2020

Decriminalizing the Mentally Ill in America: An examination of the overrepresentation of mentally ill citizens behind bars and a proposal to combat this injustice

Geraghty Alch

Decriminalizing the Mentally Ill in America:
An examination of the overrepresentation of mentally ill citizens behind bars and a proposal to combat this injustice

Presented to the Faculty of the
Ogden Honors College

Louisiana State University

In partial fulfillment of the
requirement for the degree of the
Bachelor of Humanities and Social Sciences with Honors

Geraghty Alch
Spring 2020

In what follows, I argue that diverting accused criminals with mental illness, including substance-abuse issues, away from jails and prisons and toward more appropriate and culturally competent community-based mental health care should be an important component of national policy. The benefit of such legislation is two-fold; it provides citizens with the help they need and to eliminate unnecessary involvement in the criminal justice systems, thereby alleviating at least a portion of the nation's mass incarceration crisis. A consideration of relevant American history - notably the deinstitutionalization process beginning in the 1960s and lasting through the 1980s, coupled with Clinton's expansion of criminal sanctions in the 1990s - will detail how mass incarceration of individuals, specifically of those citizens suffering from mental illness, came to be. The historical narrative also supports the suggestion that since America has deinstitutionalized once before, she can again.

Since 1931, American citizens have recognized Francis Scott Key's "Star-Spangled Banner" as the national anthem; proudly declaring the United States as the "land of the free and the home of the brave." However, there are an estimated 2,121,600 Americans that might find an issue with the assertion of the United States as "the land of the free"; held in state and federal prisons across the country, these two million citizens embody the United States' devastating mass incarceration crisis (Institute for Crime & Justice Policy Research 2019). The number is immense, but when compared to countries across the globe it becomes more significant: the U.S. incarcerates more people than any nation in the world, including China, by more than half a million prisoners; the United States also holds the world's highest prison population rate with an estimated 622 prisoners for every 100,000 citizens (Institute for Crime & Justice Policy Research 2019). In fact, there are 31 American states with higher incarceration rates than the next highest country, El Salvador, which holds 614 prisoners incarcerated for every 100,000 citizens (Prison Policy Initiative 2018). Mass incarceration in the United States is one of the most salient political, social, and economic issues facing the nation, with widespread concern and push for change. It has generated significant research across the social sciences, from political science to anthropology, criminology, economics, and sociology; and yet the issue persists.

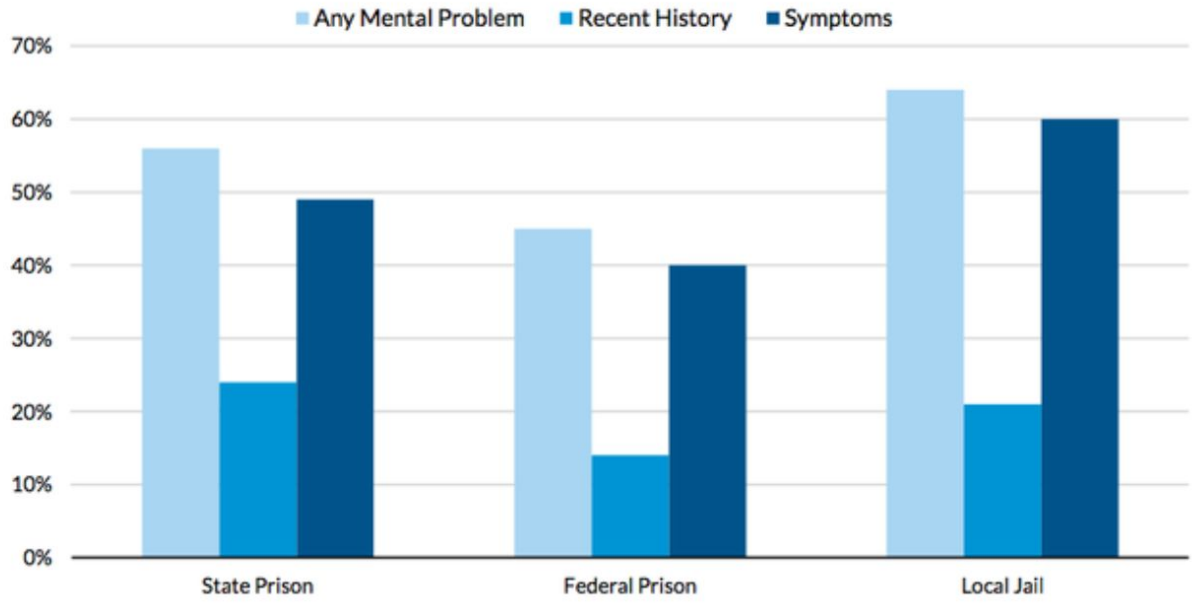
Optimists would hope that the apparent inaction from lawmakers is the result of an inability to agree on how best to address this issue and not a consequence of indifference

to the millions of citizens suffering from the results of prison overcrowding. This suffering refers to mass incarceration's severe negative impact which is felt not only by those who served time, although the suffering of inmates in overcrowded prisons is the most obvious. These citizens have lost jobs, homes, family connection, and freedom in exchange for what society expects to be a rehabilitating prison stay. However, when we incarcerate at the rate we do, we forget to consider the lack of personal treatment for inmates, the shortage of food, clothes, blankets, beds; all of which contribute to an overwhelmingly negative process that often leads inmates to commit more crime. Mass incarceration also decreases the likelihood that inmates will receive adequate, individualized healthcare, despite being exposed to more illness in such close quarters. Studies show that inmates are roughly five times more likely to be infected by blood-borne pathogens, sexually transmitted diseases, methicillin-resistant *Staphylococcus aureus* infection, and infection with airborne organisms such as *M. tuberculosis*, influenza virus, and varicella-zoster virus than the general public (Bick 2007). In addition to health issues, many prisoners are released back into society without being rehabilitated which, again, relates to the impersonal experiences resulting from the overwhelming ratios of inmates-to-volunteers and inmates-to-guards. Consequently, many inmates face homelessness, joblessness, and lack of community upon release. These effects are felt by their families and communities; former inmates are more likely to commit crime and children losing one or more parents to incarceration can set a child

up for a life of poverty. If an indifference to this issue is just a cynical view of politicians, then perhaps a marketable proposal is all that is required to start the process of rectifying this crisis; a sensible and pragmatic solution that tackles at least a small share of the issue. I will argue that redirecting the 15 to 20 percent of state and federal inmates with some form of mental illness to treatment programs is an achievable and appropriate step to combat mass incarceration.

The judgment that there is a relationship between mental illness and incarceration, in general, is justifiable; there is broad scholarly evidence that confirms that mentally ill individuals are overrepresented among the United States' jail and prison populations (Torrey, et al. 2010; Powell, et al. 1997; Bronson and Berzofsky 2017). According to the Bureau of Justice Statistics, individuals with mental health issues make up an estimated 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates as shown in Figure 1 (Bureau of Justice Statistics 2012).

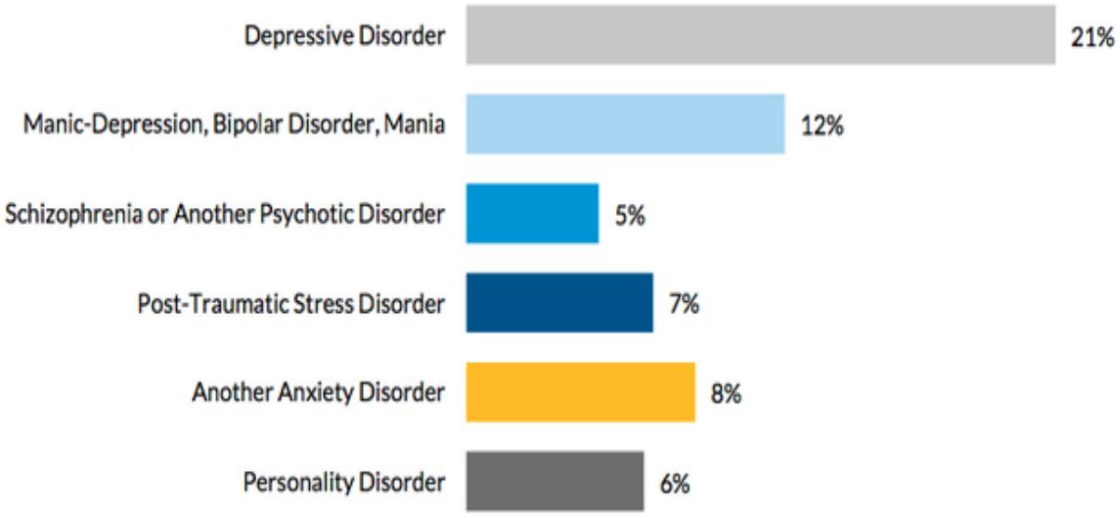
Figure 1 [1]
Percentage of Inmates with Mental Health Problems, 2007



Regarding particular symptoms and disorders, the *Survey of Inmates in State and Federal Corrections Facilities, 2007,* reported that one in five state and federal prisoners suffered from a depressive disorder. A substantial population of state and federal prisoners had also been diagnosed with mania symptoms (12 percent), schizophrenia or another psychotic disorder (5 percent), and post-traumatic stress disorder (7 percent). A further breakdown is shown in Figure 2.

[1] **Source:** Becker-Cohen, et al. 2015. https://www.urban.org/research/publication/processing-and-treatment-mentally-ill-persons-criminal-justice-system/view/full_report.

Figure 2 [2]
History of Mental Disorders among State and Federal Inmates, 2007



As far as the significance of mental illness as it relates to the potential for incarceration, statistics suggest there is a positive relationship; this will be discussed in greater detail in what comes. However, in order to address this relationship between mental illness and mass incarceration, it is imperative that one understands the history that made such a connection. I will summarize the dissolution of state-sponsored psychiatric facilities and the seemingly concurrent implementation of private prisons and the expansion of criminal offenses. Now it is important to note that while

[2] **Source:** Becker-Cohen, et al. 2015.
https://www.urban.org/research/publication/processing-and-treatment-mentally-ill-persons-criminal-justice-system/view/full_report

deinstitutionalization alone did not cause mass incarceration, it did contribute to it. With the closing of mental health institutions in the mid to late 20th century, law enforcement and correctional facilities have inadvertently become the largest providers of mental health-related services (American Psychiatric Association 2020). It seems that some of our most vulnerable Americans have been traded one level of confinement - in state-sponsored psychiatric facilities - for another, in our prisons.

In the early 20th century, many psychiatric institutions were overcrowded and underfunded, especially during periods of economic decline and wartime. Consequently, asylums became notorious for poor living conditions, lack of hygiene, ill-treatment, and abuse of patients; reports detailed patients were beaten and even starved to death when they did not respond to treatment (Fakhourya and Priebe 2007). The public support, and consequential political movement, for what came to be known as deinstitutionalization was catapulted, in large part, by a surge in exposés from magazines including *Readers Digest* and *Life Magazine* detailing the awful conditions and rampant abuse in psychiatric hospitals (Sheffield 2019). Most notably, however, is a 1962 novel that provoked the public; *One Flew Over the Cuckoo's Nest* by Ken Kesey (Amadeo 2020). The story is a work of fiction derived from the author's very real experiences as a nurse's aide in the psychiatric wing of a California veteran's hospital. The book includes explanations of some of the more inhumane treatments of patients, including electroshock therapy and

lobotomies, which galvanized public outrage, particularly among those who knew little about the conditions in psychiatric hospitals.

In 1963, President John F. Kennedy outlined a program to Congress to reduce by half the number of persons held in state hospitals and asylums for the mentally ill. His proposal offered a response to the outrageous number of citizens held in such custody - numbers that are comparable by some to contemporary levels of mass incarceration - as well as a growing public dissatisfaction with the current, deeply flawed system (Harcourt 2011). President Kennedy implored Congress to consider change:

> "I am proposing a new approach to mental illness [...] 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" (Kennedy 1963).

His strong and convincing sentiment commanded the attention of Congress and led to the passage of the Community Mental Health Centers Act in 1963.

The Community Mental Health Centers Act provided federal funding to create community-based mental health facilities that would provide prevention, early treatment, and ongoing care to mentally-ill citizens; as President Kennedy envisioned it, "reliance

on the cold mercy of custodial isolations [would be] supplanted by the open warmth of community concern and capability" (Torrey 2013). The idea drew bipartisan support; fiscal conservatives were interested in saving funds by shutting down state hospitals while civil rights activists believed in the autonomy of these patients. The act provided federal funding and legislative support, essentially codifying deinstitutionalization.

Over the seventeen years following President Kennedy's proposal, the federal government levied $2.7 billion ($20.3 billion in today's dollars) to 789 community mental health centers across the country (Torrey 1992). The newly created community centers offered a range of services: inpatient, outpatient, emergency, partial hospitalization, and consultation and education on mental health. Although the government spent a sizable amount, it was not enough for what the movement meant to accomplish; this was due to a mismanagement of funds by the states that favored patients likely able to receive private treatment. The centers focused their resources on those with less serious mental illness; federal training funds for mental health professionals resulted in a disproportionate amount of psychiatrists in wealthier areas and almost none in low-income neighborhoods; and a policy clause that made individuals eligible for federal programs and benefits only after discharge from state mental hospitals unintentionally incentivized discharging patients without follow-up (Torrey 1992). In the same seventeen-year period, the number of patients in state mental hospitals fell by three quarters and those beds were ultimately closed down. However, federal studies reported

that the individuals discharged through this process initially made up between only 4 and 7 percent of the community mental health centers' patient load, and the longer the CMHC was in existence the lower the percentage became (Torrey 2013). This led to a significant population of former (and future) patients with no viable options for treatment; the community centers were not geared toward the treatment of seriously ill patients nor were they found in low-income areas and the public hospitals closed rapidly, leaving many to homelessness and joblessness. The failure of the program is a direct result of the community centers refusing the type of patients that typically relied on state psychiatric hospitals; again, those with severe mental illnesses and/or without familial and economic support.

As early as the next decade, the effects of deinstitutionalization on our prison system were evident. A 1972 study reported a 36 percent increase in mentally ill prisoners in the county jail and a 100 percent increase in mentally ill individuals judges to be incompetent to stand trial since the emptying of state mental hospitals (Abramson 1972). A California state prison psychiatrist commented that the system was, "literally drowning in patients… [and] many more men are being sent to prison who have serious mental problems" (Abramson 1972). This trend continued into the 1980s, while the process of deinstitutionalization railroaded on successfully with increasing numbers of state hospitals and psychiatric beds closed permanently. A 1980 study of 500 defendants regarded as "in need of psychiatric treatment" in San Francisco concluded that emptying

the hospitals had “forced a large number of these deinstitutionalized patients into the criminal justice system” (Whitmer 1980). Furthermore, according to a study of 65 discharged patients from an Ohio state hospital in 1988, 33 of them had become homeless within six months of discharge and 21 had been arrested and jailed (Belcher 1988). The authors cite a deviation from prescribed medication to alcohol and street drugs (due to an inability to refill or afford prescriptions) as the main cause for this; however, they also acknowledged general misbehavior resulting from mild to severe psychosis to be a contributing factor. Furthermore, the possibility of treatment in a state-funded hospital declined every year. In 1955, there was one psychiatric bed for every 300 Americans; in 2005, there was one bed for every 3,000 (American Psychiatric Association 2020).

There were other political factors at work during this time in addition to the deinstitutionalization movement that contributed to the influx of mentally ill individuals in the prison system. Dramatic cuts to a variety of social safety-net programs in the 1980s led to increases in homelessness and the number of people with untreated mental illness on the street; concurrently, federal and state governments alike initiated massive spending on the War on Drugs and prison construction (The Vera Institute of Justice 2016). In 1994, President Bill Clinton introduced the Violent Crime Control Act and Law Enforcement Act, better known as the 1994 Crime Bill; this would ultimately become what many consider to be one of the fundamental statutes that accelerated mass incarceration (Cullen 2018). The bill funded the creation of more prisons and jails,

increased the number of federal and death-penalty crimes, introduced a “three strikes” mandatory life sentence for repeat offenders, and included other clauses that increased punitive crime control laws.

The shortcomings of deinstitutionalization coupled with the political push for crime control created the perfect storm for this mental health crisis; both movements contributed to the disproportionate number of underserved people with mental health problems becoming entangled in the criminal justice system and correctional facilities becoming their default treatment providers. According to the Bureau of Justice Statistics, about 14.5 percent of men and 31 percent of women in jails have a serious mental illness, such as schizophrenia, major depression, or bipolar disorder, compared to 3.2 and 4.9 percent, respectively, in the general population. The findings are similar in prisons; more than a third (37%) of prisoners have been told by a mental health professional in the past that they had a mental health disorder (Bronson and Berzofsky 2017). While estimates vary, the prevalence of serious mental illnesses is at least two to four times higher among state prisoners than in community populations (American Psychiatric Association 2020).

These figures are even more harrowing when considering the fact that mental illness itself is not a strong predictor of criminal behavior; yet, almost two million arrests each year in the United States involve persons with serious mental illness. The statistics vary, but it is estimated that there are 383,000 inmates suffering from some form of serious mental illness in our jails and prisons; this includes schizophrenia,

schizo-affective, bipolar disorder, major depression, and brief psychotic disorder (Carroll 2016). This number is likely conservative when considering the high rate of nonresponse in prison studies, some of whom almost certainly have paranoid schizophrenia. Still, it may sound reasonable to some; perhaps we shouldn't be surprised by these high numbers considering our mass incarceration crisis. However, the comparison of mentally ill citizens in hospitals to prisons and jails may be more convincing. There are only approximately 38,000 individuals with serious mental illness remaining in state mental hospitals; this means 10 times more individuals with serious mental illness are in jails and state prisons than in state mental hospitals (Carroll 2016). This presents, for some, a moral issue; are we substituting effective, focused treatment for what appears to be a more manageable alternative? Are we giving these inmates the chance to be law-abiding citizens if we punish their behavior without addressing the cause? Do we want these citizens off the streets because they are intentional criminals, or because we don't understand what motivates their behavior?

Even if one completely removes the moral argument surrounding the conflict of mental illness behind bars, there are still valid social, fiscal, and political considerations that support redirecting the bulk of mentally ill offenders to treatment. Studies show that mentally ill inmates remain in jail considerably longer than other inmates; a survey conducted by the Council of State Governments revealed that the average stay for inmates at Florida's Orange County Jail is 26 days, while mentally ill inmates average 51

days. Similarly, the average stay for inmates in New York's notorious Riker's Island is 42 days; mentally ill inmates stay at Riker's is almost five times that, averaging 215 days (Council of State Governments 2002). There are several explanations for this phenomenon; the most obvious is that mentally ill inmates find it more difficult to understand and follow jail and prison rules, resulting in extended sentences. A study of Washington state prisons revealed that mentally ill inmates accounted for 41 percent of infractions even though they constituted only 19 percent of the prison population at the time (Butterfield 2003). Another contributing factor is that pretrial inmates with serious mental illness experience more prolonged incarcerations if they require evaluation or restoration of competency to stand trial; reports show that some of these inmates even spend more time waiting for competency restoration than they would spend behind bars if convicted (Fuller et al. 2016). Furthermore, from a financial perspective, the longer an inmate stays in jail or prison, the more expensive they are considered to be to the state, so mentally ill inmates are more of a financial burden in that respect.

Still, even if the time spent incarcerated between an inmate with a severe mental illness and one without is identical, the dollar amount spent on the former is likely to be considerably higher than the latter. A study in Broward County, Florida, found that it cost $80 a day to house regular inmates, but $130 a day to house an inmate with mental illness (Miller and Fantz 2007). A similar study focusing on Texas prisons found that the average prisoner costs the state about $22,000 a year while prisoners with mental illness

range from $30,000 to $50,000 a year (Bender 2003). The most notable cause of increased cost is increased staffing needs; inmates with certain psychiatric illnesses require full-time observations. Another important cost is that of psychiatric medications, both the price of medicine itself and its administration (Gottschlich and Cetnar 2002). These add to the costs already associated with longer sentences.

Mentally ill inmates are also more likely to be held in solitary confinement and to commit suicide. Studies of state prisons have estimated that between 55 and 76 percent of inmates in solitary isolation are mentally ill (Ridgeway and Casella 2010, AbuDagga et al. 2016). Furthermore, suicide is the leading cause of death in correctional facilities and multiple studies indicate that as many as half of all inmate suicides are committed by the estimated 15 to 20 percent of inmates with serious mental illness (Goss et al. 2002, Johnson 2002). This is a serious overrepresentation, one that is contributing to the loss of human life. One may be able to find reason and explanation for the other statistics concerning mental illness and incarceration, but to have this daunting of a figure in regard to suicide is inexcusable and cannot be ignored; clearly, our criminal justice system needs to make a change.

The American way seems to be the following; when an obvious social disparity is at work in our society, the public takes on the responsibility to notice and react so that lawmakers are held accountable to affect change. There are several national nonprofits working to achieve this sort of policy change; NAMI (the National Alliance on Mental

Illness), the Vera Institute of Justice, the Treatment Advocacy Center, and several more programs committed to reducing the number of mentally ill citizens in jails and prisons while increasing access to treatment. Furthermore, the mass incarceration crisis, in general, is an extremely sensitive and important issue for many Americans, as there are many considerations that suggest a serious injustice is being committed in regard to the socioeconomic makeup of our country's jails and prisons. Still, criminal justice reform is a slippery slope; when a crime is committed, the general consensus is that some form of punishment is necessary. In the United States, that punishment is jail or prison time if a fine is not offered or - more likely - cannot be paid. This, of course, results in a disproportionate amount of poorer individuals - typically minority citizens from low-income areas - incarcerated.

This institutionalized discrimination is surely an issue that needs to be addressed; to do so would require a policy program that tackles the social system that seems to ensure that minority communities become low-income areas and that low-income areas positively relate to higher crime rates. This, in turn, would require a political, social, and economic overhaul of epic proportions; one that the political elites are certainly wary of and less-inclined to promote for a variety of self-serving reasons. Still, this does not mean criminal justice reform is impossible; rather, we must be patient to be effective. In my opinion, the issue of mass incarceration is somewhat similar to the issue of universal healthcare; the privileged and powerful in society tend to be unaffected and, as such, see

little benefit in complete and immediate change. Perhaps, then, those of us concerned with mass incarceration can learn from those committed to universal healthcare. In the early 1990s, then-First Lady Hillary Clinton campaigned for universal healthcare; her plan, dubbed "Hillarycare," was a high-profile failure for the administration. Interestingly, what history seems to forget about the whole debacle is an example of perhaps the greatest lesson in modern-day social politics; that is, that big change is most effectively accomplished through small victories. The collapse of Hillarycare gave way to the tremendous, bipartisan success that is CHIP, the decades-old government program that helps children without health insurance (Guo 2016). The advantage of and necessity for universal healthcare continues to be widely debated; however, even its harshest critics are hard-pressed to find an issue with providing healthcare to underprivileged children, who are disadvantaged through no fault of their own. I am of the belief that a comparable subset of inmates is the mentally ill population; citizens who, through no fault of their own, suffer from crippling diseases that affect their decision-making.

Therefore, an approach to ending mass incarceration that would likely garner substantial support is one that aims to divert accused criminals with mental illness away from jails and prisons and toward more appropriate and competent mental health care; in doing so, we would provide citizens with the help they need while eliminating unnecessary involvement in the criminal justice system and thereby alleviating at least a portion of the nation's mass incarceration crisis and the costs associated with it. Of

course, sweeping change of this nature will require investment, however, many argue that any substantial decrease in incarceration will cost the government less in the long run.

In order to be effective, legislation addressing the disproportionate arrest and incarceration of citizens with mental health conditions will require several provisions. Federal and state funding must be allocated to assisted outpatient treatment (AOT) which is also known as "involuntary outpatient treatment" or "outpatient commitment". Assisted outpatient treatment is the practice of delivering outpatient treatment under court order to adults with severe mental illness who meet specific criteria; i.e. prior history of repeated hospitalizations (Treatment Advocacy Center 2020). AOT laws have been shown to reduce arrest and incarceration, homelessness, and violent acts associated with mental illness. A study of participants in New York's AOT program, Kendra's Law, revealed that 83 percent fewer experienced arrest and 87 percent fewer experienced incarceration after participation in this program (New York State Office of Mental Health 2005). In general, this treatment reduces harmful behavior in participants by 44 percent and the risk of arrest by two-thirds in any given month (Treatment Advocacy Center 2015). Additionally, participants were found to be four times less likely to perpetrate serious violence. In regard to cost, both Ohio and New York saw reductions in criminal-justice related consequences after implementing AOT. A report obtained and matched records of arrest, jail, and prison stays were for participants in the AOT program from local sheriffs offices, the New York State Division of Criminal Justice Services, and

the New York State Department of Corrections and Community Supervision, as well as comparable offices in Ohio's Summit County (Treatment Advocacy Center 2015). The report also collected criminal justice costs for arrests and jail and prison days; arrest estimates included costs for police, booking, courts, attorney services, transportation, and jail. Both New York and Ohio's data revealed that the cost of the AOT program was substantially less than criminal-justice related costs.

Any policy proposal should also include funding for mental health courts; these are specialized, treatment-oriented courts that reduce recidivism and decrease the amount of contact that mentally ill individuals have with the criminal justice system by linking them to treatment and services to improve their social functioning (Sarteschi 2016). Through collaborative efforts between criminal justice personnel and mental health professionals, the supervised treatment ensures that both the mental health needs of offenders and the public safety concerns of communities are addressed. Individualized treatment plans rely on thorough mental health assessments and require ongoing judicial monitoring, but avoid unnecessary prison sentences and are considered a more cost-effective method than correctional institutions. Although the process currently varies from court to court, generally, a defense attorney will refer a defendant to a mental health court where the individual will be evaluated by psychiatrists. If the defendant qualifies for the court, the judge, assisted by mental health professionals, will determine the correct course of treatment. An individual will stay in the treatment program, supervised by the

mental health court, for up to the maximum sentence for his or her crime. The treatment is implemented by mental health professionals under the oversight of the court. The individual may receive inpatient or outpatient counseling, as well as housing placement, education, vocational training, job placement, and health care, as needed. When a defendant successfully completes the program, his or her case is typically resolved; in more serious crimes, the defendant may receive credit for the treatment time towards a jail sentence, but each case is still evaluated individually. Unfortunately, less than 40 percent of the United States population lives in jurisdictions with these specialized courts and even still, the ability to take cases is limited due to lack of funding (Mondics 2015). Increased government spending would introduce mental health courts into more areas and expand their jurisdiction which would allow for greater impact.

Finally, this proposal argues it is essential to promote crisis intervention team (CIT) training for law enforcement. Proper crisis intervention training prepares officers to respond to calls involving mental illness and is consistently found to reduce the arrest and incarceration of individuals with severe mental illness (National Alliance on Mental Health 2017). Dr. Michael T. Compton, MD, MPH, and colleagues assessed nearly 600 officers to measure the effects of CIT training on officers' knowledge about and attitudes toward those with mental illness. They found that CIT-trained officers had sizable and persistent improvements in knowledge, diverse attitudes about mental illnesses and their treatments, self-efficacy for interacting with someone with psychosis or suicidality, social

distance stigma, de-escalation skills, and referral decisions. The effectiveness of CIT training was also supported by data from another study of 1,000 emergency encounters. In this study, trained officers' emergency encounters were more likely to result in referral or transport of the person to mental health services and less likely to result in an arrest (American Psychiatric Association 2014).

The implementation of these measures across the country will introduce a trickle-down effect that fights mass incarceration while effecting change in the lives of our nation's mentally ill. For far too many people who are not able to access mental health treatment, the American criminal justice system leads to an even greater injustice; it is time to stop the decades-old practice of warehousing citizens with mental illness in our jails and prisons. Lionel Penrose, an English psychiatrist, developed *Penrose's Law* in 1939 to describe the inverse relationship between the population of psychiatric hospitals and that of prisons; as one decreases, the other increases (Penrose 1938). It has come to be known as balloon theory; that is, push in on one side and the other bulges out. *Penrose's Law* is certainly a simplification of this relationship, but its broad pattern remains undeniable in the United States in the last few decades. It is time to let some air out of the balloon, improve mental health care in our society, and eliminate the practice of warehousing citizens with mental illness in our prisons and jails

Works Cited

Abramson, Marc F. “The Criminalization of Mentally Disordered Behavior.” *Hospital & Community Psychiatry*, vol. 23, no. 4, Apr. 1972, pp. 101–105., DOI:10.1176/ps.23.4.101.

AbuDagga, Azza, et al. “Individuals With Serious Mental Illnesses in County Jails: A Survey of Jail Staff's Perspectives.” *Individuals With Serious Mental Illnesses in County Jails: A Survey of Jail Staff's Perspectives*, Public Citizen's Health Research Group, 14 July 2016, www.treatmentadvocacycenter.org/storage/documents/jail-survey-report-2016.pdf.

Administrator. “Promoting Assisted Outpatient Treatment.” *Treatment Advocacy Center*, www.treatmentadvocacycenter.org/fixing-the-system/promoting-assisted-outpatient-treatment.

Amadeo, Kimberly. “Deinstitutionalization, Its Causes, Effects, Pros, and Cons.” *The Balance*, Dotdash, 17 Feb. 2020, www.thebalance.com/deinstitutionalization-3306067.

Becker-Cohen, Miriam, et al. *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System*. The Urban Institute, 2015, https://www.urban.org/research/publication/processing-and-treatment-mentally-ill-persons-criminal-justice-system/view/full_report.

Belcher, John R. “Are Jails Replacing the Mental Health System for the Homeless Mentally Ill?” *Community Mental Health Journal*, vol. 24, no. 3, 1988, pp. 185–195., DOI:10.1007/bf00757136.

Bender, Eve. “Community Treatment More Humane, Reduces Criminal-Justice Costs.” *Psychiatric News*, 3 Oct. 2003, psychnews.psychiatryonline.org/doi/full/10.1176/pn.38.19.0028.

Bick, Joseph A. “Infection Control in Jails and Prisons.” *OUP Academic*, Oxford University Press, 15 Oct. 2007, academic.oup.com/cid/article/45/8/1047/344842.

Bronson, Jennifer, and Marcus Berzofsky. *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12*. Edited by Todd Minton, The

Bureau of Justice Statistics of the U.S. Department of Justice, 2017, https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.

Bureau of Justice Statistics. "Survey of Inmates in State and Federal Correctional Facilities, [United States], 2004." *Survey of Inmates in State and Federal Correctional Facilities, [United States], 2004*, Inter-University Consortium for Political and Social Research [Distributor], doi.org/10.3886/ICPSR04572.v6.

Butterfield, Fox. "Study Finds Hundreds of Thousands of Inmates Mentally Ill." *New York Times*, 22 Oct. 2003, https://www.nytimes.com/2003/10/22/us/study-finds-hundreds-of-thousands-of-inmates-mentally-ill.html.

Carroll, Heather. "Serious Mental Illness Prevalence in Jails and Prisons." *Treatment Advocacy Center*, Sept. 2016, www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3695.

Criminal Justice, American Psychiatric Association, www.psychiatry.org/psychiatrists/advocacy/federal-affairs/criminal-justice.

"Criminal Justice / Mental Health Consensus Project." *Criminal Justice / Mental Health Consensus Project*, Council of State Governments, June 2002, www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf.

"Crisis Intervention Team (CIT) Programs." *NAMI*, National Alliance on Mental Health, www.nami.org/get-involved/law-enforcement-and-mental-health.

Crisis Intervention Training for Police Officers Effective in Helping Respond to Individuals with Behavioral Disorders, American Psychiatric Association, 1 Apr. 2014, www.psychiatry.org/newsroom/news-releases/crisis-intervention-training-for-police-officers-effective-in-helping-respond-to-individuals-with-behavioral-disorders.

Cullen, James. "Sentencing Laws and How They Contribute to Mass Incarceration." *Brennan Center for Justice*, Brennan Center for Justice, 5 Oct. 2018, www.brennancenter.org/our-work/analysis-opinion/sentencing-laws-and-how-they-contribute-mass-incarceration.

Fakhoury, Walid, and Stefan Priebe. “Deinstitutionalization and Reinstitutionalization: Major Changes in the Provision of Mental Healthcare.” *Psychiatry*, vol. 6, no. 8, 2007, pp. 313–316., DOI:10.1016/j.mppsy.2007.05.008.

Fuller, Dorris A., et al. *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds*. Treatment Advocacy Center, 2016, https://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf .

Goss, J. Richard, et al. “Characteristics of Suicide Attempts in a Large Urban Jail System With an Established Suicide Prevention Program.” *Psychiatric Services*, 1 May 2002, ps.psychiatryonline.org/doi/full/10.1176/appi.ps.53.5.574.

Gottschlich, A. J., and G. Cetnar. “Drug Bills at Jail Top Food Costs.” *Springfield News-Sun*, 20 Aug. 2002.

Guo, Jeff. “The Surprising Upside of Hillary Clinton's Biggest Failure.” *The Washington Post*, WP Company, 2 Aug. 2016, www.washingtonpost.com/news/wonk/wp/2016/08/02/the-unintended-consequences-of-hillary-clintons-favorite-law/.

Harcourt, Bernard E. “Reducing Mass Incarceration: Lessons From the Deinstitutionalization of Mental Hospitals in the 1960s.” *Reducing Mass Incarceration: Lessons From the Deinstitutionalization of Mental Hospitals in the 1960s*, The University of Chicago Law School, 26 Jan. 2011, papers.ssrn.com/sol3/papers.cfm?abstract_id=1748796.

Johnson, J. “Jail Suicides Reach Record Pace in State.” *Los Angeles Times*, 16 June 2002.

Kennedy, President John F. 5 Feb. 1963, https://www.jfklibrary.org/asset-viewer/archives/JFKPOF/052/JFKPOF-052-012.

“Mental Health Courts.” *The Gale Encyclopedia of Mental Health*, Encyclopedia.com, 2 Mar. 2020, www.encyclopedia.com/medicine/encyclopedias-almanacs-transcripts-and-maps/mental-health-courts.

Miller, C. M., and A. Fantz. “Special ‘Psych’ Jail Planned.” *Miami Herald*, 15 Nov. 2007.

Mondics, Jamie. “NEW BILL TO REDUCE MASS INCARCERATION FOCUSES ON MENTAL ILLNESS.” *Treatment Advocacy Center*, www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/2893.

Pow, Joni, et al. “Deinstitutionalization of American Public Hospitals for the Mentally Ill Before and After the Introduction of Antipsychotic Medications.” *Harvard Review of Psychiatry*, 2015, doi.org/10.1097/HRP.0000000000000046.

Powell, Thomas A., et al. “The Prevalence of Mental Illness among Inmates in a Rural State.” *Law and Human Behavior*, vol. 21, no. 4, 1997, pp. 427–438., DOI:10.1023/a:1024811303834.

Ridgeway, James, and Jean Casella. “Locking Down the Mentally Ill.” *The Crime Report*, 18 Feb. 2010, thecrimereport.org/2010/02/18/locking-down-the-mentally-ill/.

Sarteschi, Christine. “Adult Mental Health Courts.” *Practice: Adult Mental Health Courts*, National Institute of Justice, www.crimesolutions.gov/PracticeDetails.aspx?ID=34.

Sheffield, Wesley. “The Community Mental Health Act of 1963.” *Young Minds Advocacy*, Young Minds Advocacy, 25 Apr. 2019, www.ymadvocacy.org/the-community-mental-health-act-of-1963/.

State and Community Considerations for Demonstrating the Cost-Effectiveness of AOT Services. Health Management Associates, 2015, https://www.treatmentadvocacycenter.org/storage/documents/aot-cost-study.pdf.

“States of Incarceration: The Global Context 2018.” *Prison Policy Initiative*, Prison Policy Initiative, June 2018, www.prisonpolicy.org/global/2018.html.

“The Burden of Mental Illness Behind Bars.” *Vera*, The Vera Institute of Justice, 21 June 2016, www.vera.org/the-human-toll-of-jail/inside-the-massive-jail-that-doubles-as-chicagos-largest-mental-health-facility/the-burden-of-mental-illness-behind-bars.

“The World Prison Brief.” *Prison Population Total*, Institute for Crime & Justice Policy Research, www.prisonstudies.org/.

Torrey, E. Fuller. *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals*. Edited by J Stieber et al., Public Citizens Health Research Group, 1992.

Torrey, E. Fuller, et al. "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States." *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*, Treatment Advocacy Center, May 2010, www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

Torrey, E. Fuller. "Fifty Years of Failing America's Mental Ill." *The Wall Street Journal*, 5 Feb. 2013, p. 15.

Weinstein, Henry C. *Psychiatric Services in Jails and Prisons*. 2nd ed., American Psychiatric Association, 2000.

Whitmer, Gary E. "From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill." *American Journal of Orthopsychiatry*, vol. 50, no. 1, 1980, pp. 65–75., DOI:10.1111/j.1939-0025.1980.tb03263.x.