here, we're still trying to help them, we're trying to support them and we're trying to to be there for them during this time.

[Villa to client]: So just go ahead and put that in and just keep building up spit. Just leave it in your mouth and don't take it out because when you take it out the air causes it to dry and I will refrain from asking you questions. I always say I feel like a dentist – "Hey, so tell me about your day!"

[Villa]: There's a lot of obstacles that we need to overcome. There's a lot of trust issues that these individual may have, there's a lot of fear.

[Phelps]: This is not their first go around in the criminal justice system and the criminal justice system has its own level of trauma with it. And then you have us and we're all about, "Hey we're different you should trust us," and that what is truly amazing is that there's an ever stepping forward.

[Mental Health Participant 3]: Our court systems are overworked, underfunded and completely packed with people. It's an in-the-door, out-the-door thing. The judge goes to the prosecutor, the prosecutor goes back to the judge. It's like an oiled system.

I spent my youth and pre-adolescence and pre-adulthood and active use just constantly in trouble, a revolving door of in and out of court systems, and uh by the grace of the good Lord, I got accepted into the mental health program, and that was the beginning of the end for me to start facing the issues I have.

[Villa, taking notes with his phone]: Client and I talked about how the weekend has been for him, and he said that he went fishing and got more fish, including a turtle, period.

[Tarnowski]: You know, I think there's probably some fear by the public when they hear that people are maybe being placed into a treatment court rather than going to Prison, I think the public should be aware that you know somebody can serve a couple years in prison and come out and commit the same crime again; they may or may not have learned how to deal with the issues that they have when they get back to the community. Whereas we teach them to be in the community.

[Mental Health Participant 4]: I just recently started this program. I've been through a lot, a lot of trauma, which kind of led up to self-medicating with drugs and alcohol. I always wanted to give back to the community, and I figured that the best way to do it would be to do a city-wide cleanup, which is happening today. For the past two years, I've been wanting to do this. But, I was using. With the whole mental health support team, I'm turning my life completely around; my mind is caught up with my heart.

[Tarnowski to client]: Thor, you're doing great. Yep, so what are you doing every day with your time?

[Tarnowski to client]: Thor, you're doing great. Yep, so what are you doing every day with your time?

[Thor, Mental Health Participant]: Um, right now, um, I have community service that I'm going to be doing this week. I have um, eight hours eight hours left. I did two hours, so I have eight hours left to community service, so I'm going to finish that this week.

[Tarnowski]: Where are you doing it?

[Thor]: At Hermantown Community Church, and that was one of the places that I had, um, wronged when I was doing the wrong things. Oh wow, yep, and um Barry, um Barry took over, and he was my, he had suggested maybe writing them a letter and stuff, so I had wrote them a letter apologizing. They mentioned that they had some community service work available and stuff.

[Tarnowski]: Wow, Thor! That's great!

[Thor]: So it worked out really nice, yeah, and kind of um, kind of healed up a sore spot too, so yeah, real nice too.

[Phelps]: Wow, what a great story. That's the essence of community service, and you know, you have such a good heart, and when you allow yourself to do well and you're not blocking that up with self-use or anything, then your good heart really shows through.

[Thor]: Thank you. Yep, I'm very grateful for Mental Health Court. I wasn't able to do those things when I started Mental Health Court, advocate for myself. This has all developed in the last two years of being on Mental Health Court.

[Tarnowski]: You've done a lot of hard work and come a long way. You've just really rocked it.

[Thor]: Thank you.

[Tarnowski]: All right, good to see you. See you in a couple weeks.

[Thor]: Okay.

[Phelps]: If we can talk with people in a way that they can hear, that is what builds the trusting relationship and that is also what leads to that next step of change.

[Ambient noise at outdoor ceremony.]

[Tarnowski]: So today's our big day for Thor and Joel and Clinton. Clinton actually technically graduated a couple weeks ago, but he gracefully agreed to push this off so we could all be together and do

this together, all three of you, and I know the rest of you participants have had a lot of experience with the criminal justice system and the courts, and it hasn't generally been a pleasant experience for you, and coming into a courtroom is probably a pretty traumatic experience for you, especially initially when you come in with us, and it's really always very incredible to me to see when that flips for you. With each and every one of you, it does. There's a day that comes that you walk into that courtroom and you go, this is not the place that's going to be so bad. This is a safe place for me, this is a place where I can tell the judge something that I would never have admitted to anybody, particularly a judge; certainly not my probation officer or the prosecutor or the police officer – all of whom are sitting in that courtroom too. And you come in and tell us because you know that you're in a safe place and that we're there to support you. And I know that that has to be such a difficult thing to learn and to believe; but you each have exemplified that.

[Thor]: Before mental health court, I was stealing to support a meth habit, and I was using probably a hundred dollars a day worth, but that's a lot of money, a lot of stealing, a lot of crime, a lot of different things. Now today I don't so much as take a penny that doesn't belong to me. But it was a 180 from how I started to how I finished, um, and I'm just really happy, and I'm happy for anybody that gets to get the privilege of going through the program. It's a really good program.

[Applause.]

[Mental Health Court Participant 5]: I just like to thank the team judge um, I've been doing drugs and dealing with mental health stuff since I was 14, and I think it was my early 20s when I first prayed and I said God, something's got to change, you know, and uh, just seemed like I could never lose the desire to use you know, and um, something something is different this time, you know. And mental health court has helped me by not just throwing me in jail but putting me in treatment, getting me back on my feet until I learned, you know. And I'm going to continue to learn to keep moving forward, so I'm just really blessed.

[Applause.]

[Tarnowski]: So for each of you, we have a certificate at the bottom, there's a quote that reads, 'Challenges are what makes life interesting and overcoming them is what makes life meaningful.' Whenever you find yourself doubting how far you can go, just remember how far you have come.

[Music.]

[Phelps]: Mental Health Court is the morally right solution for a group of people, for a group of our participants. For the people who would be and should be our participants, it is the morally right solution. It is what makes a better community, it is what makes a safer community, and it is what makes a community that we can all be proud of.

[Music.]

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Transcript for Figure 5.6, NAMI Policy Priorities: Crisis Response For Mental Health

[Anita Fisher, Mental Health Advocate and Caregiver]: Crisis response has affected, I say our family, because I always start with, mental health challenges in an individual in your family affects the whole family. I wish that instead of that call being law enforcement, that we would want that team to look very different, that it could be a clinician and a peer specialist and a family specialist and a case manager, you know, that it looked a little different. And I think it would be more accepting to the individual than to have to go out in handcuffs.

[Stacey Owens, NAMI Board Member]: I've seen firsthand the tragedy that can happen when law enforcement responds to someone going through a mental health crisis. In my experience, too, law enforcement responds; people in crisis often end up in jails, in emergency departments, on the street, or even worse, they're harmed or killed during the encounter.

And that's why this is so important. NAMI believes that public policies and practices should promote access to care for people with mental health conditions. NAMI supports the development and expansion of mental health crisis response systems in every community.

There are three core elements of the National Guidelines for Crisis Care. First, Regional or statewide 24-7 crisis call centers. Second, mobile crisis teams. And third, Crisis Receiving and Stabilization Programs.

[Fisher]: I know for me personally, it is treating the individual before it becomes a crisis. To me, that's always number one.

[Owens]: Every community needs a response system that gets people on a path to recovery.

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Transcript for Figure 5.9, Mobile crisis team hits the streets in Clark County

[Mike Fort, Battle Ground Police Chief]: If you take a police officer off the street to devote the necessary time, to devote to those that are in behavior or mental health crisis, then they're taken away from those kinds of significantly violent types of crimes. So that is why this team is needed now. They take that pressure off of the police.

[Bryant Clerkley, reporter]: Battle Ground Police Chief Mike Fort is speaking about the Columbia River Night Crisis Team, which is in its first week hitting the streets of Clark County. The team has a partnership with the Battle Ground Police. The crisis support specialists are trained in intervention, de-escalation, and risk assessment.

[Fort]: There's a fair amount of calls that we get that are people that are, and I would say the calls are there's a suspicious person.

And the suspicious activity may be talking to themselves or randomly walking up and down a street or something like that.

[Clerkley]: Mike DeLay is the program director for the mobile team. He says referrals come in from the Clark County line. They screen them and then contact the team, or law enforcement calls them directly. The goal is to get people help. There's 19 members that respond throughout the county.

[Mike DeLay, Program Director, Columbia River Night Crisis Team]: We really want to have this team minimize contact with law enforcement, minimize contact with restrictive levels of care, hospitalizations, things of that nature, so a person can stay in whatever place is most comfortable for them, and then connect to supportive services afterwards and hopefully no longer need crisis services.

[Clerkley]: DeLay says the team carries water, food, tents, and sleeping bags. They also have flashlights and branded clothes so people know who they are.

[Clerkley, in the studio]: The night crisis team was funded through a $2 million federal grant. DeLay says that should last about two years. The police chief says he would like to expand the program even more, and get more of these mental health professionals out on the streets. Brittany?

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Transcript for Figure 5.10, How Project Respond supports our community with crisis mental health care

[Lacey Evans, host, Hello Rose City]: There's a look at downtown Portland from the Hello Rose City skycam. It's going to be a beautiful day, with temperatures in the upper 80s today. Hard to believe it's fall, but get out there and enjoy it if you can.

There are a lot of people on our streets who need help, but sometimes it's not clear how to get them help or who we should call. And that is why Cascadia Health is here. Jackie Thomson is the senior director of Crisis Services for Cascadia. Hi, Jackie.

[Jackie Thomson, senior director of Crisis Services, Cascadia Health]: Hi!

[Evans]: So first, give me a quick overview of Cascadia Health and your mission.

[Thomson]: Yeah, Cascadia Health is definitely trying to incorporate whole healthcare. So we believe that mental health and physical health are combined no matter what we try to do or say differently. And Cascadia is all about providing services that incorporate that.

[Evans]: So how does the Project Respond mobile team work?

[Thomson]: The Project Respond Mobile Crisis team runs 24/7 and it's an interdisciplinary team, so it's masters-level clinicians and peer support specialists that go out into the community for anyone that is experiencing a mental health crisis.

[Evans]: And how can people access the Project Respond services?

[Thomson]: We are dispatched by our communities' crisis response teams, so we are dispatched by our crisis line. So you can call the crisis line anytime 24/7 and they are like the immediate response. So you're talking to someone on the phone immediately. And then when that mobile response is needed, we come in and dispatch to any location in Multnomah County.

[Evans]: I think a lot of people are nervous about calling 911 in certain situations. Can Project Respond be dispatched by 911? And what would you recommend in that situation?

[Thomson]: 911 also partners with our Multnomah County crisis line, so they send calls to each other. So really, it's about anytime someone's needing an emergency crisis response, call whatever you feel comfortable with. If it's going to be 911, they will send it over to the crisis line and dispatch us. And that works kind of – coincides with what we do. Like it doesn't matter how you try and get ahold of us. We want to be there for them.

[Evans]: And you are available 24/7, you said?

[Thomson]: We are.

[Evans]: That's excellent. Why are these mobile crisis services so important?

[Thomson]: That's a great question. We think it's so important because if, in our community there's an emergency, we send resources to individuals needing those. Emergencies for health, for fire, and we believe we should do that for an emergency mental health crisis as well. So if somebody feels like they can't or aren't able to go into an office, or our urgent walk-in clinic or their doctor's office, we need to have resources that go out to them in that crisis. So we feel like that's incredibly important, incredibly important to run 24/7, and also that we don't bill to insurance. We don't ask for this financial assistance for getting a resource like that to you in an emergency.

[Evans]: I've also heard you say before that your teams drive around in unmarked cars, because unfortunately there is still a stigma around mental health. And some people might not want to draw attention to the fact that they are getting help. Do you want to talk a little bit about that?

[Thomson]: Yeah, we very much don't deny that mental health is still very stigmatized. And again, that's why if you want to call 911 or any of those resources to get a hold of us, we'd never want to make that a barrier. And part of that is also not billing for services. Anyone, whether they have insurance, private insurance or no insurance at all, should be able to access care for their mental health. And the unmarked cars are part of that – we don't want to advertise in case that's a barrier to somebody accessing our services, that, hey, we're coming to talk to you about your mental health. We don't want that to get in the way. If somebody wants it as private as possible, we will definitely make sure that is part of our response.

[Evans]: Excellent. OK, so if people want to donate to Cascadia or just find out more information, where can they go?

[Thomson]: You can go to our website (cascadiahealth.org). Of course, we're also on social media, but we also have a lovely event coming up on October 27th.

[Evans]: Yes, tell us about the gala.

[Thomson]: The gala – so we will be talking about Cascadia, our services, people that have accessed services from us are going to speak at that event. And really it's just to show what we're doing and what we're trying to do in our community and to see if anybody wants to help support us. You can tune into that event.

[Evans]: Yes, it's on right here on KGW on October 27th. So yes, definitely tune in and learn more information about Cascadia Health. Jackie, thank you so much for being here with us.

[Thomson]: Thanks for having me.

[For mental health support: 503-988-4888.]

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Transcript for Figure 5.13, CAHOOTS Interview on CNN – Alternatives to Police Response

[Kate Bolduan, CNN Reporter]: So George Floyd's death and the massive protests that have followed have put a sharp spotlight on racial injustice and police brutality in the country. It also has reignited a debate over what exactly the job of police should be and should not be. Here's what the police chief of Sacramento told us here just yesterday.

[Daniel Hahn, Sacramento Police Chief]: There's a lot of mental health calls that we go to that police officers don't need to be there, but nobody knows who to call other than us. There's no other resources that can come and deal with the situation. So the fall back is police officers. I think one of the ways we can get a lot better is that we get the people who are best suited to respond to some of these things to go there as opposed to police officers.

[Bolduan]: Chief Daniel Hahn, there echoing a sentiment that seems to be shared by police activists and politicians alike.

We heard Rashad Robinson talk about this at the very top of the show. One alternative model that is now getting new attention now is based in Eugene, Oregon. The city has a different way to handle non-criminal calls with an organization known as CAHOOTS, which stands for Crisis Assistance Helping Out on the Streets. It dispatches teams that are specialized, specially trained and specialized in mental health as first responders. Joining me now is Ebony Morgan. She's a crisis intervention worker with CAHOOTS. Ebony, thank you for being here. For folks and myself, explain a little bit more about what you all do.

[Ebony Morgan, CAHOOTS Crisis Intervention Worker]: Thank you so much for having us. Right out of the gate, I just want to send my condolences and from the team of CAHOOTS to George Floyd's family.

As someone whose father died in a police encounter, I just want to be really sincere about that. CAHOOTS as a team has been around for about 30 years. We are made up of a medic and a crisis worker. We're dispatched through the city, but through the police, fire, and ambulance dispatchers, and we respond to non-criminal calls. We did 20% of the calls in the area. Last year, about 24,000 calls. We can do welfare checks, death notifications. We can transport people to necessary services. One of the things that's great about it is that out of our 24,000 calls, only 150 of them did we wind up needing to ask for police to assist us. So we can show up on the scene and assess the need and assess the appropriate interventions that will genuinely help our clientele.

[Bolduan]: Ebony, why does this system work? I've read that you all handle almost like 20% of the entire public safety call volume for your area. Why does this work? What is it?

[Morgan]: I think our greatest tool is the trust of our community. And then we are as strong as our community resources. So from our perspective, prevention and humanistic approaches are what really is effective. When people see us coming, they know that we are there to help. That's just our whole goal. We lead with the question, how can I support you today? Or some form of that. And really figure out what the root of the issue is, rather than addressing what we see directly in front of us. It's how did you get here? What do you need to help you get to a place where you can thrive?

And what if someone's in a crisis, you know, just addressing it to a degree where they feel seen and heard can de-escalate by itself.

[Bolduan]: Absolutely. I find it fascinating, important to point out that, as you mentioned, you do call in police if that situation is required. So there is work with the police in your community when need be. But in looking at your model, Ebony, CAHOOTS, from what we all know, would not have been called to respond to the situation, specific situation that led to George Floyd's death. So I say that by way of pointing out that this isn't a cure-all, if you will, for all of the problems and longstanding issues and systemic issues that we are discussing here.

Why is this, though, do you think could be, could this be a part of the solution of reforming policing in America?

[Morgan]: Absolutely. I think that since it's a systemic issue, the response and the resolution will also have to be systemic, and we will need more community supports and more, you know, unarmed mediation and decriminalization and a sense of restorative justice and truly mental health care nationwide to get to a place where we need less of that response. And then also in that system, as it's reformed, I think there's definitely a place for trained crisis personnel to respond and assess a scene and figure out what the appropriate response is. If it's outside of our scope, we can call for that. We can call for an ambulance. We can call for backup police. But those initial eyes and objectivity, we have a lens that is not coming from, you know, we're not armed. We just carry the tools that we need to assist. So we just approach with a really, as objective as we can be with a lens to make sure that we use the right tools to help the person we're visiting.

[Bolduan]: Ebony, thank you for what you do. This has been around for 30 years, and it looks like it could be a really important thing for a lot of folks around the country to be looking at right now. The work that you do, the care that you give, and the trust that you have for your community. Thank you, Ebony.

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Transcript for Figure 5.14, Stabilization Center Tour

[Holly Harris, Stabilization Center Program Manager]: Hello and welcome to the Deschutes County Stabilization Center. The Stabilization Center serves children and adults who are in need of mental health crisis supports and stabilization. We welcome individuals to walk in who are experiencing a mental health crisis, or they can be referred by law enforcement or other community partners.

Most individuals who come to the Stabilization Center receive a crisis assessment in one of our five intake rooms. The purpose of this is to assess for risk and determine each individual's needs. We offer connection to additional community resources as well as appointments for ongoing mental health treatment and medication when appropriate.

An additional service we offer for those who qualify is Adult Crisis Respite. This is a voluntary, five-recliner, short-term respite unit for adults experiencing a mental health crisis. This area provides a quiet and peaceful environment for individuals to stabilize and get connected to the appropriate community resources. To qualify for short-term respite, a crisis assessment is conducted and a determination will be made for admission to respite.

If the clinician and the individual determine additional time is needed to stabilize, they may be admitted to the Respite unit if the following criteria are met.

- The person is voluntary and willing to participate in the admission process.
- They are in need of mental health services and not aggressive or assaultive.
- They are mobile, able to communicate, and not known to have a major infection or disease in the communicable stage.

Other services that are housed at the Stabilization Center include:

- civil commitment investigations
- case management
- peer support
- forensic diversion program
- mobile crisis assessment team
- co-responder program
- crisis walk-ins

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Transcript for Figure 5.16, Assertive Community Treatment — Introductory video

[Music.]

[Jimmy]: I went to a Judy Collins concert with my mother and I had a great time, so that's that shows that – I went to Charlotte and saw Heart and had a good time – so that shows that I can get out and I can be a part of the community. I just want to be a part of the community like everybody else.

[Music.]

[Female Speaker]: Tell us what that was, Jimmy.

[Jimmy]: That's Beck's Bolero.

[Jimmy]: There's some famous people over the years who have had mental illness too, and they've learned to cope with a mental illness, and I just want to cope with mine and live out a good life.

[Music.]

[Narrator]: This South Carolina native, whom we will call simply Jimmy, has been struggling to cope with his schizoaffective illness for over two decades.

[Jimmy]: I went through a lot of hospitalizations. I went through 30 or more hospitalizations. I've been diagnosed paranoid schizophrenic, borderline psychosis, and I've been diagnosed manic depressive. And I think I have a brain disorder caused by a chemical imbalance in the brain.

[Narrator]: Before he was stabilized, in part with the help of medication, Jimmy's thoughts tortured him. He heard voices, suffered from delusions and fits of temper, and sometimes, devastating self-destructive impulses. Jimmy's mother, Jessie.

[Jessie]: You know, you'd get up in the middle of the night and the lights would all be on and the TV would be blaring and things that maybe don't sound that bad, but when you have to live with it.

[Music.]

[Jimmy]: This is relaxing. Oh, my gosh. I'm thinking about getting the great, putting that picture right, that I have right there, that I have right there, up in here. Up in this room. Add a little more color.

[Narrator]: Thanks to a program for assertive community treatment called PAC, Jimmy now lives in his own one-bedroom apartment.

[Jessie]: He just seems to be much more stable. Now he does his shopping and does his cooking, but he calls me up and tells me he's cooking this. And he's still, to me, he's very dependent on someone, though. He needs that person to help him.

[Andrea Boland, Case Manager, OUTREACH]: Jim, good morning. How are you? Okay, we're ready to do some grocery shopping. I want you to go through your refrigerator and look in your freezer and check real carefully and make up a grocery shopping list.

[Narrator]: In Outreach, a packed model, staff spend about five hours a week with Jimmy in multiple contacts. A melding of support, teaching, problem-solving, and therapy.

[Music.]

[Barbara Julius, Director, OUTREACH]: OC nothing, Almeda nothing. Patty, she gets her medications Monday through Thursday today and she's a one-to-one with Andrea; we give her a phone call at night to remind her to take her evening medicines.

[Narrator]: It's a non-traditional approach. Rather than individual caseloads typical with most mental health clinics, the team shares total responsibility for the entire client population. The team of ten mental health professionals meets daily to review each client, but most of the direct client work goes on outside of the office.

[Julius]: Good morning. I've got a present for you.

[Client]: Oh, thank you.

[Julius]: Let's see. Doesn't your place look nice?

[Narrator]: It's a kind of therapy to go where no problem is too much. PACT Director Barbara Julius.

[Julius]: What makes mental health might not just be a visit to your psychiatrist, it might also mean having your entitlements in place or it might mean having your rent paid on time. It might mean knowing how to go grocery shopping. So instead of meeting with a person and talking about how they're doing, how they feel once a month or twice a month, what we do is everything that it takes to keep people in the community living independently.

[Narrator]: Providing assistance with social relations, employment, and basic needs like housing and food.

[Boland]: That corn looks pretty good. What's the price on that? It's not bad for three fresh ears.

[Narrator]: Treatment strategies are tailor-made for each client, including facilitating healthcare.

[Boland]: I'll be right behind you.

[Narrator]: Over the years, clients remain in the program even though their need for services may fluctuate.

[Julius]: Some people come into this program needing all of those services, needing three or four staff interacting with them on a daily basis, lots of phone-call support, lots of emergency crisis intervention. And as they see that support there, they get better. So, that people who once were in this program needing three, four, five interventions a day, every day – might at this point come in weekly for a med refill. We don't fire people when they get too sick, you know, that's a key point for us, but we keep them all. They're all here and we take responsibility for that treatment, and really are willing to try almost anything that it'll take to support them in getting better.

[Narrator]: This holistic treatment concept, with its shared team responsibility, hands-on individualized service, and lifetime commitment to clients, makes Assertive Community Treatment unique.

[Boland]: It's extremely rewarding for me because I can see changes; I can see the impact that we're having. I know that what I do each day really makes a big difference, that's why I'm here. I do it because it's worth doing.

[Client, speaking to case manager]: My mother raised the seven of us, right? My father didn't do nothing but bring in the paycheck. Here you go.

[Narrator]: The intensity of involvement with clients demands a low staff-to-client ratio, one staff to 10 or 12 clients. Low staff ratios pay off, reducing inpatient hospital days by as much as 85 percent. Reduced hospital admissions mean fewer crises, but because of the close contact and constant availability of staff, when a crisis does erupt, the client gets the benefit of early, personalized intervention.

[Relative of client]: He was okay during the evening last night. He was threatening yesterday to break the windows out. Now, he's still saying the same complaints from yesterday that the pressure's on. The voices are worse. That's what's happening. He's been working up to this over the last 10 days.

[Client]: I don't know what I'm going to do. I have to go someplace. I just can't stand that boredom. I know I hurt myself. I heard somebody or something.

[Narrator]: It's a rough road for clients and families in crisis, sometimes involving the court, the police or sheriff, neighbors and landlords, hospital emergency room personnel, and 911. Not with PACT. The team handles it all.

[Music.]

With the nurse's guidance, clients prepare their own medication for the week, and all staff share in making daily morning and evening medication deliveries for those who need it.

[Boland]: All right, you take that, and you take this. It's nice and cold, isn't it?

[Male Client]: I already feel like I'm whistling Dixie.

[Boland]: You do?

[Boland]: You load your Depakote?

[Yolanda, Female Client]: Yeah, I used to take three Depakotes at night, and now I take two.

[Boland]: And the reason he did that?

[Yolanda]: The memory.

[Boland]: Your memory. To increase it?

[Yolanda]: No, to decrease it.

[Boland]: To decrease your memory?

[Yolanda]: No, I need to make my memory come back.

[Boland]: Okay.

[Yolanda]: I get paranoid. I think people are after me. I think little creatures are bothering me. And I see things on the floor or on the ceiling. I don't see it on them anymore. If I take my medicine, I'm fine. If I don't take them, I get sick, and I end up in the hospital.

[Case Manager]: And tell me why you're taking the Depakote.

[Yolanda]: The Depakote is for mood swings, and the Mellaril is for clear thinking.

[Case Manager]: When you spoke with Dr. Christie last, you said that you weren't hearing voices.

[Yolanda]: No, I wasn't hearing voices. I'm just having a hard time. I'm sleepy.

I was in and out of hospitals because I couldn't face the fact about being mentally ill. I cried a lot. I didn't want to take my medicine. I said, 'I don't need this medicine.' This medicine's not for me. This mental illness will go away. It'll go away.

[Narrator]: But the mental illness schizophrenia did not go away. Yolanda's mother, Lillian.

[Lillian]: From the time she was 16 until give or take 18, I could say in the average, she's been in the hospital about 20 or 30 times within that length of time. After she got into outreach, it was a tremendous burden relieved off of me because at least they would check on her; they would make sure she took a medication; they would make sure if she had any place to go to the store. And I feel so much better.

[Music.]

[Yolanda]: I did pretty good in the program. I came out and then in and out of hospitals sometimes, too. But I have moved into my own apartment for the first time.

[Music.]

[Yolanda]: That's nice. You can do what you want to do in your own apartment. You don't have to share anything with nobody. If you want to walk around here with your bra and your underwear on, you can walk around with your bra and underwear on. Can I say that?

[Case Manager]: That's up to you. That makes it more interesting.

[Narrator]: Now, Yolanda is taking steps toward even greater independence, studying for her GED and learning to handle her own finances with PACT Team help.

[Yolanda]: Can I open the bank account in the Bi-Lo in Savannah Highway?

[Yolanda to case manager]: I can.

[Case Manager]: Okay.

[Jimmy, at PACT BBQ]: This is delicious. Delicious. This is delicious.

[Music.]

[Narrator]: Both Jimmy and Yolanda experienced the documented benefits of PACT with fewer symptoms and hospitalizations, and greater independence.

[Jimmy]: That's my favorite. That's a guitar. That's the ocean. That's notes. That's a rose. That's a rose. That's greenery. That represents the forest.

[Narrator]: Programs for assertive community treatment offer some comfort and hope.

[Bank employee]: Are you going to be the only signer on this account?

[Yolanda]: Yes.

[Bank employee]: The minimum to open the account is $50. And then our least expensive checks are $11 and $20.

[Yolanda]: Without outreach, I'll be back in the hospital. I know I would. Sometimes I get upset about certain spats about the program, but it's best. I wish the whole country could get it. Because it would be very great for millions. It would probably make them feel like a whole new brand new person.

[Jimmy, reading]: A mother in her ninth month, ready for a girl or boy, eight pounds of love, a bundle of joy. To think that a woman can have a man's child and that child can grow up to be a successful doctor, lawyer, helper, etc.

[Jimmy]: And outreach gives me confidence because I think that it's given me independence, and that it's given me the freedom to be myself. And when I'm talking straight, I'm making sense. And when I'm making sense, I'm making progress. And when I'm making progress, I'm getting to my goal. And my goal is to be an educator. I would like to educate people. That they can do something with their lives. That there is hope. There is hope out there. And there is, you know, with hope comes faith and with faith comes hope. And you can do anything you want to. If you just get your mind in the right order, you know, you can do anything.

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Transcript for Figure 5.17, ReImagining Public Safety – Q&A with a Minneapolis Behavioral Crisis Responder

[Shamso, Behavior Crisis Responder, City of Minneapolis]: My name is Shamso and I am a Behavior Crisis Responder. BCR is first responders. We're dispatched by 911 and we deal with a nonviolent mental health crisis. You know, we come in there, we actively deal with a crisis and connect them to resources. Sometimes people just want to talk.

And sometimes it's just like somebody called and they were concerned about you. It's kind of cold outside. We can connect you to shelters if you need to. Sometimes they say no, then we're like, OK, so then do you need blankets? Do you need snacks? And a lot of times people are like, yep, I'll take that.

I have family members that suffer from mental health crisis as well as substance use disorder. There is a lot of stigma attached to receiving services in our community. I want to actively be part of a team that is working to destigmatize mental health, but also removing barriers and reducing them for non-English speaking recipients. I am Minneapolis.

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Transcript for "**ReImagining Public Safety – Q&A with a Minneapolis Behavioral Crisis Responder**" by **cityofminneapolis** is included under fair use.

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Transcript for Figure 5.21, Police officers take course teaching de-escalation techniques

[Alaric Tucker, police officer, Englewood Police Department]: When we first approached him, he was very combative, didn't want to talk.

[Leah Mishkin, reporter]: Officer Alaric Tucker remembers the call. It was for a person with mental illness who refused to take his medication and the situation was escalating.

[Tucker]: All the officers were in there just, you know, ready to go; then the sergeant came on scene and it's like tranquility just came over this dude.

[Mishkin]: Sergeant Lester Martin says it was as simple as speaking about basketball.

[Lester Martin, police sergeant, Englewood Police Department]: He really enjoyed basketball and we had an argument over who's better, LeBron or Michael Jordan, etc. And then that got him to trust me, and after 45 minutes to an hour of conversation, it was, 'Listen, I understand you haven't been taking your medication, maybe we should get you some help,' and he agreed.

[Tucker]: It was obvious that he had to have gone through some course like this before.

[Mishkin]: The course is Crisis Intervention Team. It brings together law enforcement officers and mental health professionals over a five-day, 40-hour period to learn from each other through various exercises.

We listened to a session on verbal judo which talked about body language and listening skills when speaking with people going through a mental health crisis. For example, avoiding words like 'come here', 'calm down', and 'because' – those are the rules.

[Amie Del Sordo, VP of Hospital and Community Services, CarePlus New Jersey]: It's difficult for someone who's in crisis to be able to turn that off; you can't turn your voices off – they're there forever, so it really allows them to empathize and understand how to really better work with them.

[Mishkin]: If you look around the room, you'll notice pill bottles filled with candy on the desk – that's another one of the training exercises. Each person has to take the fake medication several times a day to understand what it's like for someone living with mental illness.

Sergeant Martin says what happens is the participants forget to take them a lot of the time.

[Mishkin to Martin]: In your situation it was a matter of taking medication.

[Martin]: Correct.

[Mishkin]: So you could put yourself in a more clear mindset.

[Martin]: Absolutely. Now you understand what they go through on a daily basis. It's bridging the gap, is what we're really trying to do.

[Mishkin]: Because one in ten calls for police service are from people with severe mental illness.

[Tucker]: Prior to coming to this, those kind of situations, you know, the guy got tased. A guy had to go to the hospital because, you know, he had to be physically restrained and we had to involuntarily take him up in handcuffs because, you know, we just couldn't get him under control. Officers got hurt, things like that.

[Martin]: There are times you have no option.

[Mishkin]: And the risk of being killed during a police incident is 16 times greater for those individuals.

[Martin]: We don't want to get hurt. We don't want to hurt anybody. So it's easier to talk to somebody.

[Tucker]: All officers should have to go through this training because the mental health population is just increasing and increasing. It's rising.

[Mishkin]: In less than two years, 155 mental health and law enforcement officials have been successfully trained in Bergen County, and that number is expected to grow. In Paramus, Leah Mishkin, NJTV News.

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Transcript for "**Police officers take course teaching de-escalation techniques**" by **NJ Spotlight News** is included under fair use.

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Transcript for Figure 5.24, Alien Boy: The Life and Death of James Chasse – Trailer

[Voice 1]: And you were feeling sympathetic towards Mr. Chasse then weren't you?

[Voice 2]: He was a guy that you'd think he's going to write some great poetry; he's going to do some great art.

[Voice 3]: This person was part of the original punk rock movement.

[Voice 4]: He was dealing with inner demons.

[Voice 5]: He was frightened all the time. He told me that he was living in hell; help me, help me! And it wasn't Jim Jim anymore.

[Voice 6]: It's very difficult for people to recover from a mental illness and he was managing things well,

[Officer]: Ten years of being a police officer and I've never seen anybody look at me like that with the sheer terror in their eyes. I'll never forget seeing that face and I knew he was gonna run.

[Voice 7]: Jim was in a bad shape; he needed to be hospitalized again. We felt he had gone off his meds.

[Voice 8]: I looked up just as the four men were hitting the pavement.

[Officer]: If you try and bite me or kick me, it's gonna be really bad!

[Voice 9]: Take some pictures. Here, take some pictures.

[Voice 10]: Kicked him a few times, hit him three times, screaming, "Don't kill me, don't kill me, don't kill me."

[Voice 11]: It is my opinion that if he had been transported to the hospital; he probably would have survived.

[Voice 12]: I don't believe that a jail cell is the right place to help mentally ill people deal with their problems.

[Voice 13]: I don't believe for a second that there was ever any ill intent on any of those three officers.

[Voice 14]: It sounded to me like he had been beaten to death.

[Voice 15]: It didn't seem to me that he was urinating. He was standing there looking like a scruffy homeless guy.

[Voice 16]: Picked up the paper. My sister called me.

[Voice 17]: That was Jim Jim.

[Voice 18]: Jim happened to be mentally ill, but he wasn't beaten because he was mentally ill, and the cover-up didn't happen because he was mentally ill.

[Voice 19]: You know, I look at what happened to Jim Jim that day and I look at the city's response, and I just say it's not Jim Jim who's crazy.

[Voice 20]: Today, if you were met with the same circumstances, would you chase him down and do the same thing that you did?

[Voice 21]: Assuming none of this were happening?

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Transcript for Figure 5.25, Learning About Police-Mental Health Collaboration Programs

[Mike Sauschuck, Chief of the Portland, Maine, Police Department]: I'm Mike Sauschuck, I'm the Chief of the Portland, Maine, Police Department. We've had a police mental health collaborative program since the late 90s, and it would be commonly referred to as a co-responder model, which means that our sworn uniform law enforcement officers are responding to emergency calls for service with trained mental health professionals. So with the idea being that they walk through the door as a team, as a partnership, really the core functions of what we do in law enforcement, we know that the majority of what we do day to day involves some kind of nexus to behavioral health issues. Behavioral health issues being substance use disorders and mental health issues. So if we're not addressing those two problems accordingly, then we're not doing our jobs effectively.

Well, I was blessed really to be in the first Crisis Intervention Team training that came to the state of Maine back in 2001. So I've really been operating within the system since it began. And then after that as

a Chief. About five or six years ago, we made the commitment that I wanted all of our officers certified because I believe it's that important for everything that we do.

The very first thing we wanted to do is train ourselves internally. So, 100% of our officers are Crisis Intervention Team or CIT certified.

You know, when we provide our officers with additional skills around communication and de-escalation, that makes everybody safer. That makes our consumers, our clients safer, our community safer, and it also makes officers safer.

I can tell people, and I'm proud to say I was in the first, you know, CIT class in the state of Maine, I can tell people where we were in 1997 when I started in comparison to where we are today. I'm familiar with the things that come up when you're trying to change the culture of not just an agency but of a profession. And that's not an easy thing to do. So, change is a scary thing for people. So you just have to be able to walk them through the steps and explain why this is so important. And I always come back to two simple facts when you want to change anything in law enforcement. And you change culture by focusing on officer safety issues and resource allocation issues. So, when I'm talking to other chiefs, I always have conversations around those two items.

When we talk about officer safety, I tell people, the chiefs, that your officers are going to be safer because of these programs, and your clients are going to be happier. And then you start talking about resource allocation. You know, from an agency standpoint, 30,000-foot view, I'm looking at our officers and what they do day-to-day. It may be a formal workload analysis. It may be just talking to street cops about what you're doing, what are you facing out there, what frustrates you. And I think if a chief walked into any locker room in any community in this country, they're going to, again, come back to those behavioral health issues. So we need to do a better job providing some tools.

And the vast majority of police departments across the country are very small, and they're very rural. So police chiefs say, I don't have the officers or the money to send people to a 40-hour crisis intervention team training. I can't afford to do it, is what I hear. And my response is always, you can't afford not to do it. It's that important. It's a core part of our mission. We need to do a better job. And I don't want those chiefs to be standing at a podium answering questions about why their officers aren't trained, why couldn't they afford to send somebody to a week's worth of training. I've got three cops. I can't break somebody loose. But if you're going to the same house 30 times in a month to deal with the same problem over and over and over again, then you're losing resources on that side as well.

You know, something I also always say is, you're going to pay now or pay later. Pay now, train your officers, treat people with respect, and then you're not paying later with the criminal justice system, with the hospitals, and things of that nature. That revolving door is not the way to do business.

You know, to have the training is one part, but you have to have the relationships. You have to have the collaborative partners in your communities to make this work. So how is that scalable? I think it's very scalable in the sense that chiefs need to branch out. They need to build these relationships, whether it's a single practitioner that may be in their community or may be in their county in some cases. So take care of it on the front end, front-load this issue, and work with your people. Everybody's going to be happier for it.

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Transcript for Figure 5.27, Bellingham Police Perspective Project / 20E5: Responding to a Behavioral Health Crisis

[Officer Serad]: I heard over the radio that he was attempting to start a car that he believed was his, and that's really why I became involved. I was thinking there might be a behavioral health component to it, so I happened to be in the area. I saw several officers responding there and I pulled up and made contact with him.

[Music.]

[Officer Knutsen]: Welcome back to the Perspective Project. I'm Officer Knutsen, and in the last episode, I got to introduce you to our behavioral health team, Officer Serad and Laura Woods, our behavioral health specialist. The day before we filmed those interviews, Officer Serad responded to a call where somebody was in crisis and officers had to show up, try to keep everybody safe, and work through the de-escalation process. I was able to get body camera footage from the call to show in this episode. A couple of things to note about the footage you're about to see. First, when officers actually showed up to this call, it took about 24 minutes from the time they arrived on scene to when they resolved the situation. So for the sake of time here, I've shortened that down.

Second, some of the language is fairly graphic, but I felt it was important to leave it in because it shows how heightened and volatile the call started and then where we ended up. And third, there might be points where the audio cuts out or there's scenes that have been clipped, and that was done intentionally to try to hide the identity and protect the individuals that were involved in this call. While we want to be able to show what de-escalation looks like, we also wanted to be as respectful as possible to the people involved in this call. So with that, let's take a look.

[Serad]: I got 911 calls made by a couple citizens that were in the area and were watching this gentleman try to break into a few cars. At some point, he was throwing rocks at some vehicles. I heard over the radio that he was attempting to start a car that he believed was his, and that's really why I became involved. I was thinking there might be a behavioral health component to it. So I happened to be in the area. I saw several officers responding there, and I pulled up and made contact with them.

[Audio from body cam footage]: Stop. We don't want to hurt you, we're not going to hurt you. Drop the rock. It's the Bellingham Police Department. He's dropped the rock. We're calling him a citizen. Okay, he's sitting down now, but I can't see his hands.

[Serad]: There are numerous concerns, and you're thinking about your safety, you're thinking about traffic at the time. It's right on Meridian Street there. You're thinking about the folks inside the businesses and the complexes in there. You're thinking about the reporting parties, the ones that are calling 911. In this case, I was also thinking about people that might be in the vehicles he was trying to steal, and in

regards to our safety, if he was willing to throw the rocks at our patrol cars or try to harm us. And really, like any call, trying to figure out what the end goal of this person is, and those are always going through your mind every call you go to.

[Audio from body cam footage]

[Radio dispatcher giving directions.]

[Officer 1]: Hey just drop the rocks so we can talk with you, okay? Can you sit down for me please so we can talk with you? Can you sit right there and just talk with us, please?

[Officer 2]: He said he's holding his breath, he's still reaching toward the ground though.

[Officer 1]: Are you willing to talk with us? He said he's willing to talk with us.

[Radio dispatcher.]

[Suspect]: [Unintelligible.] Don't come towards me. [Unintelligible.]

[Officer 1]: Hey, bud, can we just talk with you?

[Suspect]: Get the fuck out of my face.

[Officer 1]: Can we just talk with you?

[Officer 2]: Get down on the ground.

[Suspect]: Who's the big dog, bitch?

[Officer 2]: Get down on the ground.

[Officer 1]: We just want to talk with you, man. All right. Thank you. We don't want anybody getting hurt, okay?

[Suspect]: Get the fuck off, Dick.

[Officer 1]: We just want to talk with you, man. We just want to talk with you.

[Serad]: When I go to calls like this, I am concerned that they could end up in the news and look poorly on our department and the officers on scene there. It's a weekly thing that seems like once a week I go to a call, and that is one of my concerns, absolutely.

[Audio from body cam footage]: Hey, what's your first name? I'm Zach. Okay, listen, we got a bunch of calls about you. That's why we're here. We don't want to bother you too much. No, can we? Can we? Hey, can I? Can I get you some? Hey, can we get you somewhere? Can we get you somewhere? Anywhere? I don't know.

Dude, I'm the behavior health officer. I deal with housing. That's what I do all day long. I'd love to, but can you sit down with my partners and I walk up to you at least? All right. Okay, I appreciate that, man. But hey, listen, you got it. You can't. Hey, hey, listen, you can't get on my partner's like that, though. So what else can we do for you to keep you from throwing stuff or getting into cars?

I got juice back here. You want some juice? Stay there for me. You want some juice? Alright. I got grub for you, man. There you go, man. Yeah, there you go, dude. Check it out. Need some food? You're okay. There you are. Drink up. There's some Nutter Butters. They're the best. I like your tattoos, man. Those are clean. Where are you from originally? How long have you been there? I grew up there and lived there. What brought you to Bellingham? My ex-girlfriend. Ex-girlfriend. That happens. That happens. Oh, he was. Yeah. He was stationed there. That's a cool place, man. Yeah, I've never been there. I've always wanted to go. How are you feeling today? What's going on today? Good. I mean, overall, you seem frustrated. It's okay to be frustrated. Yeah? You need some more food? Are you okay? You want some other grub? No, you're okay? All right. I got some more food back there if you need it. So what's going on today, though? How long? I guess let me back up. How long have you been in Bellingham for? Eight months. Okay. How many police contacts you have with us? So check it out. This is your eighth month

here, right? It's their first contact. Something's going on with you. That's what I'm worried about. This isn't you, right?

You don't do this every day because we'd have more contacts with you, right? Would you be willing to go to the hospital with me? I'll go with you. I'll stay with you. Get you all checked in. Yeah? You don't have to stay. No, you don't have to. No, no. Don't stay with me. No. If I leave you there, it takes a long time. I'll take you in. I'll get you checked in and get you away from the other people that are sick. I'll get you back into a different area back there. And you and I can sit down and talk with someone there, let them know what you need. What do you think about that? You want to work with me on that? Yeah. All right. Keep drinking. Keep eating some of your food and drinking some of your drink there, man.

So, my partner's got to come cuff you up. Are you okay with that? Just don't. She'll, hey, she's a specialized cuffer. If we need, yeah, she'll get you good. But just to get you to the hospital, yeah? Just stay seated for me. Keep drinking your Gatorade there. You all done? Okay. You want any more of your crackers? Okay. So, if you're good to go, man, just hands behind you. Stay seated. Stay seated. Just hands behind your back, okay? Stay seated. Very good. I appreciate it. Hey, we'll bring those Nutter Butters with us if you want me to bring them. Yeah, well, we're going to hang on to these, okay? Okay. Yeah. Officer Suraj, he's a rookie fan, so he's got a whole bunch in his car. I appreciate you talking to us, man. Let's try to work on this stuff. I'm going to go there with you, and we're going to sit down and talk to the nurses, yeah? Yeah. Hey, thanks for cooperating, man. You have anything in your pockets at all, sir? No.

You want your window cracked a little bit, partner? Yes, please. Okay.

[Serad]: De-escalation really does come down to the individual. Ultimately, it's up to that individual how they want to respond. I think, especially now, the past couple of years, our department has done an incredible job with de-escalation, but really, we have to go off of how that person is responding to us.

[Audio from body cam footage]: Are you okay? I want to take him to the hospital, give him some help. Are you okay with that? No, I was saying, good job. Did the officers get you? Yeah. Thank you so much, you guys. Thank you. Appreciate you.

[Serad]: Normally, once that person's in the jail or the hospital, the patrol officer's role is done. They get back in the car, and they're stuck to their screen. It's on to the next call. In my role with the behavioral health team, we're able to visit the hospital. They know us very well up there, and I walked in there and sat in the same room with them at the hospital for over an hour. I was able to connect with his mom and learn a lot about him, that I can notify patrol just in case he has another crisis incident in the community. He said his interactions with police in the past were fairly negative, and he's never been treated like he was with us that day, and that was a good feeling when he said that.

Licenses and Attributions for Transcript for Figure 5.27, Bellingham Police Perspective Project / 20E5: Responding to a Behavioral Health Crisis

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Transcript for Figure 5.28, Behavioral Health Unit: Ride along with a Behavioral Health Response Team

[Officer Billy Kemmer, behavioral health unit officer, Portland Police Department]: BH4, we can take cover. Hey, you alright? You okay?

[Sarah Scafani, mental health crisis responder, Portland Police]: We just want to see if there's anything that we can help you with.

[Kemmer]: What do you think you need?

[Patient]: With mental health and the real bad episodes, you guys have literally showed up and saved my life.

[Kemmer]: I'm glad that we can help.

[Music.]

[Kemmer]: This is what policing looks like now. When people talk about police reform, we're trying to be mindful of how we interact with the community, of populations that need a different approach.

[Scafani]: Building relationships with people, being an advocate for them.

[Kemmer]: To help someone at their worst time, it's kind of my dream job.

Hi, I'm Officer Billy Kemmer, I'm with the Portland Police Bureau's Behavioral Health Unit.

[Scafani]: My name is Sarah Scafani, I'm a Mental Health Crisis Responder with the Behavioral Health Unit with Portland Police.

[Kemmer]: Behavioral Health Response Teams are co-responder models with police officers and clinicians, so I'm actually partnered with a mental health clinician all day.

[Scafani]: My partner is Billy Kemmer.

[Kemmer]: For the BHU, we've been doing this for four and a half years. You get to see people in a light that's different than I think a lot of other people ever see.

The bad news is he's going to just be on the streets with his mental health issues. Behavioral Health Unit has five Behavioral Health Response Teams.

[Scafani]: There's one for Central Precinct, East Precinct, and North Precinct, and then two specialty teams.

[Kemmer]: Our job is to engage and interact with folks who are experiencing mental health issues.

[Scafani]: We carry a caseload of individuals who are generating frequent police contact due to their mental illness, and so we get those referrals from patrol officers.

[Kemmer]: So if patrol officers come across individuals who are experiencing crisis or mental health issues and they're kind of at a loss or they need extra assistance or someone to follow up, just deeper follow-up on that person, they'll send us the referral and why, and then it gets assigned by the sergeants.

[Scafani]: And so our goal is to go meet those individuals out in the community and try to mitigate the contact that they're having with law enforcement, and get them connected to the appropriate resources.

[Kemmer, to person on street]: All right, we'll see you tomorrow, okay?

[Kemmer]: There's a cross-section of folks who exist where criminality is an issue, but mental health or addiction are very prevalent or the driving forces of their behavior. So the Behavioral Health Unit was designed to get to the core issues that people are facing so that we can get effective results.

[Scafani]: Billy and I are the houseless individual caseload.

[Kemmer]: Folks mainly living outside. So part of what we do is take information from reports from patrol and try to locate those folks.

[Scafani]: If we find them, assess them, help them get to the hospital if they need to stabilize or whatever kind of service that would help them mitigate their crisis.

[Kemmer, to person on street]: Can you show us on the wellness check at Broadway and Harveyville? Do you need any help of any kind? Just some water. Okay.

[Scafani]: Sometimes while we're driving around, we do respond to active 911 calls as well and try to come up with some sort of safety plan for that individual.

[Kemmer]: PH4, we can take over. Did he say anything about what she was, what was going on with her? Hi.

[Scafani]: For this individual, when we approached after we got the 911 call, she was pretty immediately, clearly disorganized, not a lot of what she was saying was making sense, pretty delusional as well.

[Scafani, to person on street]: How are you getting food?

[Kemmer]: Her inability to answer any sort of safety questions when she ate food, anything like that. Due to that, due to her level of disorganization, her vulnerability in the community, we determined that she met hold criteria.

[Kemmer, to person on street]: We're just concerned that you're not able to take care of yourself, so we're going to get you to the hospital so you can get help.

[Kemmer]: Police officer hold or a director's hold, which are written by qualified mental health clinicians. The criteria is really high, but essentially it's if we believe they're a danger to themselves, a danger to somebody else, or unable to care for themselves, we have the legal authority to take them into custody and get them to a hospital for assessment.

[Scafani]: And the doctor then will determine what the next steps are for her. Now we at least know who she is, and if we interact with her again in the community, we have a little bit of history.

[Kemmer]: Whatever connection we make, we try to take that connection to the next level. We're handing that person off to whatever system is going to be able to take the reins and move forward with them, so it's not just a drop off and hope for the best. So whether it's hospital, Service providers, Clinics, or even jail, we want to follow up to make sure that person is getting connected beyond just that entryway.

So all officers get 40 hours of CIT training. It's crisis intervention training. It's communication. A lot of de-escalation. How to interact with folks who are in high-crisis situations. The BHU developed enhanced crisis intervention training, which is volunteer officers who are selected to go through another 40 hours of training and then ongoing in-service. The Behavioral Health Unit, where I work, BHRT officers have the foundational 40 hours. We are all ECIT certified. We also have to certify in other trainings. Suicide intervention training. Trauma-informed care training. Involuntary commitment program training. And a threat assessment training. Specific things that we have to certify in order to hold this position.

This is my partner, Sarah.

[Patient]: Oh, you're the partner.

[Scafani]: I'm a social worker.

[Patient]: Social worker. That's who I need to see the most. Yeah.

[Scafani]: Between my officer partner and I, we come with different backgrounds and trainings. And so having these two different approaches can be really helpful.

[Kemmer]: Having a police officer and a clinician partnership, we were able to draw from each other, you know, the expertise from both sides of the partnership in order to find better solutions for people.

[Scafani]: You know, sometimes someone doesn't want to talk to me because I'm a mental health professional and they'd rather talk to my police officer partner or vice versa. And the fact that we have like the flexibility to do that is really great.

[Kemmer]: It allows us to respond to a wider variety of folks.

[Kemmer, to person on street]: Hey, you all right? You okay?

[Kemmer]: In this job, you are able to redirect someone's absolute worst day into something that can be positive, somewhat positive, at least a different solution for what they thought was going to be the worst outcome possible.

[Scafani]: All right. Thank you.

[Scafani]: Getting them food, clothes, blankets, into a shelter, those immediate basic safety, safety, and daily life needs or getting them connected to housing and working with them until they get permanent housing and kind of just being that support for them until they get connected to longer term supports. And so you get to build that relationship with individuals.

[Patient]: At 2:30, you'll be here.

[Kemmer]: 2:30? Yeah, we'll come knock on your door.

[Kemmer]: This is what, you know, policing looks like now. And when people talk about police reform, like, you know, we're trying to be mindful of what we're, you know, how we interact with the community, populations that need a different approach. The more that we interact in this way, the more that we're approaching things holistically, the better outcomes we get for people who are caught in this revolving cycle.

[Scafani]: I really think the community needs to know about the work that we're doing because it is a resource that can be helpful for those who are in crisis or need services.

[Patient]: Every crisis I've ever had with mental health and the real bad episodes, you guys have like literally showed up and saved my life.

[Kemmer]: I'm glad that we can help.

To help someone in their, at their worst time is a very powerful place to be. It's a fascinating job and it's a fascinating window into the human experience. And, yeah, it's kind of my dream job.

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Transcript for Figure 6.1, Prosecutors: 83-Year-Old Used Walker To Kill Nursing Home Roommate In Haverhill

[Male news anchor]: An 83-year-old man charged with murder, accused of beating his nursing home roommate to death. The suspect's son says his father suffers from severe dementia.

[Female news anchor]: And the man who died was engaged to be married. WBZ's Louisa Moller spoke with his fiancé.

[Beatrice Duchesne, victim's fianceé]: They said that they had sad news.

[Louisa Moller, reporter]: Beatrice Duchesne says a late-night door knock from police came with the news that her fiancé was murdered.

[Duchesne]: They told me about him being beaten. And I just stood there in shock. I couldn't even cry.

[Moller]: 76-year-old Robert Boucher, pronounced dead after police say he was brutally beaten by his roommate at this Haverhill nursing home.

[Female voice, speaking about the suspect]: He's not oriented. While he knew he was at the court, he doesn't know the day, the month, or even the year.

[Moller]: On Monday, Jose Veguilla appeared before a judge. Investigators say a nurse at Oxford Manor found the 83-year-old holding a bloodied walker above a badly injured Boucher on Saturday. And police say when they tried to talk to Veguilla, he didn't make any sense.

[Henry Veguilla, suspect's son]: And we know he was having issues with medications and not taking them the way he should have.

[Moller]: His son telling reporters outside court that his dad suffered a traumatic brain injury last year and has severe dementia. He questions the conduct of the nursing home, which was the subject of a settlement by the Massachusetts Attorney General earlier this year. And also gets a much below average rating on Medicare.gov.

[Henry Veguilla]: How does an 83-year-old man have the time to do what he's being accused of doing, and no one stepping in to intervene?

[Moller]: Now Veguilla is headed to Bridgewater State Hospital for a competency evaluation. Oxford released a statement saying in part, its staff acted quickly and appropriately in this matter. In Haverhill, Louisa Moller, WBZ News.

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Transcript for Figure 6.8: Jail Based Competency Treatment Program – San Diego County Sheriff's Department

[Music.]

[Brooke Anarde, Program Director, JBCT]: I am Brooke Anarde, and I am the program director for the Jail-Based Competency Treatment Program at San Diego Central Jail.

We have a 30-bed unit of male patients who have been found incompetent to stand trial for mental health reasons. They have been court-ordered to participate in treatment in an effort to restore their competency so that they will have a rational understanding of their charges and the legal process, and effectively participate in their own defense. For some of our patients, having more of a visual experience like heart therapy can be more of an effective way to connect with them. We do want to foster overall wellness, fitness, and the importance of caring for their bodies.

[Marisa Hoskins, Psychiatric Nurse, JBCT]: Every day is different, so today what we're going to do is we're going to facilitate showers because we do have some patients that need help with their hygiene.

We also do lab draws, their weights, vital signs. We all work together as a team. We lean on each other and we help each other.

[John Reis, Deputy Sheriff]: This program is helping people who are suffering through a mental health crisis at the time. They're seeing psychiatrists weekly, being provided medications that could help them through that process. It kind of helps them come back to a steady baseline.

[Anarde]: We also have mock trials. They're very unique to the JBCT program. We want them to have an understanding of the roles of different people in the courtroom. And for some patients, role-playing is actually an easier way to learn that.

When someone is found incompetent to stand trial, everything is put on hold. So that impacts not only the alleged, but it also impacts potential victims, the jails, family members. By us being able to provide the competency restoration services, we can be a part of that pursuit of justice.

It's amazing to see someone who comes in. Maybe they've been neglecting their hygiene, refusing medications. To be able to get them to a point that they are receiving all the care they need, and their bodies are healthier, their minds are healthier, they're feeling worthwhile. There is nothing more rewarding to me than that.

[Music.]

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Transcript for Figure 7.4, Siyad | AVID Jail Project

[Siyad Shamo, incarcerated individual]: To a lot of people it might seem like mental health issues play a little role in people being incarcerated but, I think it plays a big role, man.

[Kayley Bebber, AVID Jail Project attorney]: An issue that we hear about frequently when speaking with inmates in jails in King County [WA] is that many inmates have to wait to have a mental health appointment for so long that they end up leaving the jail before they can talk to a provider.

[Shamo]: My name is Siyad Shamo. Currently in custody in King County, downtown. I recently got diagnosed at Sound Mental Health with PTSD [Posttraumatic Stress Disorder] and a severe case of PTSD and I came in here, and I told them about it. I told them what's going on, I told them that I got diagnosed on the outs [outside]. I wrote them a kite. I told them my conditions were worsening.…. Hearing voices. You know, I can't pay attention. I can't concentrate and I haven't got no response back.

[Bebber]: He was scheduled for a psychiatric appointment eight weeks out, which is the wait time that most people at that jail have to wait to be seen by a mental health provider, and Siyad only spent two weeks at that jail. The average length of stay in most jails in Washington

is two to three weeks, so scheduling mental health appointments out two to three months results in denying care to many people who need it.

[Shamo]: I… to tell you the truth, it's getting to the point where you don't wanna do nothin' about it no more you're like, nobody cares, why should I care? It's probably not that serious. Since they're not really worried about it, why should I be worried about it?

[Bebber]: Another issue that we see across the state, and really across the country is that there's not centralized oversight over jails, and there's no uniform standards applied to jails.

We met with Siyad at two jails in King County he informed both jails of his diagnosis, his outside provider, his past treatment, and his current symptoms, and at the 1st jail he was housed in minimum custody, which means he can move around freely and interact with other people. The 2nd jail housed Siyad in administrative segregation or solitary confinement, which means that he was confined to his cell for 23 hours a day. And this is when study after study is concluding that solitary confinement is extremely harmful for people, especially people with mental illness.

[Shamo]: So you're in your cell by yourself all day, you get an hour out a day, and sometimes, you might get your hour out at 1AM, at night. You know what I mean, it depends on where they start from. Sometimes you might get 8AM in the morning, so you don't even know. You're just thinking to yourself, talking to yourself. and this is hard man, it's hard.

[Bebber]: So, the same person was treated completely differently by two different jails, in the same county, from one day to another.

[Bebber]: How long did they talk to you for?

[Shamo]: Like five minutes.

[Bebber]: Okay.

[Shamo]: …like five minutes, yeah. They just, they told me: Are you suicidal? Are you eating your food?

[Bebber]: Siyad received a response to his request for treatment the day before he was released. So, he didn't receive mental health treatment from either jail.

[Shamo]: They're not helping and even if they are trying to help, they're not doing it on time, you know.

[Bebber]: Okay.

[Shamo]: So, I don't know what to do.

[Narrator]: Follow Siyad's story and other stories of people with mental illness in jails from the AVID Jail Project at Rooted in Rights on Facebook, Twitter, and Instagram or AvidJailProject.org.

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Transcript for Figure 7.5, Tallon | AVID Jail Project

[Tallon Satiacum, incarcerated individual]: I smile a lot, to be honest. I'm not an angry person. I'm not like how they said I am.

My name is Tallon Satiacum, dash 27-182, inmate at SCORE County Jail. I got fetal alcohol syndrome, bipolar. It's just a list.

[Kayley Bebber, AVID Jail Project attorney]: My name is Kaylee Bebber, and I'm a staff attorney at Disability Rights Washington. I work on the AVID Jail Project.

Since the beginning of our program, we've met with hundreds of inmates with mental health issues. Many jails that we speak with don't think that jail is an appropriate place for someone with mental health issues. They aren't set up to be treatment facilities. But at the same time, that's where many people are. That's an unfortunate reality. And so that's why there's a number of safeguards in place for people with mental illness in jails.

So when someone comes into the jail who has a mental health issue, jail policy requires that there's a health assessment with a mental health screening within two weeks. That didn't happen in Tallon's case.

So we met Tallon Satiacum in late spring, early summer of 2015. I requested Tallon's jail and medical records, so I looked over those. He reported his symptoms and his diagnosis, the fact that he'd been taking medication about one month after he'd been at the jail. And it wasn't until another month after that that he actually had the mental health screening and started receiving his medication.

[Satiacum]: I told them I needed pills. I needed medication, basically. Nobody listened.

[Bebber]: His symptoms kept getting worse and worse. He kept exhibiting behavior that appeared to be related to symptoms of his mental health issues.

The jail, instead of responding with treatment, responded with punishment after punishment after punishment. He received 13 formal disciplinary infractions, and he had 20 documented informal disciplinary issues.

[Satiacum]: They were infracting me for every little thing. I could yell at 'em and it would be an infraction.

[Bebber]: The sanctions that he received included some minor things, like losing commissary, to more serious punishments, like being placed in solitary confinement. At first, it was only for maybe one day, and then it was for 10 days, and then for 30 days, and then he was permanently placed in solitary confinement.

[Satiacum]: I'm isolated. I don't have nobody to talk to. It's just me and my wall. They would keep me in there for 72 hours at times. I was getting angry, frustrated. It felt like what they were doing was picking on me.

[Bebber]: There's no evidence in Tallon's records that indicate that mental health staff were consulted about the appropriateness of his disciplinary sanctions, even though the jail's own policy states that the disciplinary process shall consider whether an inmate's mental disabilities or mental illness contributed to the inmate's behavior when determining what type of discipline, if any, should be imposed.

[Satiacum]: Yeah, they don't even care. That's how I feel.

[Bebber]: We reached out to the jail as we were getting ready to present Tallon's story in this video and the jail made a valid point that it's difficult for jails to always know what someone's mental health and medical needs and history are, because they rely on inmate reporting, self-reporting. But that's exactly why most jails, including this jail, have policies in place that provide for multiple different times and ways in which inmates and staff can report mental health concerns.

And in any case, he did after one month and nothing was done.

[Satiacum]: I needed to get back on my meds. I needed to get back to me being sane and not going insane.

[Bebber]: So after two months, he finally had his psychiatric medications. After he got his medications, he received drastically fewer disciplinary infractions.

[Satiacum]: The pills that they got me on now changed me. It made me calm, I've been just doing, doing good and I'm just trying to maintain.

[Bebber]: This is not unique to this jail or to Tallon's case. This is a problem that we see in both jails that we go to with the AVID Jail Project and in jails around the country.

So, what we'd like to see is not anything radical. We'd like to see them follow their policies that provide these protections. Inmates with mental health issues shouldn't have to be subject to harsher punishment than other inmates, solely based on their disability and their mental health condition.

[Narrator]: Tallon was released December 24th, 2015. The AVID Jail Project continues to work with Score Jail on the problems faced by inmates with mental illness, as a result. The jail has cut its wait time for health assessments and reports, changing the disciplinary policy to avoid situations like Tallon's.

Find out more at AVIDJailProject.org. The AVID Jail Project is a project of Disability Rights Washington. Produced by Rooted in Rights.

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Transcript for Figure 7.6, Living With Schizophrenia, in Prison and Out

[Cindy Rodriguez, WNYC reporter]: Do you feel anxious a lot? Do you have a lot of anxiety?

[Sedlis Dowdy, incarcerated individual with schizophrenia]: I try to stay in my cell as much as possible.

[Rodriguez]: How much of prison and jail is violence and having to sort of be on guard?

[Dowdy]: All the time.

[Rodriguez]: All the time?

[Dowdy]: Yeah. I think that's just, life is dangerous, so that's just how you've got to expect it.

[Rodriguez]: When you go from facility to facility, does your medical record follow you? So do they know?

[Dowdy]: Yeah, they know exactly what to give you, precisely what to give you.

[Rodriguez]: They do, okay. So when you got here, they knew what to give you?

[Dowdy]: The first day I was here, they gave me my medication. That was good. Because if I don't get it, then I can't sleep.

[Rodriguez]: I see, okay. And what about Rikers Island? Did you get it at Rikers Island?

[Dowdy]: Yeah, but sometimes they play a lot of games on Rikers Island.

[Rodriguez]: Like, what kind of games?

[Dowdy]: Not— No. They—how can I explain it? Well, they just—they're mean down there. I can't explain it.

[Rodriguez]: New York City is such a loud, crazy place. I mean, it can be.

[Dowdy]: Yeah.

[Rodriguez]: Is that a hard place for you to be?

[Dowdy]: So many things can set you off. You know, it is a hard place to be. The traffic lights, the cars, the buses, the—

[Rodriguez]: Do you ride the subway when you're there?

[Dowdy]: Yeah.

[Rodriguez]: Does that bother you at all?

[Dowdy]: I see things that other people don't see and stuff like that. So it's, you know, it's dangerous.

[Rodriguez]: Do you hear the car alarm and what do you think after that?

[Dowdy]: I think that it's a signal to me from God to, you know, do something evil. Or sometimes it might even be something good. Now that I'm on medication, it doesn't affect me the same way, though. I just hear it and it goes away. It's not beckoning me or nothing like that.

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Transcript for Figure 7.8, Stories of Life in Solitary Confinement | Short Film Showcase

[Inmate voice]: It can either break you or make you, and if it breaks you, you know what, you're just gonna just be broken, physically and mentally.

[Inmate voice]: I haven't seen a tree or a plant since 2003. The only thing that I've seen is a spider in the corner, and I find them little bugs sometimes and I feed the spider. That's about the only closest thing to nature I have.

[Inmate voice]: It's not to the point where you want to commit suicide, but sometimes I've been at the point that I've been on the right to judge, saying, just give me the death penalty. Just give me the death penalty, man.

[Music.]

[Inmates in solitary confinement spend 22.5 hours a day in an 8' x 10' cell. They have access to a small concrete yard for one hour a day.]

[Inmate voice]: We're in our cell 22 and a half hours a day. And then our yard is just brick walls.

[Inmate voice]: I'm not able to go out to a yard and be with other people. I'm not able to see things around me, whether it's trees, grass, birds. To talk to my family, to get sunlight.

[There are no windows, phone calls, or contact visits. (At the highest security level.)]

[Inmate voice]: You had people in here that's been in solitary confinement longer than I've been alive.

[Inmate voice]: If you could put every emotion of the human spirit, of hopelessness, pain, agony, hatred, frustration. A sense of continuous, silently screaming all these emotions while you're locked in this cage treated like some animal. Most people wouldn't even treat an animal like that. An animal who was suffering pain, they would take them to the vet and do something for them.

[Daniel Treglia, Pelican Bay S.H.U. inmate]: I had to take a lot of deep breaths before I came in here. Just being around people, it's not awkward. It's a good feeling. But it's still an anxiety feeling because I haven't been … It's like, wow, I'm around free people. I'm around regular people.

[Daniel Treglia spent 8.5 years in solitary confinement after being accused of prison gang association.]

[Inmate voice]: This is a behavior modification, psychological, a low-intensity warfare against the mind of a human being. That's what exists here at Pelican Bay.

[Inmate voice]: It's the same thing day in and day out. Don't change.

[Inmate voice]: It's just psyching ourselves out to make the best of it. I love the day.

[Inmate voice]: It's kind of robotic. Have you ever spoken to 100 guys today? It's the same thing.

[Inmate voices]: I get up in the morning. I wash up. I drink my coffee. I roll up my mattress. I get up. I brush my teeth. I wash my face. I drink some coffee. I drink water. I clean the cell. I clean the seat. I wipe the floor. I wipe the walls.

[Inmate voice]: You do certain things just to fill up that time.

[Inmate voice]: Where you can hear the vent and you focus on it, man, did I just hear a whisper right now? And the person starts focusing on this little noise because the noises and the vision are the senses, and that's what we have to constantly survive. But if I had a window to look out, I think if they came by every half an hour, I'd be sitting in that window.

[Isaac Garcia, Pelican Bay S.H.U. inmate]: Yes, I committed a crime to come to prison, but don't make the assumption that my current situation, here being Pelican Bay SHU, is due to my continuous criminalization. It's a criminal behavior because I have grown that a long time ago.

[Treglia]: Humankind has a history of ugliness, and humankind also has a history of beauty. It's in all of us, and you need laws to have a society not go into chaos. Ultimately, people have the ability. The ability to look at what is bad and good in a way that is not insulting, not aggressive, not with bullets. Through psychology, creating a better understanding of each other, everybody deserves a chance. Thank you for taking the time to hear my voice, because our voices are rarely heard.

[In 2011, inmates across California began the first of hunger strikes to protest prison conditions in solitary confinement. In January 2016, state officials finalized a settlement that will limit its use – but not end it.]

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Transcript for Figure 7.9, Ricardo | AVID Jail Project

[Ricardo Rodriguez, incarcerated individual]: You know, you don't have rights. There's no treatment in here, the way there's treatment out there.

My name is Ricardo Rodriguez, and we're in King County Correctional Facility, and I've been here for six months.

[Kayley Bebber, AVID Jail Project attorney]: With the AVID Jail Project, we go to jails in King County every week. We are constantly meeting new inmates and keeping in touch with inmates that we've already met with. When I first met Ricardo, I learned that he'd been infracted, or punished for hurting himself.

[Rodriguez]: I'm bipolar and schizophrenic and I hear voices. I have this diagnosis since I was like thirteen or fourteen. And the voices keep telling me to hurt myself, cut myself, any kind of way I self-harm.

[Bebber]: The fact is that people, in jail, attempt self-harm. They attempt suicide. The suicide rate in jails is three-times the rate as it is in the community. So most jails have policies in place for responding to inmate self-harm, including the jail where Ricardo is incarcerated. If an inmate either attempts to or does hurt themselves, they will receive medical treatment, they get transferred to psych housing, and they receive monitoring by mental health providers, and unfortunately at some jails, and at this jail, you can also receive a disciplinary infraction for self-harm.

[Rodriguez]: I can't control, you know, what's going on in my head, like, or my body, you know, like, physically. Like if I'm banging my head and I don't stop and then they'll be like, 'Well, we're gonna take your hour or we're gonna infract you.' Basically, you know, they punish you like that too, like.

[Bebber]: So this is, this is a list of four different infractions that Ricardo received for self-harm. The first one was in October 2015, he was infracted for tearing up his suicide [prevention] blanket, in an attempt to hang himself.

[Rodriguez]: So what happened is like, I start hearing all these voices, and then I took my smock, and I, well not my smock, my blanket and I tear it up. I was planning, you know like, to put it on the sprinkler. The guard came and was like, 'Well, you know, what are you doing?' you know, and that's when they told me to give up, you know, the contraband before I start hanging myself.

The list of infractions that they infracted me with was 203, refusing orders or causing a supervisor to respond. Uh, self-mutilation, which is self-harm. Possession of contraband, that was the teared-up blanket. Property damage, you know like, because I destroyed the smock,

or the blanket.

[Bebber]: Ricardo was infracted again for self-harm on February 2 for hitting his forehead against his cell door and wall. This time, he received serious infractions number 203, refusing orders or causing supervisor response, and 217, self-mutilation, tattooing, piercing. He was found guilty of both, and sentenced to seven days in solitary confinement, where you get one hour out of your cell every other day, and you can receive a bill if any property damage was involved with the self-harm.

[Rodriguez]: $52.90. That's what they charged me for that security smock that I tear up in that cell for self-harm. They don't understand like, how I feel about, you know, what's going through my head, and they're not doctors, they're, uh, officers. So, they do things in a different way, you know, like they disciplinary you, they use uh, force on you.

[Bebber]: So instead of responding with discipline to self-harm, we want the jails to stop disciplining people for self-harm. So we reached out to the jail to find out what their reaction is

to Ricardo's story, what their position is on, on this issue and this is what they said.

[Narrator, reading correspondence]: We agree that there is no benefit in disciplining [inmates with serious mental illness] who self-harm. We also understand that those in isolation, regardless of degree of mental illness, are emotionally challenged as this environment is not therapeutic. We will, therefore, continue to work with [the AVID Jail Project], and evaluate….current policies regarding self-harm and property damage specifically for identified [inmates with mental illness].

[Bebber]: Ricardo is still in jail. Um, we keep talking with him and working with him.

[Rodriguez]: It affects me in so many ways because, I'm alone, I hear voices, I hallucinate and there's one you know, there to talk to me, or help me, and I start you know, like, thinking that nobody cares. It's not fair, for them to punish you because of your harming yourself, when you already have a problem. Instead of solving the problem, you creating a lot more problem to it.

[Bebber]: Follow Ricardo's story and others stories of people with mental illness in jails, at AVIDjail-project.org.

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Transcript for Figure 7.10, Five Mualimm-ak | AVID Jail Project

[Five Mualimm-ak, Director of the Incarcerated Nation Corporation]: My name is Five Mualimm-ak. I am the director of the Incarcerated Nation Corporation (INC). I served twelve years. In 2000, through 2012, and throughout that time, I've served over five years in solitary,

some time at Rikers, sometimes at MCC (Metropolitan Correctional Center), and the majority of my time in New York state.

It's a different lens living in a world of punishment. It's a different lens to navigate through incarceration because people don't understand, you know. If you're problematic in the city,

in New York or wherever you live at in the community, and you need a therapeutic environment to function, you're going be even more problematic inside of this microcosm of an environment

of incarceration.

The problem in this state is that there was no comprehensive mental health rounds. I mean I did time in Lakeview, Upstate, I never see nobody. Nobody came around, even in a person with Bipolar Disorder or schizophrenia sometimes needs constant talk therapy. Every time before an appointment, I had to prove that I needed that appointment. It felt more that I was proving it

and validating why I was there than treatment.

In the state I've done years of solitary at a time. And the problem with that is that you keep getting reoccurring tickets, right. First I went to solitary for reasons that were just ridiculous,

sharpened wooden objects which were described as weapons, and hoarding and unauthorized exchange. The sharpened wooden items were pencils; I'm an artist so I do portraits. The hoarding was too many postage stamps; I had more postage stamps than I was allowed to have. I had too many t-shirts.

For me, it was like [being] locked in there with like two other people. I have two voices in my head – everything seems personal. The wind under the door is talking to me, cursing at me,

and you end up talking to yourself because, you know, you're just having a conversation out loud, you end up catching yourself, you're trying to talk to the person two cells down, you gotta repeat yourself everything he says, every little thing frustrates you, and you're being ignored. Your officers come by, they feed you, they're not to have any eye contact, they're not to have any type of physical contact, and it's an odd impersonal process. They put the tray on the slot,

you step back, you grab the tray, you pick it up and they move on. You try to have a conversation with them, they're ignoring you, you become upset. You yell at them, "What…you don't hear me. I'm talking to you," and the person doesn't validate you.

And when you suffer from extreme paranoia when a person doesn't validate you instantly start thinking what that person is thinking, and you're thinking that, oh this person is…looking at me,

and you get angrier and you get louder. It doesn't get no attention you start banging, still doesn't get any attention. But every step that you go gets you even more angry. And you're like, this guy didn't even talk to me he's probably… And you start having this conversation with yourself.

Human validation. It doesn't mean a lot, but it means a lot when one thing can have your thoughts spinning off and off.

One of the major problems with the system is that we don't realize that even though you have people with mental illness when you go to jail it's just unrecognized.

[Narrator]: The AVID Prison Project, Amplifying Voices of Inmates with Disabilities, is a collaboration between The Arizona Center for Disability Law, Disability Law Colorado, The Advocacy Center of Louisiana, Disability Rights New York, Protection and Advocacy for People with Disabilities of South Carolina, Disability Rights Texas, Disability Rights Washington, and the National Disability Rights Network. This video was produced by Rooted in Rights.

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Transcript for Figure 7.11, Daniel Perez | AVID Jail Project

[AVID Jail Project representative]: Would you please state your name?

[Daniel Perez, inmate at Washington State Penitentiary]: Daniel Jay Perez

[Representative]: And can you tell us, can you define segregation for us?

[Perez]: Segregation, for me, was pretty much hell. It's a 23-hour lockdown, one hour out a day, five days a week, little stimulation, little interaction with anybody, and concrete walls that seem to close in on you.

Like I said, it's hell, at least that's the way I would say it would be. Out of the entire time that I've been locked up, which is ten years, I've only been outside of seg a year and eight months, so that would be, what? Eight years, four months total in solitary.

At this point, I'm diagnosed with psychosis NOS (Not Otherwise Specified) obsessive-compulsive disorder, and mood disorder NOS, and borderline personality [disorder].

Solitary confinement breaks you down, and it's a form of punishment that can really do some serious harm. I question whether or not I'm able to survive outside of that environment, because I did it for so long. I'm struggling to survive day to day out here, just have a normal life. I can't go to the big yard because there's 200 people out there. I can't go to the little yard because there's 100 people out there. I'm afraid to come out of my room at times because there's 30 people, you know? Cause you spend so much time isolated by yourself, so much stimulation, it gets frightening at times.

And there's days, and today's one of them, actually, that I feel like I'm not gonna be able to survive in a population, in a setting outside of an IMU (Intensive Management Unit), because of the damage that was done. It caused paranoia, causes me to hallucinate, it causes me to feel unsafe. Today's one of those days that it's contemplating, you know, do I give up? Cause I just…

there's no support here, even though there's days that I contemplate going back, it's not something I would… wish on anybody. It can really mess you up, and it has messed me up to the point where I'm out here, not able to function at times being around people, where I have to isolate in my cell.

That's kind of scary when you don't know if you can make it outside of an environment that you wanted out of so bad.

[Narrator]: The AVID Prison Project, Amplifying Voices of Inmates with Disabilities, is a collaboration between The Arizona Center for Disability Law, Disability Law Colorado, The Advocacy Center of Louisiana, Disability Rights New York, Protection and Advocacy for People with Disabilities of South Carolina, Disability Rights Texas, Disability Rights Washington, and the National Disability Rights Network. This video was produced by Rooted in Rights.

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Transcript for Figure 7.18, Forced Medication Behind Bars | AVID Jail Project

[Narrator]: According to the Bureau of Justice Statistics, 60% of jail inmates have symptoms

of serious mental illnesses. Jails can force these inmates and others to take psychiatric medications even if the inmates don't want to. Who gets medicated and how is determined by holding hearings.

[Kim Mosolf, AVID Jail Attorney]: Although they're lawful, the hearings have to follow certain guidelines and procedures. Because our society highly values a person's right to control their own medical treatment, the law requires that we follow very specific rules to protect these rights

when considering forcing medical treatment. Certainly the jail can have these hearings, but they need to make sure they have them in a certain way.

I'm Kim Mosolf. I'm an attorney with the AVID Jail Project at Disability Rights Washington.

So generally, you have a fundamental right to control what type of medical treatment you accept or refuse. For example, if you have cancer and you don't want to get chemotherapy, generally speaking, you can say no and not get it. Similarly, if you have a mental illness and you don't want to take certain medications or get certain therapies, generally speaking, you don't have to do that.

[Narrator]: In the case of Washington v. Harper, the Supreme Court held that even people in jails and prisons possess "…a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment." This case lays out the specific procedures for considering whether to force medication.

[Mosolf]: We came to find last year, though, in speaking with inmates at the King County Correctional Facility in downtown Seattle, that, in fact, there were significant problems in how the jail was protecting these inmates' due process rights at these forced medication hearings.

[Narrator]: If the jail is successful in ordering forced medication, they must always give the ordered inmate a chance to take medications voluntarily. If the person refuses, corrections officers are authorized

to use force in order to physically restrain the person on a board while a nurse gives the person a shot of antipsychotic medicine. These forceful medication orders can last for months.

[Mosolf]: When we've spoken with a lot of people in the jail who were subject to these forced medication hearings and orders, they talked about a lot of reasons why they may not want to take the medications.

[Dwayne Stelivant, inmate at King County Jail]: My name is Dwayne Stelivant. Dwayne Fitzgerald Stelivant. Since I've been diagnosed with a mental disorder, I've been in and out of King County [Jail] several times.

A lot of that medication has side effects. I think I was taking Zyprexa – I noticed my vision getting blurry. I'm knowing that it's the effects of the medication.

[Tyler Howells, inmate at King County Jail]: I'm Tyler. I'm 23 years old. I've had a bad experience once before, a couple of years ago. I got a shot of Haldol and I had tardive dyskinesia. Your muscles seize up. It was pretty awful. It was the worst pain I've ever been through in my life.

[Bob Boruchowitz, Director, Seattle U School of Law Defender Initiative]: I'm Bob Boruchowitz. I'm the Director of the Defender Initiative and Professor from Practice at Seattle University School of Law. The impact of the medication, which could be sedating to the person, could affect very much how they look, both to a judge and ultimately to a jury.

[Mosolf]: That can be very relevant if that inmate is not yet convicted. If that inmate is still facing charges and potential trial, because being on antipsychotics can really alter how you present to the world.

[Stelivant]: When I made it back from Harborview [Medical Center] to King County Jail, the doctor I dealt with previously, on a different detention in King County Jail, he's coming back with the same medication again, "I think you need this medication." I'm like, "At that time, I was misdiagnosed. Now my diagnosis is Bipolar, and I'm dealing with it with no medication." He's like, "No, you're gonna need medication and I can't let you move or let you leave." He's the one who brought the involuntary panel.

[Narrator]: We asked the King County Jail to comment on the issues of forced medication addressed in this video. They wrote to us saying: "While you underscore in your video a patient's right to refuse treatment, we also hold that patients have a fundamental right to alleviation of decompensation and acute distress that is a direct result of their current presenting symptoms especially when one of those symptoms is a lack of current insight or reasonable decision making."

[Mosolf]: Someone might wonder, why does the jail want to force a person to take antipsychotic medication if the person's already locked up? I think it can be for a variety of reasons. I think, certainly, the jail's psychiatric and medical staff is trying to help that person and treat that person, and when someone with mental illness is in a jail, which is really not the right place for them to be, it's not a treatment facility, the jail and psychiatric health staff are really limited in the tools they have available, and for psychiatric conditions, one of those main tools is antipsychotic medications. They can have great success with those, and I think that that is why they oftentimes seek these forced medication hearings.

[Narrator]: Jails have their reasons for wanting to force medicate, while inmates have their reasons for not wanting to be medicated. The hearing is meant to weigh these two options in order to make a fair decision as to whether or not the inmate will ultimately be forcibly medicated. When you think of a hearing, you probably think of everyone gathering in the courtroom. The jail on one side and the inmate on the other. Each side's lawyer argues their point of view, offers evidence, and the judge rules. But in this type of hearing, the jail doesn't tell the inmate's criminal defense attorney that the hearing is even taking

place. The inmate doesn't get an attorney at all. They get what's called a lay advocate, who's a member of jail health staff.

[Mosolf]: The lay advisor advocate is supposed to take a somewhat active role in putting forth the person's position in terms of whether they want or don't want medications and why, and we saw pretty consistently that the advisor was not doing that in these hearings, and may not have even understood that that was their role.

[Boruchowitz]: To call the person a lay advocate implies that they're actually an advocate for the person. If they're advising them, they should be advising them on what alternatives there might be, as well as on how to present their case to the people making the decision in the jail.

[Mosolf]: Also, a lay advisor or advocate should, under the law, have some knowledge of psychiatric medication. Enough so that they can really challenge the psychiatrist's recommendation and have some basis in understanding to do that.

[Boruchowitz]: That would be at a minimum what would be needed.

[Narrator]: Jails only give a 24-hour notice of the hearing, making it hard to gather witnesses and basically impossible to call an expert witness, and the jail isn't required to hear those witnesses. If they do, it's usually by calling them on a cell phone during the hearing. There's no judge. There's no jury. Everyone running and ultimately deciding this hearing works for jail health services and there's no courtroom. These hearings are usually held right in front of the inmate's cell where other inmates can hear confidential health information.

[Mosolf]: When there is a hearing held in front of one of those cells, pretty much everyone around can hear what's happening and the information being discussed. This is confidential health information.

[Boruchowitz]: How a person acts in a jail cell surrounded by other prisoners and guards is going to be very different than they would in a room like this or in a courtroom.

[Mosolf]: Now from the jail's perspective, I think they probably would like to be able to easily hold all these hearings in a confidential setting, and again, this is why it's probably not good to have

people with serious mental illness in a jail. So, from their perspective, while they would like to take everyone out of those cells, put them in a room and have the hearing there, they have to work with security staff, who may have reservations about removing certain people from their cells.

[Narrator]: The inmate is generally allowed to argue their point of view at the hearing. But the jail's not actually required to allow the inmate to participate at all.

[Stelivant]: You could participate if you want, or you don't have to participate. At the end of it, if we say you need it, then it's gonna be forced on you regardless to what you want.

[Narrator]: Hearings resulted in allowing for forced medication in 25 out of the 29 cases from King County Jail reviewed by the AVID Jail Project.

[Mosolf]: And when that person, if that person, decided to appeal to the director of psychiatric services there, across the board, the decisions were approved.

[Howells]: The last appeal review I had lasted only, not even two minutes. They just rejected the appeal. They just continued the forced medication.

[Mosolf]: Also, the inmate has the right to access court appeal. It is written in the notice the inmate gets that they have, that nothing that the jail's doing keeps them from seeking court review. But that's all that's written. We found in reviewing records, that they are never really told that, certainly never helped with that process, and oftentimes don't even know that they have that right.

[Howells]: You're allowed to have a judge review it?

[Mosolf]: So you didn't even know that?

[Howells]: I had no idea.

[Mosolf]: When we have sought advice from appellate attorneys, other criminal defense attorneys, about how a person in jail would seek court review or appeal, no one really knows exactly how that would work.

[Boruchowitz]: Basic fundamental fairness, Due Process, requires that there be some sort of opportunity for judicial review. So unless there is an established procedure to get them into court, there's a real question in my mind as to whether this kind of forced medication administrative decision is lawful, even under the case law that we have, if there's no meaningful judicial review.

[Mosolf]: So our ultimate point and goal in doing this investigation is not to condemn the jail. I don't think that the jail health staff is doing this from a malicious standpoint. They are doing their best and they are trying to treat these people as they need to do and as they want to do, to get them out of solitary, to get them services. The issue is that it implicates an incredibly important right to control over your body, to your mind, and when that is at stake, there has to be some process, some protection and some transparency, and that's where our concerns lie.

[Mosolf]: For more information on the AVID Jail Project and more inmate stories, please visit AVID-jailproject.org.

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Transcript for Figure 7.27, Oregon State Penitentiary Diversion Program

[Nina Volkova, Behavioral Health Services Manager]: I have worked in the addiction field for over 15 years before joining the Department of Correction and I have never experienced what I have experienced here. If we are able to increase insight into one person's existence, then they're able to either reach out for help when they're ready for it or at least recognize that this is going on for them versus dealing with it through you know, either self-medicating or avoiding a problem because it's so embarrassing or difficult for them to tolerate the pain that they have to go through.

[Music.]

[Theron Hall, CRM/CADC 1]: We recognized that there was a need for substance abuse treatment and support, and peer recovery services is a needed field in the community, and so we thought it would be a good idea to try to mimic it on the inside.

[Austin Boring, CRM]: I've seen a lot of guys who have just had no hope whatsoever; didn't know what walking a path of recovery even looked like.

[Austin Keever, CRM/CADC 1]: Am I in action, taking action to be in groups to get help for whatever I'm going through? I can always receive help. That means I'm in maintenance, that means I'm in recovery, that means I'm growing. So I'm always wanting to receive help, and that's what you get in the program. If you don't have a program inside the prison like that, then people are stagnant and don't grow.

[Volkova]: The diversion program that we have here at OSP does not exist anywhere else.

[James Giggy, CRM/CADC 1]: It means everything. I think opportunity for change creates hope.

[Jordin Stepan, CRM]: This program is something that's absolutely needed for not only the people that are transferring to society or leaving, but the people that this is their society. If their whole life is going to be here, some people like to do what they're doing and it's good for them, but what about the people that don't know any different that want to change and want to do something more? And this is what they have, but yet the tools aren't being provided for them.

[Hall]: I think my favorite moment is when I was able to see guys who were a participant of the program graduate, remain clean, and now serve.

[Giggy]: At some level, us, the inmate community and staff, can actually work together to create better chances and opportunities for individuals doing wrong things because we're always penalized for the trouble we get into. But rarely are you even awarded a second chance or given the opportunity or rewarded for all the good you've been doing.

[Keever]: People who wouldn't even be in recovery right now are in recovery. They would have never been introduced to it. They're out in the yard talking. To other guys who have never even been in recovery on a maximum security prison yard, talking about diversion and what they're doing in their classes, talking about it with their families, and they would have never done this without a peer-led support system.

[Stepan]: This program, what it does is it gives people the opportunity to not only be in or work on rehabilitation, but to also transform themselves and evolve into a better person.

[Music.]

[Volkova]: We haven't done a good job shifting understanding that addiction is inside everyone else's household. It is no longer a problem of some distant neighbors.

[Music.]

[Hall]: The most effective part of the program is the peer-to-peer rapport that is built. If you are a drug addict or if you identify as someone who has struggled with addiction, people are more likely to respond to that because inherently there's this belief that, you know, I'm not worthy enough. And so when you're trying to correct behavior, oftentimes the best way to address that is to show a person that you went through this.

[Boring]: I understand being an addict myself and going through the things that I've gone through, what it's like to be in that headspace and to be in that place of life where you don't have any worth or want or strive to live and to have a better life.

[Giggy]: I always found myself being part of the drug community one way or the other. And since I grew up in it and I'm so in tuned into it, that I felt if I joined the side of helping people break away from it, I have a better opportunity to find out the problems or the holds it has on my family.

[Stepan]: You're always going to have things that tempt you. You're always going to have things that try to pull you back in, whether it be old friends, whether it be triggers, whether it be different things that remind you of the good feeling you got from doing the wrong thing.

[Volkova]: Having them here and watching them, making them grow and questioning their own ability to give it back to the community and fostering that level of integrity and hope, that is really hard to recreate somewhere else.

[Keever]: I had to go through this process and experience all of what it was like to finally surrender and say, like, yes, I am dealing with addiction. Yes, I need recovery. My life has become unmanageable and I need help. And so it took me literally getting arrested.

[Giggy]: I think it's extremely effective. I do believe in it. We put a lot of energy into it.

[Hall]: It means that I am a professional. It means that I have more job opportunities upon my release. It means that I can see myself in a different light. And one of the things that I foresee is being able to be a mentor in the community. Those who were struggling with mental health as well as addiction.

[Giggy]: My mistakes don't define me.

[Keever]: It gave me purpose. Yeah. It gave me hope that, like, recovery, my recovery is strong.

[Stepan]: I get to see people that have had severe addictions and just, I guess, been as bad off as they can. To see them be really excited, as excited as they were to use a substance or to get some drugs, they're now excited about doing the things that keep them away from it.

[Giggy]: I can be a beacon of hope for those who are looking for change.

[Boring]: When I became a CRM, it was probably one of the biggest accomplishments I've had in my life.

[Stepan]: Through gaining some self-worth, I can now go help other people do the same thing that are in the same position that I was in.

[Keever]: I'm very thankful for it.

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Transcript for Figure 8.8, "Behind the Tattoos" – Episode 2: Navigators at Homeboy Industries

[Steve Avalos, Navigator]: So imagine having a life or just having a place where you could come and you're not excluded. You have a sense of belonging. There's no expectation, no

you're just good, you know. All we want is the best for you and I don't think there's really too many places in this world that you can have that. I feel like as a navigator like that's what they create, is an environment where everybody belongs. And to have that consistency and mentorship is, um, it's important, especially in the beginning, because that's your example of hope. I know that was for me.

[Robert Juarez, Head Navigator]: So a navigator is a mentor and a trainee as are those individuals that walk to our doors and are getting our services and we're walking with them.

[Jose Arellano, Navigator]: My name is Jose Arellano and I'm a navigator at Homeboy Industries. For me, it's like, it's like a family you know, it's like, it's like building a relationship that goes beyond friendship. It's like, I'm there. As we're getting all of our duties squared away, we're connecting with one another. You know it's about saying hey I'm here for you. What do you carry? Let me carry it with you so it's not heavy.

[Music.]

[Kusema Thomas, Navigator]: My name is Kusema and I am a navigator here at Homeboy Industries. For me it's very important to join in with the work with the trainees every day because I believe that there is something empowering about working together. It gives them the sense that you care enough to do the same work that they do so they can, too, understand the importance of it.

[Janet Conteras, Navigator]: My name is Janet Contreras. I've been a navigator for two years. My relationship with trainees – it's like a parent, you know, you don't give up no matter what they throw at you. You're there 100%, you got their back. I get a phone call from somebody late that they're going through it and I'm gonna be there you know because I remember and my struggles I needed that one person.

[Cruz Lopez, Trainee]: I'm thankful my navigator is always not giving up on me. When there's times where I feel like I should give up on a certain goal that I'm trying to achieve and you know I'm like really low, but you know, I'm able to speak to a navigator and they'll tell me oh whoa don't give up you know, you come this far, why give up now. My navigators teach me to be strong.

[Music.]

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Transcript for Figure 8.9, Inside the Transition Center

[Narrator]: Every year 13,000 people are released from the Clackamas County Jail, many without a plan or place to go.

[Steve Fletcher, Transition Center Client]: I don't want to reoffend, but you know what, if a guy's just like kicked out with nothing and no place to go and it's pouring down rain and you got some guy in the bus who's like, "Yeah, come with me," and you know him from jail, where do you think you're going to go?

[Narrator]: This time Steve Fletcher, who ended up in jail after relapsing with his addiction, took a different path. He walked over to the Clackamas County Transition Center where he received clothes, food, and help applying for jobs.

[Fletcher]: They weren't giving me, you know, a hand out – they were giving me a hand up.

[Narrator]: In February Clackamas County opened up the Transition Center, the first of its kind in the state of Oregon. The Center offers low-level offenders leaving incarceration and re-entering Clackamas County, an all in one place to plug into a host of services to help the transition and help prevent them from committing future crimes.

[Bridgette Mountsier, Transition Center Client]: You know, coming here really, like, helped motivate me to just keep pushing cuz they're just so helpful and they just want the best.

[Brian Imdieke, Transition Center Manager]: And it's fun to see people, once they start realizing the potential they have, that they don't have to keep living life that way, that that doesn't define them, that there is something new that they can go do.

[Fletcher]: I can come in here anytime during the day, take my coat off, plug my phone in, get a cup of coffee and sit down with either your guys or go talk to Shawna.

[Narrator]: At the grand opening it was clear support for this new center is far-reaching. Not just law enforcement but a number of Community Partners who have come together to offer services

here – all in an effort to stop the revolving door at the county jail.

[Cpt. Jenna Morrison, Director of Community Corrections]: Serving someone in the community is much less expensive than serving them either in our local jail or in the Department of Corrections custody, um, it's, I mean, it's like a tenth of the cost.

[Narrator]: Saving money and helping put lives back together, one person at a time.

[Fletcher]: I got a roof over my head, I got food, and I got this place where I can go during the day. It's pretty awesome.

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Transcript for Figure 9.5, What it takes for a patient to be committed involuntarily

[Brenda Gardner, mother to son with mental illness]: I thought he was just a typical obnoxious teenager. Eric was always very social. He was athletic. He had played high school basketball and [had a] good sense of humor. In his senior year of college at the University of Washington, we started to notice some changes.

[John Yang, reporter]: Brenda Gardner remembers her son, Eric, telling her something was wrong. Eric was in his early 20s when he told his parents he needed brain surgery. Brenda and her husband brought Eric home from college to see a doctor. That's when they first experienced the terrifying symptoms of his mental illness.

[Gardner]: Spittle coming out his mouth, in my face, screaming at me. His parting shot was, and if you try to make me see a shrink, you will never see me again.

We had never seen anything like that before. And then that kind of behavior just continued, this really volatile…. And then just not being in reality, that became much worse over time.

[Yang]: Eric threatened to kill his family members, expressing delusions, acting aggressively, and sending violent and disturbing text messages.

[Gardner]: We put contraptions on each side of the door frame and ran a bar through it at night, so that… he had threatened to kill us. We were afraid he could just break down the door and come in and kill us at night.

[Yang]: After one outburst, police arrested Eric and ordered him not to contact his parents. But after six weeks of staying with family friends, Eric returned home.

[Gardner]: We had no history of this in our family. It can happen to anyone, and it's not Eric's fault. What I say is, he is the victim. We're just collateral damage.

[Yang]: After a suicide scare, mental health evaluators placed Eric on a hospital hold, forcing him to get treatment. He took medicine, some of his symptoms stabilized, and he was released. But his psychosis later returned.

[Gardner]: It just can't last, right? I mean, they can try really hard to hold it together, and maybe they go through a period where it works for a little while, but, at some point, it crumbles.

[Yang]: Eric is now living homeless in Seattle and still suffering from mental illness. After years of trying to find solutions, Brenda Gardner said she felt helpless. Eric turned down treatment, but he didn't meet requirements for forced mental health care, also known as civil commitment. The state can force someone to stay in a medical facility and receive treatment for up to six months, but only if they have proven to be dangerous to themselves or others.

[Gardner]: I think that should be his right to refuse medication. But I think that he should be in supported housing. Or, if that was the only choice, I would rather have him hospitalized than spending winters on the street.

[Yang]: Gardner says our mental health system's failure to get people like Eric the help they need is directly contributing to the homeless crisis. She says, if a person doesn't choose housing for people with severe mental illness, which is already very limited with long wait lists, they're left to fend for themselves.

KGW reviewed Multnomah County data between 2013 and 2021. Of the thousands of people who showed mental illness, over a quarter of them were homeless, with mental illness symptoms dangerous enough to warrant a forced hold, less than 7 percent received a civil commitment ruling from a judge. Most people didn't make it that far.

Some of these people agreed to voluntary treatment, exiting the process. Many others, like Eric, were released because they didn't meet state standards, left to take care of themselves.

[Gardner]: As far as I'm concerned, the homeless situation is an open air psych ward. It's those people that should be in psychiatric facilities or in supported housing with, you know, with a caseworker that checks on them, are instead living on the streets and being treated like animals.

[Yang]: But each person's experience with this process is different. Laureen remembers sitting in the back of a police car in Washington County on the way to a hospital on a mental health hold.

[Laureen, former mental health patient]: I had some beliefs that weren't accurate and put myself in harm's way. I easily could have gone to jail for trespassing. I was making people afraid. Because I was not acting like the person that they knew. They're like, what is going on with her?

[Yang]: She knew people were concerned about her mental health.

[Laureen]: Things weren't right, but nobody could figure it out.

[Yang]: Except this time she was forced to stay in a hospital as doctors evaluated her mental illness.

[Laureen]: It was only when I couldn't leave, I was like, oh.

[Yang]: It's different this time.

[Laureen]: Because I couldn't leave. I wanted to leave.

[Yang]: A doctor said Laureen's mental illness was a danger to herself, filing a notice of mental illness. Laureen was diagnosed with bipolar 1 and put on new medication. Then something changed. Laureen says she's fortunate. Her symptoms became more manageable. She started agreeing to treatment.

[Laureen]: I just remembered a certain point, everybody kind of agreed, well, she's, she's doing everything we're asking her to do. As opposed to if I had refused to participate in treatment, then it could have been different.

[Yang]: Laureen is an example of a voluntary diversion when a person being held against their will agrees to a plan to treat their mental illness.

[Yang]: You'd say in your case, the system worked well?

[Laureen]: Yes. I don't know if I would be alive. And it's hard to know what would have happened if somebody hadn't stepped in. I know my life would be a lot different.

[Yang]: Now she works as peer support for other people experiencing the civil commitment process, telling them she's been there. It'll be okay. Even if she knows forced treatment doesn't always work out like it did for her.

[Laureen]: But I do acknowledge that there are people that do slip through the cracks every single day. And that breaks my heart.

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Transcript for Figure 9.14, Washington State's Sex Offenders Are Sent To This Island (HBO)

[Ben Anderson, Reporter for VICE News]: And this is the only way onto and off the island?

[Bill Van Hook, CEO, McNeil Island Special Commitment Center]: That's it. This runs every two hours, both ways.

[Anderson]: This island is where Washington State sends its worst and most dangerous sex offenders. They are deemed sexually violent predators, whose crimes and personality disorders are considered so extreme that they need to be separated from society. Bill Van Hook has been in charge here for almost two years.

[Van Hook]: So this is our central control room. This is where all the security operations are centralized and monitored.

[Anderson]: And do people try and escape?

[Security Officer]: Very rarely. We haven't had anybody attempt it in years. It doesn't generally happen.

[Anderson]: While this certainly looks like a prison, legally it's a treatment center. But all 236 residents were sent here against their will. Despite having already served their prison sentences elsewhere, and when they arrive, none of them have a release date.

[Van Hook]: We are the first civil confinement facility for sexually violent predators in the United States. It was established in 1991. People who have served their prison sentence are evaluated at the end of their sentence. And if they're evaluated to present a high risk of reoffending, they're referred to prosecution to have them committed for treatment at our facility.

[Anderson]: Forced confinement facilities like this are legal for people with mental abnormalities who are considered high risk, and only if treatment is offered, and if there is a chance of release. Nineteen other states have similar programs, and in 1997, the Supreme Court ruled that they were legal.

[Van Hook]: There's nobody here who walked in here and said, please pick me for civil commitment. The way that they're now seeing the way to leave is, I've got to get involved in treatment. That's how I'm going to get out.

[Anderson]: Is there any way they're going to get out?

[Van Hook]: Well, they could go out by dying, which is not the preferred way, obviously. They can go out if they become so old and disabled that they no longer meet the criteria.

[Anderson]: Justin, who asked that we only use his first name, began molesting children when he was a child himself. He was convicted at age 13 of first-degree child rape, and molesting his half-sister for over a year. He spent five years in prison, and ten more years here on McNeil Island.

[Justin, inmate at McNeil Island]: We're going to go to my room now, and I'm going to put my briefcase away.

[Anderson]: And the briefcase and the suit, is that for us, or is that for your attorney?

[Justin]: I always like to dress appropriately, so, yeah. I'm very festive. I like decorating.

[Anderson]: Like many sex offenders, Justin was himself abused. He was also diagnosed with ADHD and antisocial personality disorder.

[Justin]: I'm both a victim of a sexual assault and a physical assault. And. Uh. I will tell you that it took forever for me to forgive myself for what I've done. I got my siblings, you know, who I victimized, and it's like, you know what, I have something to prove to them. I need to leave them a legacy and say, hey, you know what, Justin is not this bad person anymore.

[Music.]

[Elena Lopez, Clinical Director, McNeil Island Special Commitment Center]: So, the predominant modality of treatment here is group therapy, but we also offer something called case management, which is up to an hour of individual therapy a month for each resident.

[Anderson]: Elena Lopez is in charge of the treatment program, which aims to manage residents' compulsions to the point where they are no longer likely to re-offend.

[Lopez]: This visual depiction helps them understand that certain things come from inside ourselves and certain things are external to us that we still need to be mindful of.

[Anderson]: So, the aim is to manage their urges and instincts rather than get rid of them?

[Lopez]: Absolutely. So, the purpose of our treatment program is to manage their risk. It's not to eradicate or eliminate or get rid of, because most of our residents may always have a proclivity for deviance in some way, whether that's for children or non-consensual sex or other.

[Anderson]: Justin, who has spent 19 years of his life incarcerated, eventually engaged with the treatment program and is now convinced he will not commit sex offenses again.

And, you know, given the crimes you did commit, do you think you were born capable of committing those crimes?

[Justin]: Absolutely not. Absolutely not.

[Anderson]: So what do you think now, you know, made you capable of doing those things?

[Justin]: I would beg to ask the question what led up to, you know, being in an environment where I felt hurt, where I felt angry, where I felt rejected.

[Anderson]: But those are fairly common feelings for people to feel. You could feel those things again.

[Justin]: Of course I could. But now I have different ways of dealing with them. You know?

[Anderson]: So you're managing your desires, your emotions, your reactions to situations. Does that mean you still have desires about children?

[Justin]: No, I don't. And I. No, I don't. It's just. It's just, it's a weird thing. I mean, I don't have any urges towards children. I don't have any struggles about urges towards children. And I mean, I honestly, I'm baffled. You know, because it's like, I just stopped thinking about it.

[Anderson]: Whatever it was that worked, Justin has now convinced the state that he should be released. He's scheduled to get out later this year with major restrictions and monitoring.

Rachel Forde has represented Justin for five years.

[Anderson]: What benefit does McNeil Island actually offer?

[Rachel Forde, Public Defender]: No benefit at all. I mean, if the treatment is better on the outside, the opportunities to reintegrate into society are better on the outside. So there's no purpose. If our society gets together and says we want life sentences for all sex offenders, then we should just be honest about that and say that and change our laws.

[Anderson]: Good treatment has been proven to reduce reoffending rates. The 30 states deal with sex offenders without places like McNeil Island. There are no studies that show civil commitment is much more effective than community treatment.

Wayne, who also asked that we only use a single name, repeatedly sexually assaulted young children and was convicted of child molestation and statutory rape. But after 13 years on the island, he's now been released unconditionally and is studying to be a social worker.

Are you, are you still a pedophile today?

[Wayne]: I don't see myself as a pedophile today.

[Anderson]: You were convicted for multiple offenses against children.

[Wayne]: Yes.

[Anderson]: Are you saying that at the time you had no idea what you were doing was wrong?

[Wayne]: I always knew it was wrong. Okay, but my desire for wanting a form of intimacy and love, even though I learned later that's not what it was. But growing up in an abused background, I had a lot of conflict. I had a lot of conflict of messages, which are lies we tell ourselves to justify our actions or our behaviors. And I thought it was the truth that what I was doing was out of love.

[Anderson]: You're definitely no longer a risk?

[Wayne]: I feel that there's always potential for a risk based on what a person has done in their past. Okay. But it's what we do to eliminate those risks. I don't come down here normally and hang out at the park when I know there's kids around down here. This is a park that kids frequent during the summer. Because I don't even want the appearance. You know, the reality is people can change.

[Anderson]: Even if serial child molesters can change, it will take a lot to convince the public that they are anything but monsters.

Do you think this will exist in, say, five years' time?

[Van Hook]: It'll be here for longer than that.

[Anderson]: And do you think there's, you know, there'll ever be the political will to close it?

[Van Hook]: I don't know. It would be a tough sell.

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Transcript for Figure 10.2, Law, Public Safety, and Corrections Overview | Career Cluster/Industry Video Series

[Narrator]: The law, public safety, and corrections career cluster is all about protecting and serving the public. People working in this sector deal with protecting life and property, enforcing laws, providing legal counsel, sentencing defendants, and rehabilitating offenders.

Government organizations at the city or county, state, and federal levels are the major employers in public safety. First responders such as fire and police departments, share a mission to keep people and property safe, along with workers that patrol city streets, coastal waters, ski slopes, and swimming beaches.

Laws exist at federal, state, and local levels to guide relationships among people, institutions, and government; workers in the law sector enforce and, at times, create these laws. Lawyers represent individuals, groups of people, or corporations in legal proceedings. Much of their work is to conduct research and prepare documents, as well as to gather testimony, and argue cases before judges or juries. Judges interpret laws and sentence defendants.

The corrections subsector consists of city and county jails, state and federal prisons, community correctional facilities, and juvenile detention centers. The industry confines the incarcerated population, provides for their basic needs, and seeks to rehabilitate offenders.

Quick facts to know:

- About 5 million workers are employed in the law, public safety, and corrections cluster.
- Over 30,000 new law school graduates pass the bar exam each year, emerging into a tight job market of more than 1.3 million lawyers.
- Because laws apply to many different entities, legal specialties vary greatly, from real estate or tax law to family law and environmental law.
- Over 2.3 million individuals are incarcerated in the U.S. annually, with an additional 4 million on parole or probation.

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Transcript for Figure 10.3, The Washington County Sheriff's Office Serves You

[Pat Garrett, Washington County Sheriff]: No matter what part of Washington County you live or work in, your Sheriff's Office serves you.

[Deputy Orozco]: The Washington County Sheriff's Office provides police services to the urban, unincorporated parts of the county.

[Corporal Richards]: And even in the more rural areas, where there's a little more room to roam around.

[Siren sounds.]

[Jail Deputy Cage]: But even if you live inside the city limits, you can still benefit from a wide variety of county services.

[Jail Deputy Toney]: The Sheriff's Office operates the county's one and only jail. With 572 beds, it takes a large staff of dedicated professionals to keep it running safely and efficiently.

[Deputy Cooley]: We even help our city partners by transporting many arrested people. From places like Beaverton and Tigard to the jail located in Hillsboro, which helps keep your local police in your city.

[Sound of brakes and motor vehicle accident.]

[Crash analyst]: And if there's a serious crash in your community, our interagency crash analysis reconstruction team responds to do the most thorough investigation possible with the latest technology anywhere in the county.

[Forensic scientist]: Here in the Forensic Science Unit, nearly 40% of all work conducted annually by forensic analysts is for other police departments in Washington County.

[Corporal Plewik]: Another benefit that the Sheriff's Office brings to the entire county is a remotely operated vehicle team. We have robots, and even drones.

[Music.]

[Tactical Negotiations Team Member]: When a dangerous situation arises, the Sheriff's Office Interagency Actual Negotiations Team, comprised of local law enforcement agencies from the entire county, ensures a safe resolution for everyone involved.

Hands up! Hands up!

[Sergeant Lascink]: If there's a hostage situation or a person in crisis, our Crisis Negotiation Unit is here to help.

[Mental Health Response Team Officer 1]: Every day, the Sheriff's Office Mental Health Response Team hits the road with a certified mental health clinician.

[Mental Health Response Team Officer 2]: Our goal is to help connect our mental health community to the best resources possible. Thank you. Oftentimes, instead of taking them to jail.

[Civil Deputy Malensek]: As the enforcement arm of the court, the Civil Unit serves civil paperwork border-to-border within each city and in the county. That includes stalking and restraining orders.

[Search and Rescue Team Member]: No matter where you live or who you are, if you're lost, search and rescue will search for you. We search local cities and unincorporated parts of Washington County.

[Garrett]: No matter where you live, in Washington County….

[Citizen 1]: Cedar Hill.

[Citizen 2]: Beaverton.

[Citizen 3]: Reedville.

[Citizen Groups and Individuals]: North Plains. Oak Hills. Here we are in Raleigh Hills. Hillsboro. Helvetia. Banks. Forest Grove. Garden Home. Bethany. Gaston. Scholls. Cedar Hills. Gales Creek. Bull Mountain. Tualatin. Cherry Grove. Laurel. Aloha. Cornelius. Tigard. Blooming – Fern Hill. West Slope. Sherwood. West Haven – Sylvan. King City.

[Garrett]: You get it. The sheriff's office serves you.

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Transcript for Figure 10.6, Snake River Correctional Institution Recruitment Video 2023

[Corporal Valerie Klitsch]: I'm Corporal Valerie Klitsch. I've been here for 16 years.

So when you first come into the institution, if you look on the wall, you'll see a large plaque that's nearly full. That's the people that have opened the institution, worked in the institution, and are now retired from the institution. Because of the attrition just through retirement, there is a large movement to recruit and to hire.

[Officer 1]: We look for people that are flexible, moldable, trainable, self-starters, people that want to take pride in what they do.

[Officer 2]: If you have people skills and you enjoy interacting with people, you can do this job. So that opens it up to a wide variety of people. You don't have to be a certain stereotype of person to work here. We can recruit you. We can recruit you from anywhere.

[Officer 1]: The days of the knuckle-dragging turnkey, that's gone.

[Officer 2]: When you grow up and you hear about working at a prison, you see what's on the movies and TVs, it is so not that. It's a safe environment, especially here at SRCI. Are there times that we have to act and have to respond to things? Absolutely. But for the most part, it's a real family-oriented place. We have a lot of people develop friendships out here, lifetime friendships.

[Officer 3]: Before I became a correctional officer, I was enlisted in the Marine Corps for five years. The transition from military to corrections was an easy one for me, like putting on the uniform and wearing it with pride and honor. Along with that, with the transition, is obviously the monetary benefit and the insurance for your family. And coming from the military and then going to sole proprietorship, I would definitely recommend this avenue as a career if you're looking to take care of your family and yourself.

[Officer 2]: Because you've got people working their entire careers here and they're not looking for other places to go because they can retire, and they can retire comfortably, based on what the state of Oregon offers them.

[Klitsch]: At Snake River, after you've completed your probationary period, there's opportunities for you to join teams. You can join the ESS, you can join the field training program, you can be part of the SWAT team. The training is top-notch, the equipment is top-notch, the experience is top-notch.

There's just all kinds of opportunities once you get out here and you don't have to stay in security if you find something else within the department that suits you better. For instance, we have plumbing, we have electrical, we have nursing, we have vision. Everything you can find in the city, we have right here at SRCI.

You should come out here and apply. At least check it out and see what it's all about. Come out for a tour, get a feel for what's going on in your community. Don't let your education, your background, your associations, don't let any of that prevent you from coming out here because we are a diverse culture. We want everyone that has an interest in the progress of human life to come, apply, and help us get there.

[Officer 2]: I mean, this is a job, but it's also a career. And it's a career. It's a career that you can go from a basic standard, whatever you start at, all the way up to, you know, the sky's the limit on that.

[Klitsch]: There are those that wouldn't normally look at corrections, but because of the way we're doing our recruiting and letting people know: this is not just a prison; this is a place where we have individuals who are trying to make a better life, who are going to be our neighbors.

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Transcript for Figure 10.7, Parole and Probation Mental Health Unit

[John McVay, Criminal Justice Manager]: Officers with the Mental Health Unit work with a particularly difficult population, and the amount of dedication that they have to the folks that they serve, both the community and the folks on supervision, is extremely admirable.

[Music.]

[McVay]: The acuity level of the symptoms that we have in the mental health unit really vary. We have folks who are maintaining pretty well with medication, and then we have folks who really are not on medication yet and who are extremely symptomatic.

[Music.]

[Harley Earl, PPO Mental Health Unit]: From our point of view, again, we are going to be one of the positive encounters they have throughout their day. So they know if they come here, they're able to talk to someone, they can get something to eat, they can maybe get some referrals and some resources, and stuff can improve for them from that sort of interaction. So we have bus tickets, we have snacks and usually some sort of juice or something like that for them. And then we have a lot of very talented staff here in the building we can connect them to, whether it's for housing, employment, nurses, counselors, things like that.

[Music.]

[Earl]: For a lot of our clients, this is one of the calmest, safest places for them to be, is here in our building. So, if they are homeless and if they're out on the street during the night, they may not sleep more than 45 minutes or an hour. So they come in here exhausted in the morning, some of them will come to our breakfast club, which is something that […] run for many, many years. And then a lot of them will come up here and try to catch some sleep up here where it's kind of a safe spot for them.

[Music.]

[McVay]: The idea of it is to create a bit of a sense of community for the individuals who are on mental health court because a lot of them don't have a lot of sense of community. Unlike a kind of a traditional court is really for folks to be able to check in at a particular place and kind of receive feedback on how well they're doing and also receive praise if they're doing well or kind of redirection from the court.

[Earl]: Dogs are always very calming so just having them around there a lot of clients can kind of you'll see them when they're kind of get a little more anxious they'll reach out and they'll go to something to calm them.

[Music.]

[McVay]: It takes a while for individuals to really begin to manage their symptoms and to realize that there could be something different for them out there and that the life that they have right now is not the life that they are stuck with or that they have to have.

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Transcript for Figure 10.8, Inside The City: Victim Advocate

[Gwen Anderson, Victim Advocate]: Hi, my name is Gwen and I'm a victim advocate for the City of Vancouver in the Domestic Violence Prosecution Center. The Domestic Violence Unit is made up of both city and county employees. We're a collaborative agency. The purpose here is that all of us are working towards eliminating domestic violence by holding domestic violence perpetrators accountable.

My role here is to provide victim advocacy for domestic violence survivors. What that entails is informing them of court dates, of what their rights are as victim survivors, and helping them find any particular resources necessary to help them overcome barriers in leaving a domestic violence relationship.

I love being a victim advocate because it allows me an opportunity to affect change within the community that I grew up in. It's a very fulfilling role and although very challenging at times, I get to see firsthand how aiding a survivor in overcoming those barriers, whether that be helping them find housing or a support group or additional financial resources or filing a protection order, all of those things help them overcome escaping a domestic violence relationship.

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Transcript for Figure 10.9: Victim Assistance Program: Sarolyn (2021)

[Ms. Morgan, ICE Victim Assistance Specialist]: She was brought here from El Salvador by some traffickers to be trafficked. She was 16 in the midst of being trafficked, she suffered a lot of trauma, forced, drugged, forced to sell sex. She said, 'Miss Morgan, I stopped counting after 20 men.' When I met her, she had already been placed in a safe house by the agent. She was terrified; she was also pregnant by her trafficker.

As a victim assistance specialist, my job is to provide psychological 101 care, which means I'm making sure their basic needs are met, making sure they know they're safe, providing trauma-informed healing help and hope so that they can be willing to engage with law. Enforcement because oftentimes they don't trust law enforcement.

I visited her three times a week initially, I took her to appointments, helped her with finding information, and then I took her to the police station and I took her to the police department. Helped her with baby shower. After we got her situated, she got a job; she decided to leave her safe home and get an apartment. By this time she's 18 years old, but when she went to her apartment, she realized she didn't know how to budget; she realized that she didn't know how to manage money; she realized the freedom that she had in an apartment was much different from a safe house. So, those are some of the things that I had to help and teach her. Even went with her when it was time to go to court; sat with her in court as she faced her traffickers.

I will be a friendly face, and I will just coach them in breathing, helping them with their posture, helping them to stay focused. I'm a safe place to look at. She made it through court successfully; she was able to testify, face her traffickers. But she survived it, and that young lady today is now again living in her home apartment. She has two children; she's living on her own with some transitional support, but not as intense, and she's learned a lot of great lessons, and we've been able to help her in some great ways.

The Victim Assistance Program provides trauma-informed care for individuals that have been victimized, whether it's human trafficking [or] identity fraud. We advocate for them, we educate, we provide outreach to the community; we also do anything that needs to be done as it relates to victim services. So is it a difficult job? Yes, but when you're called to do it, it makes it rewarding and it makes it worth it.

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Transcript for Figure 10.10, Drug and Alcohol Counselor: Careers in Mental Health

[Michael Kemp, Director of Peer Recovery Services]: My name is Michael Kemp. My title here at the hospital is Director of Peer Recovery Services, but I'm also an addictions professional.

When I practice addiction counseling, I basically develop a relationship with the person who has been referred or has come to me to get to know that individual and then discuss their relationship with the substance, what their desire is in regards to their substance use and changes in their life. And then I work with them to develop their own individualized plan, help that person gather the resources and the necessary instructions to be able to make those changes and continue to evaluate as we go along.

Some of the qualities that I think I have are the ability to be there with the person, to really actively listen to who that person is and what they are experiencing in the moment and what their story is, and also what they would like their story to become. I think that the ability to encourage, the ability to reflect back what they're saying to make sure that I'm hearing correctly, the ability to help them figure out how they can best use their strengths in their own personalized recovery program is a skill that is essential for a counselor to have and one that I continue to try to improve upon.

One of my own philosophies is: I need to be down there interacting at least several times a week. And one of the things that I've chosen to do is become involved with Dual Diagnosis Anonymous, which is an offshoot of a 12-step program that was developed by a person out of California, called Corbett Monica, and he developed a support group program specifically for people who have been diagnosed with both substance use and mental health disorders because there are various groups that would say, you know, well, you have mental health issues, you can't be part of the substance use recovery. People in mental health say, but you're, you know, you're a drug addict.

My interactions with patients are usually with patients that are working towards advocacy and leadership within the hospital and having their voice listened to. We have a patient advisory council made up of patients who desire to be part of it to address some of the issues to make their living conditions more tolerable, to attempt to provide input to how we can run a better hospital, better treatment, better environment.

The reward from this profession is, again, based upon my own personal belief. Part of my native heritage is to believe in making the world better for several generations. And I believe that when people find their own recovery, they make the world a brighter place. They make a brighter place for their spouses, their children, their families, their communities. And that's the effect that I desire for the world that I live in. So to watch that happen, to watch people's stories evolve. To see people that were, I was involved with years back, just making the world such a greater place just inspires me to keep showing up.

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Transcript for Figure 10.11, Co-Occurring Disorder Treatment – CRCI 2023

[Narrator]: Outside the Columbia River Correctional Institution, you see a prison. But inside these walls, there's so much more happening. Addictions counselors and mental health professionals are working hard to prepare these adults in custody to re-enter society successfully.

[Shawn Wise, adult in custody]: The tools that they teach here are indescribably life-changing. I came here with very low self-esteem, very secluded and kind of reserved. And being here has opened me up into being a productive person, a leader, somebody that uses his tools and takes into perspective that other people are human too and that other people have their issues.

[Narrator]: Shawn Wise is one of the dozens of adults in custody taking advantage of the co-occurring disorders program called New Foundations.

[Willie Shaffer, qualified mental health associate]: So the name in itself is huge for me because it's about building new foundations. And with anything that you build, a foundation is key to having that strength at the base and to be able to build on top of that.

[Narrator]: Willie Shaffer has come full circle. He used to live at the facility as an AIC, his room across the hall from his office. Now nearly two decades sober, he works as an addictions counselor and mental health associate.

[Shaffer]: It just reminds me of where I've been but how far I've come. And I share with my clients on a daily basis in group and individuals that I'm no better or worse than them. Like, I just decided that I was willing to do whatever it took to change my life after paying my debt to society. And I've done that. And I just encourage them that they can do it. And that we will support them and give them every opportunity and every skill that we have to allow them that.

[Marnie Holmes, qualified mental health associate]: We are a co-occurring program, meaning that we address both substance use as well as mental health issues simultaneously. That's important. Research shows that when someone has an addiction and a mental health issue, addressing both of those at the same time gives you a better outcome. People tend to be more successful.

[Narrator]: AICs usually spend 9 to 12 months in the program. Each day consists of group and individual counseling sessions with several different addictions and mental health specialists.

[Joshua Allen, qualified mental health professional]: There's trauma exploration-based groups. And then there's just a lot of addiction-kind-of-based groups. There's a lot of different groups. We also have just supplemental things like art group we try and run. The benefit of this program is we just get to be out there and play chess and play Uno and play Connect Four.

[Holmes]: This is the most in-depth and supportive program I've ever worked in. The curriculum that we use is evidence-based. It has been proven to help others that are incarcerated to be successful upon leaving prison. And we really are vested in our clients and their futures.

[Wise]: I was scared at first. I didn't really necessarily want to change. But as I started going through the program, it became a habit. And it became a comfortable habit. And then it became a lifestyle. And then here I am. I mean, I'm out in like 15 days. I feel rejuvenated. So we've all got big plans in our head. But we've got to be able to learn something new. So rehabilitation is very important. Very important. I don't want to come back here again.

[Holmes]: If we can help one man change his life, the outreach of that is so important. We've come so far that people don't think about that. They don't think about how that one man being clean and being successful affects his children, his family, his neighbors, and society as a whole. We need to support these men and not put them down and not judge them, but give them what it is that they need and they want so that they can be successful in the world.

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Transcript for Figure 10.12, Peer Recovery Specialist: Careers in Mental Health

[Malcolm Aquinas, peer recovery specialist]: As a peer recovery specialist at the Oregon State Hospital, and that role takes on many different responsibilities. Sometimes it is responding to requests for support from either a resident, so somebody who currently is receiving services at the hospital, or from a team member, someone who is providing services. It could be also someone from treatment mall, which is a part of the hospital where people go and take classes or other groups to help in their recovery journey. Additionally, I serve on different bodies within the hospital that are designed to improve the treatment that people receive. The ultimate goal, of course, always is helping people to regain a sense of empowerment, of their own voice, and establishing a path forward for themselves from the place where they currently find themselves, which is unfortunately at the Oregon State Hospital, a place of confinement.

Peer means somebody who has a similar shared life experience. Now, the word 'similar' is very, very important because we always want to make sure that we know that my experience is not your experience, and your experience is not my experience. And what we do then is we allow at least a sense of some maybe more global understanding of, for example, I have been involuntarily hospitalized, I have been arrested before during a mental health crisis, I've had involuntary medications, I have been restrained forcibly. These are things that when people come to know this about me, it allows an equaling of the relationship and, in fact, when I do trainings around for people who are coming into the field, one of the things that I always get asked is, you know, well, how do you know if you're doing it right?

And I answer, I think, somewhat differently. I said, if you ever find yourself saying to someone what they should or ought to do, you might be doing something that's helpful, you might be doing something that's beneficial, but what you are not doing is peer support. Peer support is always non-prescriptive, non-directive.

All these that I think serve me the best as a peer recovery specialist are patience. It takes a long time for people to be able to feel comfortable with another person who starts out as a stranger. The next is related to that, and that's bringing compassion, you know, being present and understanding that, you know, people have gone through difficult circumstances, they are going through difficult circumstances, and they anticipate there will be more difficulty ahead before they reach the end of this current journey at the Oregon State Hospital.

And lastly, one that is spoken of many times in the peer movement, sometimes referred to as the consumer-survivor-ex-patient movement, is called holding hope. And holding hope means you're coming alongside someone, and this is typically somebody who everything that they're saying, is I can't go on. I can't take it anymore. This is unendurable. And whatever form that takes of what they're going to do, it's some form of I'm going to quit. It might be I'm going to quit in that I'm going to seclude myself in my room. Or it could be I'm going to quit, I'm going to fight back against everything they give me. I don't care if they're offering me, you know, 'You get a walk out the door right now,' I'm going to tell them where they can shove the door.

Or it could be I'm going to look for the opportunity to take my own life, if I have it. And what you do then is you come alongside, you listen, you validate, and then you share with respect similar times that you have found that. And you tell them, 'Will you allow me to hold hope for you?' Because I have hope for you. I know and believe you will be better. That time will pass and things will improve. And I have never had a person, and I've been doing this formally for about seven years, informally for about 35, I've never had a person who has said no to that. And I have had countless people come to me later and say, 'I'm here today doing what I'm doing because you held hope for me.'

What I frequently will offer is peer walking as an option because then it allows me to do the peer support work, which is that nonjudgmental, mutual, equal-level relationship and where I'm listening. But also it's incorporating some of the trauma-informed approach recommendations, which is, get people moving. And what I have found is that helps people be very successful in talking through otherwise complicated and upsetting issues while remaining very, very calm, having a very conversational approach.

My greatest rewards in this job are the times when I get to see people move from despair where they are disconsolate. They can't see anything getting better. Where family members come in and say, 'I've lost my child or I've lost my husband, I've lost my wife.' And then, after a period of time, when people are crying and hugging each other, and they're hugging me, and they're saying, 'Thank you for not giving up on me. Thank you for being there through all the hard times.' And now I'm going to go out, and I'm going to carry forward the same mission that you gave to me, and I'm going to help someone. I'm going to pay it forward. You can't put a dollar value on that for me.

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Transcript for Figure 10.13, Psychiatric Social Worker: Careers in Mental Health

[Kristy Dees, psychiatric social worker]: I am Kristy Dees, a psychiatric social worker.

I started off wanting to go into nursing, changed my mind, went into criminal justice, changed my mind, went back to nursing, changed my mind, went and had a family, went back to school in my late 30s, got my degree at Chemeketa, my associate's of transfer degree, then went and did night classes at PSU for my bachelor's degree for a couple years and then started the distance option program with PSU to get my master's in social work and that took me three years. I've been here for over 12 years at the hospital but

I've only been a social worker for a year and a half. I was a mental health therapist for the previous ten and a half or so years.

I had a real compassion for those patients who were suffering with mental illness because, like cancer, none of us asked to become mentally ill, none of us asked to become you know cancer patients. So that's what led me to go back and to work here; and then as I worked here, I slowly started wanting to have more of a voice on the team and have more of a clinical opinion. I love my job. I get to really support the recovery model and work, and help patients leave the hospital. Social work is very broad, but I think one of our main focuses is discharging patients. It's getting patients ready to go out into the community, getting the community ready to accept their people back, working with partners to provide the best care possible when the patient leaves.

I'm able to be a part of a team who stabilizes a patient and moves them back into their community and I meet them the day they come in and discharge is talked about from the first meeting. We really want to pin down what we need to do to get this patient back into their community so I try to be involved every step of the way.

Teaching them the expectations, what's expected from them on the outside is another big thing. Getting them prepared for what's going to happen when they leave the hospital. I have a client right now who's having a lot of stress about leaving the hospital. He's been here four or five years and it's every day, it's a new question. Am I going to be able to do this? Am I going to be able to do that? And it's having, it's very gratifying to be able to sit down, let him vent his frustrations, his unknowns, his stress, and then validate that for him and say this has to be very, very, you know, scary for you. And so being able to say that you're stressed out so that somebody can help you, I think is important.

My greatest rewards are when I can work with a client, maybe one-to-one, to accept a discharge. On my end, I have patients who don't always want to leave the hospital. And when I can do that and I can work with them, I can do individual therapy with them, and we can move them out into the community in a safe manner, that's always rewarding. Any discharge is a rewarding discharge. Getting someone back to their community.

The way community views people with mental illness is the greatest challenge we have. Not in my backyard, not in my neighborhood. We can't have a patient in our neighborhood. Well, and the fact of the matter is, is that these patients are just like you and I. They have, but they have a mental illness. And who knows, you and I may have a mental illness, too, that just happens to be, you know, controlled, and maybe this one doesn't. But that still means that they're humans, and they deserve to be treated like humans.

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Transcript for Figure 10.14, Clinical Psychologist: Careers in Mental Health

[Franz Kubak, clinical psychologist]: I'm Dr. Franz Kubak. I'm a clinical psychologist.

Oregon State Hospital is a large place, but I think a lot of people are here for the same reasons, you know. We have a lot of people here who have compassion and want to help these folk out and kind of understand the mission. And all of our work does overlap in a lot of ways. I mean, the patients that come in here on admissions will have a lot of different teams along the way, but our work kind of carries over from team to team. So I think that collaboration is just like a huge part of what we do. A lot of my clinical work actually focuses on creating what we call wellness recovery action plans, pretty much relapse prevention plans, where we teach the person to recognize, like, what are the early warning signs of mental health relapse? What are some things in the environment that could increase their stress or lead to worsening of mental health problems? What are the plans for dealing with that when they show up? So part of being able to do that is understanding the responsibility that they have to manage their own mental health after they leave here. And I like to help them create plans on how to do that.

We offer a lot in the way of treatment classes. Like, I'm heavily involved in the dialectical behavior therapy program, or DBT for short. But at this point, I focus more on individual therapy because one person's needs are going to be very different from another person's needs. Like, someone might be learning how to manage their symptoms of schizophrenia. Another person might be learning how to manage themselves more in interpersonal relationships or romantic relationships. Someone else might have substance abuse issues. So individual work is required there.

My version of recovery, I want the person to become their best expert in knowing, like, what they need. And to be able to also know that information so well that they can share with other people the skills that they're using. Make them understand why it's so important that they keep a consistent sleep schedule, what they use to, like, reduce their stress, why exercise is so important to them. Like, whatever it is to that person. Like, what types of cognitive techniques. Just so other people can, well, understand. And they are their own best advocate to, like, remind themselves of the skills and the reasons why they're using them.

Greatest rewards for my work? I can think of a lot. I can think of seeing people really progress through the system here at the hospital to really learn to manage their mental illness on their own, to come to terms with the realities that brought them here and not to resist them or fight against them. To learn how to be more effective in their day-to-day life and in their own care. And then eventually being able to leave the hospital and have productive, happy, meaningful lives. Like, when I get a card sent to me from an old patient who's now, like, pursuing education, I think that's awesome. I also find satisfaction in working with teams and getting people to collaborate and to really put their heads together on, like, what a patient needs or what the community needs to be able to manage a person safely.

I like teaching, and that includes both patients as well as staff, and getting people to understand the importance of things like relapse prevention planning. So there's a lot of reward available here at the hospital, whether it's working with our patients or working with our other team members.

I think that a good therapist role is a teacher because you are not going to be there for your patients, following them around in the community, telling them how to, like, take care of their mental illness or make healthy decisions, right? You want them to learn how to do that for themselves. So I am most gratified when my patients learn from, like, what I'm trying to teach them, and they understand it and kind of take it and do well with it. Like, nothing's more gratifying than seeing someone leave the hospital and just not coming back.

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Transcript for Figure 10.15, Forensic Psychiatrist: Careers in Mental Health

[Michael Duran, forensic psychiatrist]: My name is Michael Duran. I'm a forensic psychiatrist. For me, it's a great job. And so, I am a medical doctor, so I've gone to medical school and I've completed training in psychiatry and particularly in forensic psychiatry. And what I do is I have the, really, I find it the kind of deep privilege of talking with people about their lives and then trying to sort out, based on what I'm being told and what I'm observing, what do I need to do both in my talking but also with medications to help that person feel better and to get more stable.

For a psychiatrist, your stethoscope in many ways is your mouth and your ears. It's the human interaction part of our job that creates the most healing. So, you're using your, what people are telling you and your questions that you ask them to try to figure out what is the mental illness that I'm seeing. And an important part of that is not only what the patient is telling you but also what their history is. You also utilize things like labs. So, you may do blood work to make sure that things like their kidneys are working properly, their liver is okay. It may involve doing like CAT scans or MRI scans to make sure that there's not some tumor or other issue that could be causing the mental health problem that you're seeing. And once you've gathered all of that data, you then think through what medication will be most helpful for this person.

We function absolutely as teams. And here's why that's really important. We have patients that are in the hospital 24 hours a day, seven days a week. And as the psychiatrist, the physician on the unit, I may only see the patient, you know, 20 minutes every week. And so you're really relying on your whole team to be observing and giving you information about how they're doing. On a treatment team there are various disciplines like the psychologist, social worker, rec therapist, nurses. All of those individuals take progress notes, work with patients maybe in groups or observe folks on the unit. And then all of that information is brought together in what's called a treatment team meeting, where it's basically just a meeting of everyone working with the patient where you discuss what are you seeing, what am I seeing, is it consistent across different areas. And then based on all of those observations, you put that data together to formulate what you're seeing and then how to be of help.

For me, there's a couple big challenges here. The first would be that there's really some pretty deep human drama here of folks that have had really tough goes in life and have been under really tough circumstances. And listening to the stories and trying to care about that person can affect you. And you have to figure out how do you keep yourself healthy and present to be able to hear those stories, be empathetic, but also not to let it affect you negatively. A second big challenge is that some of our folks can be aggressive and violent. And as the physician on the unit, oftentimes you feel responsible for the decision making of certainly medicines, but also safety precautions and treatment.

This is a really deeply rewarding job. And I would say for me, the most poignant remembrances or memories I have of where I've just felt incredibly humbled, delighted, happy for working here, is when

families get reunited. So it's not uncommon that we'll have someone that comes in from another state, for example, and they have been homeless, they've been traveling, they end up in our system, and I get the privilege of being able to call their mom and say, you know, Ms. Smith, I just want to let you know Johnny's okay, and we have him, and we're working with him, he's safe, and they're like, oh my god, we didn't even know if he was alive. And those experiences happen in this facility daily. There are miracles that happen here, and it's deeply rewarding work.

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Transcript for Figure 10.16, Within the Walls: Nurse Practitioner – Women's Prison

[Rhonda Smith-Bass]: I love my job because I make a difference. When I can walk in here and an inmate says to me, 'thank you so much.' That makes me feel good because it makes me feel like I've done my job.

When I came here and I started talking to these women and finding out the traumas and the things that they went through, I became more interested. So I decided to start a program. Self Love Breakthrough teaches women to love themselves and help them understand the trauma that happened to them in the years. A lot of them are here because of child abuse. A lot of them have been raped. A lot of them have been abused. So once they grow up and get older, they start getting involved with people that draw their energy, that kind of control them.

If you love yourself, you wouldn't take that kind of treatment. A lot of people leave out of here, even people that are on drugs, they leave out of here trying to seek that love again. Once you connect with that child that was hurt years ago and become old, they can heal.

Women's care is my passion because when I look at these women coming in here I realized that it could be my mother, my daughter, my sister. It was more of a ministry to me than a job because I really love what I do.

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Transcript for Figure 10.17, Psychiatric Nurse: Careers in Mental Health

[Lori Martin, psychiatric nurse]: My name is Lori Martin. I'm a psychiatric mental health nurse practitioner. I currently work on two different units where I take care of five patients on each unit, so I'm considered the clinical lead of the team for my patients and I will work with them figuring out what their diagnosis is, then work with them trying to figure out if they need medications and what medications they need. I think it's really important to try and work with my patients to find out the best medicine for them.

My goal is to help people feel relaxed, help them feel like I care about what they have to say and that my goal is to understand what they are going through and try and help them along their path to recovery.

You know, I could come out and have the list of questions that they've gone through a million times, or I can just have that conversation to see if they're improving. Within that conversation, I can find out if they're doing well with their memory – how's their long-term memory? How are they oriented? I can figure all that out just by having a nice conversation. So sometimes that might be for instance the flower in my hair. I started wearing a flower every once in a while, and pretty soon when I didn't wear one people would say, 'Laurie, where's your flower?' So now I wear the flower, and what I've noticed is that sometimes that in itself will start a conversation.

Same with my fancy shoes I have a pair of shoes that are bright red, and when my toes are together they say 'smile' on the toes of them. Somebody who, last week may not have been able to answer a question or make a statement like, 'Oh, Lori, where's your flower?' Or 'I liked the one you wore yesterday better.' Remembering that I was wearing a flower yesterday, or remembering that I'm not wearing a flower today. So things like that can help me know if the things that we're doing for this patient – is it helping them along the way or are they still not understanding what's going on? So just the privilege of being able to spend time with people and have these conversations and I get to do this and it's my job and it's so amazing.

Because we work in a team environment where we have somebody here 24 hours a day recording and watching our patients, we can make changes pretty quickly. So if we see improvement and we know we're on the right track, like fabulous. We can keep moving down that track. If we see something that's not seeming to be good, we can make assessments and make adjustments based on what people are seeing. Oftentimes my biggest challenges are also the things that are so rewarding. As a chief nursing officer, trying to figure out how to make sure that our new employees got the orientation that they needed. I was able to help create a training program that could help do that. And then now getting to see how it's seeming to help on the units and change the way that we provide care.

I love what I do. I love the staff that I get to work with. I love the idea that I get to see people when they come in who maybe are not doing well. Just recently, I had a young lady who came in and she had been very, very sick. She'd been using drugs. Two weeks later, I'm talking to her. She's doing really well. And she said, 'Thank you so much for being here for me. I feel like getting arrested and having to come to the Oregon State Hospital was what saved my life.'

It feels really satisfying to end my day knowing that somebody's life might be better just for the fact that I was willing to listen, I was willing to understand where they're at and try to help them in their recovery.

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Transcript for Figure 10.20, A Psychologist and Former Cop on Mental Health and Suicide | We Are Witnesses: Chicago

[Carrie Steiner, former Chicago police officer]: My first day as a Chicago police officer on the street, I was sent to the 18th District. The field training officer said that we were going to go to a wake tonight and I said okay and I thought that was kind of strange and I was like 'Well, who is the wake for?' and he said 'Well, it's for an officer in the 18th District that had killed themselves.'

I grew up in Appleton, Wisconsin. It was very safe. I kind of felt like I lived a little sheltered life, so when I came to Chicago, it was quite a big surprise. I never thought of being a police officer when I grew up. I was kind of a rebel and a punker. My boyfriend at the time said he was going to go to the public library to get an application for the Chicago Police Department, and I said, 'Hey, why don't you pick up one for me, too?' So I thought that would be cool, because I can show that a woman can do the same job as a man can, and I love adventure, and I would love to try to get bad people. So I applied, and I got in.

As a police officer, your day starts out by putting on your bulletproof vest and your gun belt. And that being a reminder that you're wearing all of those things, because it's a dangerous job. When Chicago police officers or I had to deal with gang members shooting each other, I expected that. So those incidents usually don't bother me, but it's those incidents where you're not expecting it, or another person was hit rather than your target, that's when it's going to be more difficult.

I remember one time. I was responding to a call where officers just said that they had seen a stolen vehicle. So I started heading into that location. There was a family of five, a mom and her four kids, and they were all young. And one of them was in a baby stroller. And the vehicle was an SUV, and it ran all of them over, and slammed into a business. And I ran out of my vehicle, and I was running to them. And I knew as soon as I saw the four- or five-year-old kid on the ground that he was bleeding from his nose, ears and mouth. I knew he was dead. And he looked exactly like my nephew at the time that was around the same age. And it was difficult because I knew that it could have been my sister just crossing the street. And it could have been my nephew right there. And the four-year-old did not make it.

One of the things that bothered me a lot is when I heard that woman scream when I first got on scene. There's nothing like a woman's scream when they see their child injured, and I had that scream in my head; the dad came in, and then I had to tell him what happened. He screamed like the mom did, and that was really hard.

Then after that, I was told I had to go to a traffic complaint violation of a parked car, and it was very difficult going there and talking to someone about a car being parked too close to their driveway. You learn as an officer to not be emotional and to keep it in. Well, I kept it in because I'd already gone to calls where people were shot, or I saw a baby sexually assaulted; so I already learned how to just gulp it down

and keep it down, and don't share it, and don't feel it. Numb yourself out. Put it in a little box, put it over here, and forget about it.

I started to see more and more traumas happen and more officers doing things that weren't normal and that weren't right, and I even saw that in myself. It was just very common that after work you would go out drinking with everybody and that's when you would talk about what happened on the street or the difficult things that occurred.

I was very hesitant to get treatment for myself because I didn't think that they would understand. I thought that they would pathologize me or think that something was wrong with me, or try to take my gun, and I didn't want that to happen, so I didn't want to get treatment. I know that's how a lot of officers feel.

I've known 18 officers personally that have killed themselves, and that's not all that I know have killed themselves on the Chicago Police Department, but that's all the people that I know in my 13 years.

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Transcript for Figure 10.23, Recognizing Compassion Fatigue, Vicarious Trauma, and Burnout in the Workplace

[Lisa Callahan]: Compassion fatigue really extends beyond being empathetic with someone. This is something that can affect anyone who works with people, and it's especially important for people who work in very trauma-filled situations, like in the criminal justice system, to be aware of the fact that working with people with problems can become emotionally exhausting. Compassion fatigue takes some time to develop. It's not something that's going to come on in the first two weeks where someone is on a job. It really extends over a longer period of time, where it just becomes a weariness of listening to and responding to and helping people with their problems.

Compassion resilience is a really important, relatively new concept that is being examined. Compassion resilience is the counterbalance to compassion fatigue. For people who do work with people with complex problems, it can be very rewarding and very professionally and personally satisfying to see people make accomplishments and reach goals in their recovery journey. So that positive response that you feel both as a team and as an individual would be considered compassion resilience, and can help to outweigh the effects of compassion fatigue with working with a very complex population.

The difference between compassion fatigue and vicarious trauma is that vicarious trauma resembles primary trauma. What I mean by that is that the symptoms of vicarious trauma are often the same symptoms that people experience when they have experienced a primary trauma, such as hyper-vigilance, being very jumpy, having a lot of difficulty sleeping, having difficulty concentrating. Compassion fatigue, on the other hand, is more of an emotional exhaustion. It's more of a fatigue in working with people with complex problems, but it doesn't include developing symptoms of trauma that vicarious trauma does.

Burnout is another term that you frequently hear people talk about, especially in organizations that work with people. But burnout is something that develops over a long period of time, similar to compassion fatigue. It is a form of emotional exhaustion. But it doesn't necessarily arise from the interactions with the clients that people actually work with. It can result from work overload, too little time to do too much. It can result from work conflict among coworkers and your supervisors. Burnout really takes a while to develop, whereas compassion fatigue can develop in a relatively short period of time. Burnout takes a while, and it's when people really eventually just become ineffective in the job that they're doing.

I think that one of the major difficulties that organizations have when working with people with complex trauma histories, especially those in the justice system, is they don't care for themselves very well. People who are trained in behavioral health, such as social workers, psychologists, psychiatrists, and others, part of their training and education is to practice self-care. Whether they do or not is a different issue, but they're at least aware of the fact that, when you work with people, you need to take care of yourself also so that you can help them effectively. In the criminal justice system, there's no similar kind of process in the education of going to law school or getting your degree in criminal justice and becoming a probation officer.

Basically, the attitude in many criminal justice agencies is just to suck it up and to just move on to the next case. We're realizing that that is not a very effective way to keep your workforce well. It's just as important for people who are justice professionals to practice self-care around the issues of compassion fatigue, and burnout, and vicarious trauma as it is the behavioral health professionals. It can affect anybody in the criminal justice system. It can affect people who sit on juries. It can affect the prosecutors, defense attorneys, probation officers, correctional officers, and judges. Everyone who works with people in that environment, especially as they get to know defendants and participants' stories more, they can experience the same kinds of difficulties of burnout, and compassion fatigue, and vicarious trauma.

The kinds of areas to really be on the lookout for in yourself and in coworkers would be probably the most obvious first step would be if someone's work product begins to slip. If they've previously been a very conscientious coworker or a person who you supervise, and they no longer are, that may be a red flag. Also, take into consideration their health, their general medical health. People who begin to take a lot of sick leave, are tardy a lot, have a lot of illnesses also might be underlying signs of vicarious trauma or compassion fatigue.

You also can look at mental health issues and included with that, substance abuse. If again, you see an increase or a change in the kinds of ways in which people deal with stress, maybe they become more angry, more irritable, become more frustrated, detached, no longer are participating in activities in the workplace that they typically have. Those would be all signs that you should look for and be concerned about in your co-workers and also in yourself as you become more aware of the importance of self-care, working with this population.

There are both individual level and organizational level ways of addressing self-care and wellness. There are lots and lots of resources available through employee assistance programs. And if they don't have specific workplace wellness programs around dealing with stress, dealing with complex trauma, ask them to develop a program and tell them that your organization needs that because that organization can't simply be the only one who they serve that need that input. Also, you can practice self-care in that you can seek out different forms of stress relieving exercises, practicing mindfulness, meditation, yoga. All of these have been shown to reduce stress on an individual level. And obviously, if people find that those interventions, those practices aren't helpful, they should seek professional care through a psycholo-

gist, psychiatrist, or social worker who specializes in dealing with traumatic stress, dealing with complex issues like this.

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Transcript for Figure 10.24, 3 signs that you've hit clinical burnout and should seek help | Laurie Santos

[Laurie Santos, Professor and Cognitive Scientist at Yale University]: These days we talk a lot about burnout, but as a psychologist I recognize that we have a lot of misconceptions when it comes to burnout. We think burnout is anytime you're feeling a little bit overworked or a little bit stressed or a little bit tired, but it turns out that burnout is a very special kind of clinical syndrome that has a couple very particular symptoms. One of the symptoms we often think about is a sense of emotional exhaustion, but this is richer than just a sense of physical exhaustion. Emotional exhaustion isn't just about being tired. It's really about feeling like you cannot emotionally handle another thing on your plate. If one thing comes on, you know, that's it. The whole house of cards is gonna fall.

Even when you get a really great night rest or a week off, you're still feeling kind of emotionally tired and overloaded. That's the first symptom, this sense of emotional exhaustion. The second symptom, which I think is even more profound, is a sense of what's often called depersonalization or cynicism. You're just kind of on a short fuse with the people around you, whether that's the people you're serving in your job, your clients, or your patients, or your other teammates. It's like everything they say kind of irks you a little bit and it feels like if there's one more request, you're just gonna lose it and freak out. You're also very cynical about people's intentions. You kind of feel like they have bad intentions for the asks that are coming your way.

That's a sense of depersonalization. But the third symptom is the sense of personal ineffectiveness. You just feel like even if you were doing your job perfectly, it wouldn't matter. Or there are structural constraints that make it impossible to do what you really value doing. So even if you're doing your job well, you feel like it kind of doesn't matter. It's not giving you the same value it was before.

So this is burnout. It's not just a sense of stress or overwork. I think it's important to distinguish between stress and burnout. We sometimes lump the two together, but burnout is a very particular kind of clinical syndrome. We tend to think of burnout as a modern phenomenon, but there's evidence that something like burnout has been happening for a while, at least since the Industrial Revolution.

But some of the best research on burnout happened in the 1980s and 1990s, and was mostly done by this fantastic researcher, Christina Maslach, who's talked about some of the features that tend to lead to burnout. One of the features that tends to lead to burnout is an increased workload, or a workload that really feels just too overwhelming. That isn't enough to lead to burnout over time, but this can be an exacerbating feature. Another feature that tends to lead to burnout is what Maslach calls a values mismatch.

You get into your job thinking you're doing something, but in practice, in the trenches, the job feels like something else. I'm speaking about burnout right now as a scientist, but also as somebody who's experienced the syndrome a little bit myself.

I feel like I became a college professor and a head of college on campus because I wanted students to have a fantastic experience, but then when COVID hit, it just felt like what we were doing wasn't what I signed up for anymore. There was this mismatch.

Another feature that can lead to burnout in an organization is a sense of unfairness. This can also cause a certain sense of community breakdown. When there's a sense that things are a little bit unfair, maybe there's differences in compensation, that can lead to a sense of burnout.

The final thing that's really important for burnout is your sense of reward. What leads us to kind of get flow and feel happy in our jobs, is a sense of intrinsic reward. When things become pushed more towards the extrinsic reward, and also when those extrinsic rewards, especially when they start feeling a little bit unfair, that can lead to a sense of burnout over time.

If you're wondering if you're going through burnout, a few questions you can ask yourself involve those big symptoms we just talked about. First, this sense of emotional exhaustion. Are you really, really exhausted? Not just physically exhausted, but emotionally exhausted. When you take a weekend off, are you still as depleted when you go back on Monday morning? And does it really feel like a form of exhaustion that's very emotional? It's not just that you're tired, but that you're feeling really depressed, that emotionally you're on just a really short fuse. Are you experiencing changes in how you relate to people at your work? Either the people that you serve, your clients, your patients, or the people that you work with. Are you embarrassed about the length of your fuse? Do you feel like you're going through some compassion fatigue? That's a clear sense that you're experiencing depersonalization. And is your sense of meaning going away in terms of what you're doing? Do you feel like your work has changed, that you simply can't do a good job right now because of some of the structures of what you're asked to do, or the fairness in your own institution? If you're answering yes to some of those questions, you may be on the verge of burnout, and it's important to address that before it gets worse.

So what if you're already feeling a little bit emotionally exhausted, a little bit cynical, a little bit like your job isn't effective as much anymore? This is the point when you need to think about treating burnout. And we can think about treatment as having an organizational side and a personal side. Organizationally, I think different industries need to pay a lot of attention to burnout. And one of the main ways to fix burnout is to make some changes to people's workloads, to people's sense of values, and to the rewards that people are getting. Those changes are really essential steps to treating burnout once it's there. But as an individual, you know, the best thing that you can do, aside from kind of trying to promote more of these structural changes at work, is to really take good care of yourself. And I mean that in particular, not just in terms of the kinds of things you do which matter, getting more social connection, making sure you have some free time, but also to think about how you're structuring your relationship with work.

Often, we bring the best of ourselves to work and leave the leftovers for everything else, for our families, for leisure, and so on. If you're really putting too much of your identity emphasis on work, that's the kind of thing that can lead to burnout, because those values feel like they matter so much to you. It's all of your identity that's wrapped up in this. When there's a mismatch, it can hit you even harder.

So to address my own burnout, I decided to take a sabbatical, but it was important that I stayed very intentional about paying attention to my value systems during that sabbatical. I really tried to invest more in my relationships outside of work, so it wasn't just friendships at work that were making up my whole

social life. I tried to re-engage more with other things that I value, hobbies, things as silly as like playing a little bit more Guitar Hero. But also engaging a little bit more with things like my health, like making sure I'm moving my body. It's really trying to engage all the values and the things you care about outside of work, so you can start to develop an identity in that and not just in what you're doing for your job.

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Anne Nichol

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Kendra Harding

Kendra Harding currently works for Lifeworks NW as a Service Director. For several years, she worked for the U.S. Courts as the treatment services Senior U.S. Probation Officer. She graduated from the University of Iowa and obtained her bachelor's degree in Psychology with a minor in Sociology. She graduated from the Chicago School of Professional Psychology with her master's degree in Forensic Psychology. Kendra is a licensed professional counselor (LPC) and a certified alcohol and drug counselor (CADC). She has primarily worked with survivors of intimate partner violence and sexual exploitation who are also involved in the criminal justice system. Kendra has worked in a variety of settings, including

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Instructor Resources

Author Message to Future Instructors

Instructors, I am pleased and honored that you are considering using this resource in your own teaching. Creating this text was a labor of love for me, offered in the hope that it would reach as many students as possible. I have tried to leverage my many years of experience as a lawyer and as an advocate for people with disabilities to provide accurate information in a clear format, accessible – and hopefully interesting – to a wide array of students. I use this text to teach students in our college's criminal justice program, and I am pleased each term that the course draws students from programs throughout the college, from paralegal to emergency medical technician to psychology.

For students in any of these areas of study, the text offers information about a historically marginalized group of people in our society, those who live with mental illness and disability, both generally and particularly as they interact with the criminal justice system. This book connects to standard criminal justice topics of criminal law, criminal courts, and law enforcement, but goes far beyond the standard curriculum in those courses to explore the history, needs, and problems associated with our focus population.

The text should enable instructors with expertise in criminal justice, law, or behavioral health to guide students through the material. Throughout the text, I have linked resources (such as the federal government agency and authority SAMHSA, and the mental health advocacy organization NAMI) that can provide instructors and students alike with additional and supporting information. Likewise, numerous videos are linked to provide additional perspectives, such as from people with lived experience of incarceration, mental illness, disability, substance use disorders, and recovery, as well as experience in the various career opportunities available and introduced in the final chapter.

The text is divided into ten chapters to align with the typical 10-week term at Oregon public colleges and universities. There is certainly room to expand any chapter (I would suggest Chapter 4, focused on criminalization of mental disorders, or Chapter 5, focused on crisis response and law enforcement) to fill a 12-week term. Throughout the text there are boxed sections highlighting areas of interest that could be extended, depending on student interest.

Integrated Openly Licensed Course Materials

This book includes openly licensed course materials that fully integrate with the open textbook. Anyone can retain, revise, remix, reuse, and redistribute them. Best of all, future instructors can build on existing learning pathways that are aligned with textbook and chapter learning outcomes.

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- **Mental Disorders and the Criminal Justice System Instructor Course Packs**: A collection of aligned and accessible course materials shared by pilot instructors teaching at multiple Oregon institutions. Instructors designed each course pack with an equity lens in consultation with an instructional designer. In most cases, each course pack was revised with feedback from Oregon students and an advisory board of workforce members. Each course pack includes a complete course map, an

instructor guide, and ancillary materials including weekly assignment prompts, rubrics, and suggested activities.

- **Mental Disorders and the Criminal Justice System OER Commons Group**: An ongoing repository of instructor-created course materials that integrate with the open textbook. Materials may include syllabi, assessments and assignments, lesson plans, activities, and entire course shells. Please note: not all OERC resources are reviewed for digital accessibility.

You are welcome to contribute your own openly licensed course materials that align with this textbook to the OERCommons Group. Thank you for building a more inclusive future for students and future educators!

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Manuscript Development Process

This book went through an extensive pre-production process before it was launched in order to be accountable to the project's equity lens; revise drafts for quality; and incorporate feedback from scholars, practitioners, and students in the discipline.

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- Marlene Howell, Portland State University
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Additional Resources

Google Doc Version of This Book

Link to view-only Google Doc version of this book – make a copy to start editing! **Mental Disorders and the Criminal Justice System**

Detailed Outline

The following detailed outline lists the sequence of topics and sub-topics covered in each chapter. We hope that reviewing this sequence will help future educators who may wish to adapt parts of the textbook for a specific course or project. Please note that the Pressbooks Table of Contents offers a high-level outline of this sequence, whereas this detailed outline shows each subtopic. Content can also be located by keyword by searching this book (upper right).

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