

**Virginia's Criminal Justice System's Current Treatment for People with Mental Illnesses:
Some Recommendations Based on What Has Worked (and What Has Not)**

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Abstract

In this research we critically review information on Virginia's criminal justice system's response to people with mental illness. We first investigate issues that persons with mental illnesses experience as they navigate three stages of Virginia's criminal justice system. The stages are: first, when people with mental illness are apprehended by the police, second, when they must stand trial, and third, when they are incarcerated. At the apprehension stage, the main issues we identify are that most officers do not have proper crisis intervention training, and that there are not sufficient options for diversion from jail for people with mental illnesses. When defendants with mental illness face trial, we find existing opposing perspectives as to how to approach cases and stringent requirements in mental health dockets to be the main issues at this stage. Finally, upon incarceration, we note long wait times for mental health assessments and state hospital beds, and the delay or mismanagement of medications to be the main issues at this stage. Upon seeing how people with mental illnesses are incorrectly treated in jails and prisons currently, we began to look for alternatives to incarceration. At the apprehension stage, it would be beneficial for communities to create crisis intervention teams and conduct in-depth and continuous crisis intervention training for emergency responders. When the defendants with mental illnesses are in court, we recommend redirecting them away from prison using mental health dockets or assisted outpatient therapy. Ultimately, through our research, we found that incarcerating people with mental illnesses comes at too large a cost for the people themselves, taxpayers, and the criminal justice system. Therefore, alternatives should be created and utilized.

Keywords: mental illness, incarceration, Virginia, diversion alternatives, criminal justice system, crisis intervention, therapy, diversion, dockets

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Introduction

In this paper, we set out to critically review information about a variety of criminal justice system responses to people with mental illnesses, nationwide, with the ultimate aim of assembling recommendations that would be helpful to the police and courts (particularly those in Virginia), and of course the people themselves. People with mental illnesses are often arrested because they are perceived to be a threat to public safety when they should be treated instead. Currently, the overarching problem is that the criminal justice system does not have enough resources or knowledge to appropriately treat offenders with mental illnesses. First, we will look at the current state of Virginia's criminal justice system and its treatment of offenders with mental illnesses in jails. Then, we will look for effective alternatives to incarcerating individuals with mental health issues or find ways that they can be treated better while in the criminal justice system. Not only would this increase efficiency in the criminal justice system, but it would help people with mental illnesses get the treatment they need.

Methodology

Our research was done remotely. We usually met once or twice per week with each other and our advisor, Associate Professor Doran, while remaining in contact throughout the research using Zoom meetings, email, Google Docs, and cellphone communication. For the research itself, we initially analyzed the current state of affairs by pulling together the perspectives of prosecutors, public defenders, non-profit organizations, and other relevant literature. We had access to some of this information through Tomás' connections with the Richmond, VA public defenders. Tomás carried out interviews with Rebecca Pensak (Public Defender, Richmond Public Defender's Office), Stacey Davenport (Commonwealth's Attorney, Chesterfield County), Dr. Sarah Scarbrough (Founder and CEO, REAL LIFE), and Dr. Kristen Hudacek (Director of

Psychology and Pre-Trial Forensic Services, Eastern State Hospital). We also used the internet and Hamilton College's library database to access relevant news articles, compensation board reports, and research articles. Associate Professor Doran sent us articles she found that were relevant. We also used an existing research paper called "The Treatment of People with Mental Illness in the Criminal Justice System: The Example of Oneida County, New York" written by one of Professor Anechiarico's classes in 2019 to find some helpful sources.

What issues do individuals with mental illnesses experience as they encounter and move through the criminal justice system in Virginia?

Mental health problems have been increasingly criminalized since the closing of mental health hospitals during the 1960s, which turned the responsibility to underfunded community service boards (Dvorak, 2020). In this section, first I (Tomás) will bring attention to horrifying incidents of Virginia's criminal justice system injustices towards mentally ill individuals. It will be followed by a brief overview of the current prevalence of mental illness (MI) among inmates in Virginia's local and regional jails. Then, I will highlight issues that individuals with mental illnesses experience as they navigate through three stages of the criminal justice system in Virginia.

The first stage is when the police respond to situations involving people with mental health issues. But most police officers are not adequately trained to manage engagements with mentally ill individuals, and that officers don't have sufficient options for diversion from jail. The second stage we will examine is focused on when the defendant is tried in court. Existing opposing perspectives as to how to approach defendants with mental illness, and mental health dockets that do not offer viable diversion options are key issues at this stage. Lastly, we look at

the incarceration of people with mental illness analyzed. This stage includes pretrial and post-conviction individuals who are affected by similar circumstances at regional and local jails. Major problems at this stage include long wait times for mental health assessments and state hospital beds, and the delay or mismanagement of medications.

Notable Incidents

There have been gruesome cases of police and jail failures to treat subjects with mental illnesses incorrectly that have increased public awareness. Three of such incidents that caught the eyes of Virginia residents were the deaths of Jamycheal Mitchell, Marcus-David Peters, and a defendant (whose name was kept private from the news source) who died in Richmond's Gilpin Court housing project. Jamycheal Mitchell, was a 24-year-old African American Virginian who suffered from schizophrenia. He "was charged with stealing \$5.05 worth of snack foods from a convenience store" (Early, 2015). When he was jailed, he "refused to eat, became sicker without treatment, shed 36 pounds and died" (Early, 2015). Marcus David-Peters, also 24-year-old, was a high school biology teacher. While he was undergoing a mental health crisis, "he was shot and killed by a Richmond Police officer as he charged the officer after a taser was deployed" (Staff, 2020). Lastly, Richmond Police killed an unnamed defendant in the Gilpin Court housing project because the defendant chuckled as he testified to the police "the killing of his best friend in front of the friend's family" (Albiges, 2019). It was later found that the chuckle "was a symptom of a long-underlying psychosis, if not schizophrenia" (Albiges, 2019). Although most cases do not culminate in such terrifying deaths, these are symptoms of a failing, unjust system that needs changing.

Prevalence of Mental Illness Among Inmates

Although Virginia's criminal justice system's maltreatment of individuals with mental illnesses has gained more public attention in the last few years, MI are still very prevalent among the state's inmate population. The latter is evident in the Virginia Compensation Board Mental Illness in Jails Report of 2018 which surveys 57 out of 59 local and regional jails on "the incidence of mental illness among individuals incarcerated in Virginia jails, characteristics of this population and methods by which jails seek to manage mental illness within their facility" (Virginia Compensation Board, 2017, p.1). The report found that out of the general inmate population with MI, 34.48% of females, and 16.74% of males had a MI; 19.84% (or 7,852 individuals) of the general inmate population overall was noted to have a MI in 2018 (Virginia Compensation Board, 2017, p.6). Disturbingly, the share of total inmates that have mental illnesses has been rising steadily over time. While in 2012, 11.07% (or 6,481) were accounted to have a MI, this number increased to 16.81% (or 7,054) in 2015, and to 18.63% (or 7,451) in 2017 (Virginia Compensation Board, 2017, p.6). Furthermore, women have been impacted at disproportionate rates. The share of females from the MI inmate population has increased at alarming rates from 14.40% in 2012, to 25.29% in 2015, to 34.48% in 2018 (Virginia Compensation Board, 2017, p.6). These appalling statistics, and the stories of the individuals who died at the hands of *justice*, are the results of multilayered systemic problems.

Apprehension

When families and communities in Virginia need assistance when someone is facing a mental health crisis "there is no one else to call except the police, even if you call EMT and ask for an ambulance, the police come with the ambulance, so there is no way around the police." Said Rebecca Pensak, a Public Defender at Richmond's Public Defender's Office that works on mental health docket cases (R. Pensak, personal communication, December 31, 2020).

Responding officers and others in the justice system are faced by the question “what do I do with that fellow?” as signaled by Richmond’s former Commonwealth’s Attorney Mike Herring, while he was discussing ways to help the mentally ill defendants in the criminal justice system of Virginia (Albiges, 2019). Importantly, the well being of Virginia’s residents, mentally ill defendants, and first responders, is at stake devising how to answer this question. At this stage, two main issues arise: insufficient options for diversion for individuals with MI, and the lack of proper crisis intervention training for police officers.

I inquired Dr. Kristen Hudacek, a licensed clinical psychologist and Director of Psychology and Pre-trial Forensic Services at Eastern State Hospital, who also ran a regional Jail diversion team that worked in several jails in central Virginia, about the options officers have when dealing with someone that is undergoing a mental health crisis. Dr. Hudacek said officers could jail the individual, take them to a hospital, “give them a summons to appear [in court], they could let them go,” or take them to Crisis Intervention Team (CIT) Assessment Sites (K. A. Hudacek, personal communication, January 11, 2021). Assessment Sites function outside of traditional criminal justice settings as they “keep those experiencing crisis related to a mental illness and who become or are likely to become justice involved, from inappropriately ending up in jails when therapeutic intervention best serves the needs of the individual and the public” (Virginia Department of Behavioral Health & Developmental Services, 2017b, p.1). The Assessment Sites provide a service that “offers Consumers a vital link to therapeutic intervention and assessment while also allowing law enforcement officers to quickly return to crime prevention and response duties within their localities” (Virginia Department of Behavioral Health & Developmental Services, 2017b, p.1). CIT Assessment Sites seem to be one of the best options that Virginia currently has for diversion from the criminal justice system.

However, although their reach has been growing rapidly all over the state, as of 2017 there were only 36 of these sites in Virginia leaving more than 15 counties in need, far from the existing sites. The need for more diversion treatment programs and centers was also noted by Dr. Hudacek, because in Virginia “we do not have as many drop off centers, as they are called, we have assessment centers but people have to be willing to go, [and] they are not in every portion of the state” (K. A. Hudacek, personal communication, January 11, 2021). Importantly, unless police officers are adequately trained in crisis intervention to identify when diversion to these sites is the best option to undertake, there will probably still be calamities like those of Jamycheal Mitchell and Marcus-David Peters.

Police officers in Virginia receive crisis intervention training, which is supposed to “enable law enforcement officers to more effectively communicate with and understand the particular needs of individuals with mental illness” (Virginia Department of Behavioral Health & Developmental Services, 2017a). Dr. Hudacek explained that “CIT [training] is a 40 hour training on which they [police officers] receive didactics on the system (information provided by everyone in the community who works with mentally ill individuals), on mental health conditions, verbal de-escalation techniques, and [information] on local resources”(K. A. Hudacek, personal communication, January 11, 2021). Dr. Hudacek expressed that this training is crucial in that “all law enforcement officers should be receiving [it].” However, Dr. Sarah Scarbrough, voiced concerns on the efficacy of single-time CIT training.

Dr. Scarbrough is also very experienced in working with the criminal justice system. She is a doctor in public policy and administration, directed an in-jail diversion program in Richmond, and is now the founder and CEO of REAL LIFE, a non-profit organization based out of Richmond, Virginia that serves re-entry populations to overcome barriers to better livelihoods

such as addiction and lack of mental health treatments. Dr. Scarbrough pointed out that one-time CIT training “is just the start” because in time, say five years from their training, officers will begin to forget it (S. Scarbrough, personal communication, January 5, 2021). She added that “the police are not trained and equipped to deal with that [situations involving mental health emergencies], you have got the CIT training, cool, but ultimately how deep is that? People go to school for social work and psychology- that is years- you can’t compare that to an 8 hour training...sometimes they [police officers] are doing the best they can and they just do not have the expertise to do the right thing (S. Scarbrough, personal communication, January 5, 2021). On alternatives to this issue, Dr. Scarbrough asserted that her organization does “a 4 hour trauma informed training that [teaches] the correlation of [how] significant childhood trauma has led adults to where they are now” and teaching recruits with the police training academies in Richmond about trauma triggers (S. Scarbrough, personal communication, January 5, 2021). This could be a way to provide continued training to officers.

On more thorough training Dr. Hudacek highlighted that “there is also scenario-based training, where they [officers] are put into real life scenarios with increasing difficulty, where they need to de-escalate and problem solve the situation in real time and get feedback that is provided by a panel, that is watching them and listening to how they are intervening with the subject” (K. A. Hudacek, personal communication, January 11, 2021). However, not all police officers receive this deeper training. I inquired with Stacey Davenport, a Commonwealth’s Attorney (or Prosecutor) in Chesterfield County, Virginia, about the breadth and level of CIT training that officers receive. Ms. Davenport said that both Henrico and Chesterfield counties, where she previously and currently works at, “have a specialized CIT training that they give to their officers, so if they know there is a mental health situation, they will send officers with that

specialized training” (S. Davenport, personal communication, January 6, 2021). Although implementing this more specialized training for all police officers will probably be costly, it prevents needless incarceration which also incurs costs, it will likely save lives, and make the jobs of police officers easier.

Officers with this more in-depth training could also respond to crises with other responders such as social workers, to improve diversion from incarceration and treatment of mentally ill subjects. Dr. Hudacek explained that this is “called a co-responder model,” which requires “a kind of social worker-mental health professional to respond to calls with a police officer” (K. A. Hudacek, personal communication, January 11, 2021). She also emphasized this model is being instated in Virginia: “here in Richmond, (and Virginia as a whole) we are certainly going towards a co-responder model with the Marcus Alert, which is now law in Virginia” (K. A. Hudacek, personal communication, January 11, 2021). This “Marcus Alert,” or “Marcus Alert System” came as a reaction to the killing of Marcus David Peters by a police officer when he was undergoing a mental health crisis (Hargrove, 2020). The bill will eventually “create teams of mental health service providers and peer recovery specialists to accompany police officers responding to individual crises” (Staff, 2020). Although this is a great step towards the right direction, lack of funding continues to slow down and hinder the implementation of justice system mental health related programs. Dr. Hudacek underlined that because of “funding and planning, it is probably going to take anywhere up to five years to get it really off the ground” (K. A. Hudacek, personal communication, January 11, 2021). In this area Virginia lags behind other states such as Oregon which have more advanced responder systems.

According to Dr. Hudacek the program based in Eugene, Oregon “has no co-responder, it is actually just social work-mental health professionals that are going out on certain calls, and

really reduced the number of persons with mental illness going to jail” (K. A. Hudacek, personal communication, January 11, 2021). The program is called Crisis Assistance helping Out On the Streets program (CAHOOTS). It is made of a team of a medic and a crisis worker that respond to calls that do not need the presence of a police officer contingent on a lack of legal issues or safety concerns (Shapiro, 2020). On the matter of safety for responders Dr. Scarbrough warned of the danger that having just social workers respond to certain calls involving mentally ill crises could bring to those responders.

From Dr. Scarbrough’s perspective “when people are having psychotic breaks...they are often violent, they are often wielding guns and things like that...but the people that say *just send in a social worker*, well what if that person starts shooting a gun then what? At that point it is too late to call the police” (S. Scarbrough, personal communication, January 5, 2021). However, she simultaneously raised the question of “where is that happy medium, do we put in more money so that there is essentially always a social worker type of person that accompanies the police so that we make sure that we have somebody credentialled but who is also safe?” (S. Scarbrough, personal communication, January 5, 2021).

In contrast Rebecca Pensak, a public defender who works with cases involving the mental health docket, stressed that police often charge pretty crimes on people undergoing mental health crises such as “spitting on an officer who is trying to restraint them”. She argued that an improvement at the apprehension level would be “some sort of in between where they are not immediately arrested and charged but instead, they are given an opportunity for actual diversion, diversion without being charged, which does exist in other places but they haven’t implemented anything like that in Richmond” (R. Pensak, personal communication, December 31, 2020).

Court

When defendants with MI are brought to trial, they face systemic issues that prevent their hearing from being as just as it should be. Outdated and misinformed perspectives of mental health illnesses sometimes plague the criminal justice system. These paternalistic perspectives often view defendants with MI as people that should be *safely* locked up instead of receiving care from community organizations. However, I will highlight examples worth following that shift away from those toxic lenses. Regardless, two main issues at this stage are opposing perspectives as to how the courts handle mental illness related cases dealing, and that existing mental health dockets should have more options for true diversion from incarceration.

Court officials should prioritize defendants' mental illnesses and their need for care. Some officials correctly stress that defendants with MI should be viewed differently. For example, Roanoke General District Judge Jacqueline Ward Talevi said of mentally ill defendants that they're not bad people...they are different...and the way to help those different people is to have the criminal justice system look at them differently" (Albiges, 2019). However, there are others in the criminal justice system of Virginia that have a different perspective.

Stacey Davenport, mentioned above, offers a different perspective. For instance, she said that "no one piece of any case is the most important piece until I have seen all of the pieces, mental health does not automatically trump because it is mental health" (S. Davenport, personal communication, January 6, 2021). She also added that "everybody likes to talk about the cost and how much we pay to incarcerate somebody or how it affects everybody else in the jail, but the reality is each case is individual to itself, I can't do the wrong thing on that case because it's going to cost the state money" (S. Davenport, personal communication, January 6, 2021). On the

other hand, former Richmond City Sheriff C.T. Woody, Jr., recognized that “jail is no place for the mentally ill” and that his jail had “worked with what funding we’ve had to do what we can for [mentally ill inmates] but it’s difficult to give them the quality of care that they deserve.” (NAMI Virginia, 2017). To ameliorate this issue, some courts have opened mental health dockets.

Defendants that suffer from mental illnesses in Virginia have the option of having their case heard by a mental health docket. Mental health dockets are supposed to provide an alternative to the traditional court settings. Rebecca Pensak explained that “when someone’s been arrested they have to be evaluated for the mental health docket and then it’s an alternative treatment based docket that ultimately ends potentially in a misdemeanor conviction, no active jail time and no felony conviction”(R. Pensak, personal communication, December 31, 2020).The dockets’ intended purpose is that the court makes sure defendants are taking their medication, complying with their treatment programs and staying out of trouble, if they follow the course the judge sets for them “they graduate from the program” (Dvorak, 2020). However, Ms. Pensak argued that “at that point the system has already failed them [mentally ill defendants]” (R. Pensak, personal communication, December 31, 2020).

In contrast with other perspectives on the dockets, Rebecca Pensak added that the “prosecutors office thinks the mental health docket is a true diversion but it’s really not because they’re under a probationary period” (R. Pensak, personal communication, December 31, 2020). She explained that defendants are placed through strict scrutiny in such that they “need to not only not get new charges, but they need to be compliant with all treatment all medications, they need to remain completely negative drug screen for many, many months, which is hard for most people to do especially people who are also suffering from mental health issues, so it’s not true

diversion, and they get convicted of charges that they were having mental health crisis during” (R. Pensak, personal communication, December 31, 2020). It would be best if some of those guidelines were relaxed for individuals with mental health issues. The dockets could also be improved by establishing direct state funding which currently does not exist (Albiges, 2019). That way defendants could really stand to benefit from the mental health dockets and from being compliant with treatment.

Incarceration

This stage includes inmates with MI that are held in Virginia’s local and regional jails awaiting trial and postconviction. They are exposed to similar living conditions and treatments in the jails. Notably the share of inmates has increased significantly from 32% in 2012 up to 43% in 2018. Because of this, when looking for ways to aid the jail populations that have MI, intervention strategies should pay special attention to pretrial inmates. Notwithstanding, the main issues that arise at this stage are slow mental health screening processes at the jails, long wait times for state hospital beds, and problems with the provision of medications.

According to the Virginia Compensation Board Mental Illness in Jails Report of 2018 “all local and regional jails are required to screen individuals coming into jails for mental illness (Virginia Compensation Board, 2017, p.9). The report also cites that 536 inmates were not screened upon admission to the jail because mostly because of safety concerns of the intake officers. However, Stacey Davenport stated that individuals are only screened at the jail when they show “an active symptom of [a] extreme mental health [illness]” and that otherwise the mental illness is self-reported (S. Davenport, personal communication, January 6, 2021). This was also corroborated by Rebecca Pensak. Nonetheless, jails are notoriously slow to deliver, if

any, other crucial mental health assessments could help prevent future costs and suffering to those suffering from MI.

The screening processes that do take place in the jails are very slow. For example, for the average number of hours that an inmate is confined to a jail before receiving a comprehensive mental health assessment (which reviews the inmate's clinical condition to determine their treatment needs) 51% of jails reported the time to be 24 hours to seven days, for 21% of jails it was 7 to 14 days, and for 3% of jails it was longer than 14 days (Virginia Compensation Board, 2017, p.12). Only three percent of jails reported completing the task within 24 hours of confinement. On the same note, the average amounts of time between the comprehensive and more in-depth clinical assessments had very similar values. It was reported that 26% of jails completed clinical assessments 7 to 14 days after mental health assessments, while only 14% of jails did it in less than 24 hours (Virginia Compensation Board, 2017, p.13). Coupled with long wait times for state hospital beds, these long wait times can prove to be very hurtful for inmates with MI that need prompt continued medication and treatment.

Virginia also experiences long wait times for state hospital beds. In 2015, the same year that Jamycheal Mitchell died waiting several months for a state hospital bed, the wait time was 73 days (Early, 2015). Long wait times were also corroborated by Stacey Davenport. She recalled seeing wait times of up to 6 months to receive a state hospital bed just a couple of years ago (S. Davenport, personal communication, January 6, 2021). These are the symptoms of lack of funding and a shortage of much needed staff. Stacey emphasized her perspective as she said that “Central State Hospital is so overwhelmed with people (patients) that they essentially view their job as moving people in and out” (S. Davenport, personal communication, January 6, 2021). Dr. Hudacek who is the Director of Psychology and Pre-trial Forensic Services at Eastern

State Hospital, reported that “there is a shortage of psychiatrists to the degree many hospitals are using psychiatric nurse practitioners to prescribe medication, in lieu of a psychiatrist. While [there is] not a shortage of psychologists per se, the pay for psychologists in local and state government is often less than the private sector, making recruitment difficult. That is especially true for forensic evaluators” (K. A. Hudacek, personal communication, January 11, 2021). Because of this lack of timely care, continued care is often very difficult causing individuals with MI to continuously cycle in and out of the criminal justice system.

Cycling in and out of jail for mentally ill people can certainly be a symptom of inadequate treatment. For example, Rebecca Pensak brought attention to the fact it takes at least a few days after incarceration for jails to supplement medications to inmates with MI that need them (R. Pensak, personal communication, December 31, 2020). She also underlined that jails substitute brand name medications for generic ones due to the cost difference, and that this can affect a person’s wellbeing. (R. Pensak, personal communication, December 31, 2020). Dr. Hudacek also believes that cycling in and out of jail is a crucial issue that needs fixing. When asked she expressed that at the hospital, they “have people that we see who are on their third or fourth orders for restoration on different charges, they are often misdemeanors or nuisance related crimes, sometimes assault to law enforcement is tacked on to a misdemeanor crime so then they have a felony” (K. A. Hudacek, personal communication, January 11, 2021). Some of these issues could be improved by providing continued case management and medication post-release.

It is crucial that jails provide some type of treatment continuity for inmates and for those reentering the community. Research has found that “treatment discontinuity has the potential to affect both recidivism and health care costs on release from prison” placing a higher toll on

communities already in need (Gonzalez, 2014). Organizations working on re-entry services say that Virginia jails should provide a 30-to-45-day supply of medications that inmates were taking while incarcerated (Albiges, 2019). Implementing steps that lead to solutions on these issues will not only decrease the suffering of individuals with MI, but also decreased costs due to lower rates of recidivism. The multifaceted nature of the issues involving the cycling of people with mental illnesses through Virginia's jail will continue to require that stakeholders work together to insure better outcomes for these vulnerable populations.

Are there alternatives to incarcerating people with mental illnesses? Is there a chance for reform or a better way to treat them in prison currently?

Looking at how people with mental illnesses are treated in jails and prisons currently, one can see that the criminal justice system does not help them receive adequate treatment or escape the cycle between hospitals and incarceration. Often, they are stuck in a vicious cycle where they go from jails to prisons to hospitals and then back to the outside world with no consistent treatment, causing them to stay in that cycle. In this section, I (Anokhi) will explore various alternatives to incarceration. The alternatives I will examine are grouped into three different stages people with mental illnesses may find themselves in when it comes to the criminal justice system. The first is when they are apprehended for a crime or accused of a crime. At this stage, the alternatives include crisis intervention training for police officers and the creation of crisis intervention teams. The next stage is when the accused is in court. A couple of diversion options at this stage are mental health court and assisted outpatient therapy. Finally, the last stage is when people with mental illnesses are incarcerated. The best remediation practices generally occur before this stage. There are many examples of successful diversion programs and

alternatives to incarceration for those in the criminal justice system with mental illnesses to successfully escape the cycle that keeps them in the system.

Apprehension

There are alternatives for the treatment of people with mental illnesses beginning at the first stage. Now when people are arrested for possibly committing a crime the system often exacerbates mental illnesses. For example, is that of Derrick Clay (a pseudonym). He grabbed another customer's order in a restaurant when his card was declined and then, when the police sent an ambulance to check on him, he panicked and assaulted the paramedic. Later he "received a felony summons to appear in court" for that incident (Tullis, 2019). He was taken into custody after posting threats on social media about the paramedic in response to the felony summons because the judge declared he could be dangerous to himself or others. The judge "ordered the state to provide him with competency-restoration services" but there were no beds available so Clay ended up waiting for the 55 days "with no psychiatric treatment" (Tullis, 2019). Clay had no other choice but to wait for months, delaying his treatment and ability to return to the outside world.

And this sort of response is not a rare occurrence. Because there are increasing demands for inpatient services for people charged with crimes, people often have to wait just to be evaluated. A poll by the National Association of State Mental Health Program Directors "found in 2017 that eight of the 37 states with relevant data reported having average wait times of longer than 35 days just to be evaluated for competency" (Tullis, 2019). During this time, the people with mental illnesses are waiting in jail. Being forced to wait in jail contributes to the never ending cycle that people with mental illness in the criminal justice system face: in jails, their symptoms get worse. Then, even when they are finally admitted into a hospital, "it can take

longer to restore them to competency, which increases wait times for those still in jail” (Tullis, 2019). Therefore the current system is hurting people with mental illnesses in every part of the first stage. From delayed treatment, their symptoms worsen causing longer hospital time which delays the next person’s treatment. All of this is clear evidence that the current procedure in the criminal justice system for apprehending people with mental illnesses is inefficient and causes harm to people.

The main alternative I found for this stage is crisis intervention teams (CIT). One important distinction to make is that, although the majority of crisis intervention teams include police officers, this is not solely a law enforcement program. It is a community-based program that brings together law enforcement officers, mental health professionals, and other community members to improve community responses to mental health. Some goals a CIT program might have are to “improve safety during law enforcement encounters,” “increase connections to effective and timely mental health services,” “use law enforcement strategically,” and “reduce the trauma” for mental health crisis situations in their community (Usher et al., 2019, p. 5). In order to create an effective CIT program, it is pertinent that the team creates a program that fits the specific needs of their community. This requires research and cooperation in the community. Some key factors for success are building a strong network of relationships where the team can trust each other, “ongoing commitment from leaders,” “an understanding of your community-wide response to mental health crisis situations,” “building the infrastructure to strengthen your crisis response system and sustain your program” (which requires revising existing strategies and collecting data), and “a training program for law enforcement officers and 911 call-takers and dispatchers that prepares them to respond safely and compassionately to people in crisis” (Usher et al., 2019, p. 6). The most essential part of this are the relationships among law enforcement,

mental health professionals, and other community members because they help create a team that trusts each other and is committed to helping improve their community's response to mental health crises. Without those relationships, it would be difficult to find a solution for the community that everyone would cooperate with and advocate for. To achieve all of this, a grant might work for the short-term. However, the program will be more sustainable if the state helps with funding.

One part of a CIT program may include crisis intervention training for law enforcement officers. This is the case for Miami-Dade County with their Eleventh Judicial Circuit Criminal Mental Health Project (CMHP). Their training model is based on the Memphis model where it was first developed. The CIT officers do regular officer work but also “receive 40 hours of specialized training in psychiatric diagnoses, suicide intervention, substance abuse issues, behavioral de-escalation techniques, the role of the family in the care of a person with mental illness, mental health and substance abuse laws, and local resources for those in crisis” (“Eleventh Judicial,” n.d., p. 3). They are able to de-escalate situations where there are people with mental illnesses because they better understand their behavior. Then, the officers can decide whether to let them go, send them to jail, or send them to get treated. This training has been extremely successful. The Criminal Mental Health Project Program has “provided CIT training, free of charge, to roughly 4,000 law enforcement officers from all 36 local municipalities in Miami-Dade County” which has resulted in the county closing “one entire jail facility at a cost-savings to taxpayers of \$12 million per year” because “the average daily census in the county jail system has dropped from 7,800 to 4,800 inmates” (“Eleventh Judicial,” n.d., p. 3). These facts help to demonstrate, at the very least, that crisis intervention training has helped save money and direct people with mental illnesses out of the criminal justice system if it is avoidable for them.

Court

The second stage where people with mental illnesses could be rerouted away from jail or prison is when they are in court. One alternative is to create mental health dockets. These responses are used in some Virginia courts and other courts throughout the United States. Mental health dockets are “created within the existing structure of a criminal court, and are designed to quickly identify and treat individuals with mental illnesses to improve criminal justice and clinical outcomes” (Ward Talevi et al., 2016, p. 3). They are different from mental health courts because new courts cannot be created freely by judges, but these dockets can be in Virginia. Dockets create a process in which the criminal justice system processes defendants with mental illnesses in court without necessarily incarcerating them. Similar to crisis intervention team programs, the dockets are tailored to fit their specific communities to achieve the best results. Some of the goals that mental health dockets aim for include: increasing public safety by reducing recidivism rates of perpetrators with mental illnesses, increasing the likelihood of long-term treatment, improving the quality of life for participants, and saving communities money (Ward Talevi et al., 2016, p. 6).

Mental health dockets will vary from community to community. It is legal for them to be created nationwide and the specifics vary in different courts. However, there are some parts to the dockets that all of them should have and we have good, successful models from which to extrapolate recommendations. There should be a Mental Health Docket Planning Committee (that undergoes some type of training/education on this specific topic); a Mental Health Docket Team (to keep track of progress in the docket); a predefined model that the docket will be structured after; a simple process to receive referrals for defendants; a timely assessment to see if

the defendant is eligible to participate in the program; the condition that a participant should only be in the program if they are informed and it is voluntary; clear and predefined eligibility criteria; a process/model to follow to decide who and how to prioritize participants (some factors to look into are criminogenic needs, clinical or treatment needs, criminogenic risk, and responsivity); case plans that are made for each individual; effective treatment and support; teamwork; and individualized incentives/sanctions (Ward Talevi et al., 2016, p. 16-28). It would be best for each docket to have some form of those elements, but they are not required for the creation of a mental health docket. This is a plausible option that is slowly expanding throughout the country.

Another alternative is assisted outpatient therapy (AOT). AOT is “a process that allows courts to compel individuals with severe mental illness and a past history of arrest or violence to stay in treatment as a condition for living in the community” (“Laura’s Law,” 2017). One example of this is Laura’s Law which is specific to California. Other versions of AOT include Kendra’s Law in New York. AOT has very strict criteria, such as being repeatedly arrested or hospitalized because they continuously cannot complete treatment, causing the amount of people who are eligible to be small. However, it is still beneficial to those individuals and their communities. Someone other than the person in question will submit the petition to enroll them in an assisted outpatient treatment plan. Therefore, a person with a severe mental illness could be put into AOT involuntarily. Laura’s Law “is the only community-based program for individuals with mental illness who refuse treatment” (“Laura’s Law,” 2017). But it is needed to prevent more harmful actions that trigger the laws that usually lead to the treatment of involuntary patients.

Laura’s Law and other forms of AOT have been successful. The services it includes are: “medication; blood or urinalysis tests to determine compliance with prescribed medications;

individual or group therapy; day or partial day programs; educational and vocational training; supervised living; alcohol or substance abuse treatment” and more (“AOT,” 2019). Looking at its effects in Nevada County, CA, Laura’s Law helped reduce hospitalization by 46%, incarceration by 65%, homelessness by 61%, emergency contacts by 44%, and “saved \$1.81-\$2.52 for every dollar spent as result of reducing incarceration, arrest, and hospitalization” (“Laura’s Law,” 2017). Looking at the New York AOT law helps to demonstrate the efficacy of AOT. By implementing Kendra’s Law, its patients saw reductions in physical harm to others by 47%, property destruction by 43%, homelessness by 74%, suicide attempts by 55%, substance abuse by 48%, and money was saved by reducing arrests by 83%, incarceration by 87%, and hospitalization by 77% (“Laura’s Law,” 2017). Looking at multiple states and counties across the nation, “AOT reduces violence, arrest, hospitalization and incarceration of persons with serious mental illness in the 70% range and thereby saves taxpayers 50% of the cost of care” but is “vastly underutilized” (“Summary of Nationwide Studies,” 2017, p. 1).

Laura’s Law and other AOT treatment plans in the United States are effective in treating patients and saving costs, but it is still underutilized. This is most likely due to the fact that it is a type of plan that targets a very small and specific group of people. Nonetheless, that group of people is important and it is pertinent that counties across the nation implement AOT in their court systems. The funding for Laura’s Law comes from the Mental Health Services Act, California’s mental health tax money. This resource remains untapped in parts of California. Kendra’s Law is funded by New York State. Its AOT programs, along with other ones in the United States are still being created.

Incarceration

The final stage I examined is incarceration. The main point, though, in this stage is that it is better for people with mental illnesses not to end up incarcerated in the first place. Putting people with mental illnesses in prison is detrimental to the people's mental health, the monetary cost to society, the strain on criminal justice resources, and more. For example, a sheriff at the Cook County jail in Illinois talks about how the guards have to adopt more roles than ever before. This is because "in 1990 found that 1 in 15 prisoners at Cook County Jail had some form of mental illness. Today, a conservative estimate is 1 in 3" (Ford, 2017). Rising mental illness rates in inmates combined with mental health cuts means that guards do more than before. The staff, "including the 300 to 400 new correctional officers hired annually, now receive 60 hours of advanced mental-illness treatment training" (Ford, 2017). This puts an immense amount of pressure on inadequately trained staff to help treat inmates with mental illnesses.

There are also many reasons the mental illness rates in inmates are increasing, one of which being that people with mental illness will commit crimes to be treated (but this does not necessarily account for the increase). A 1976 ruling by the Supreme Court in *Estelle v. Gamble* said that "that prisons are constitutionally required to provide adequate medical care to inmates in their custody" which resulted in the presence of "mentally ill people who committed crimes simply to receive treatment" (Ford, 2017). This is alarming in itself because the criminal justice system is the only hope for consistent treatment for some. But looking at national data shows that while "serious mental illness has been documented in 14.5 percent of men and 31 percent of women in jail settings," "between 83 percent and 89 percent of people with mental illness in jails and prisons do not receive care" (Cloud & Davis, 2013, p. 1). Again, this demonstrates that the system is inefficient and is failing people with mental illnesses.

Overall, it is evident that prison is the worst place to send someone with a mental illness. Offenders with mental illness should be treated outside of prisons and there are many plausible alternatives to incarceration to achieve the best results for people with mental illness in the criminal justice system. In the first stage of apprehension, the creation of crisis intervention teams and crisis intervention training would be beneficial in deciding the best place for the defendant (whether that be a hospital, prison, etc). In the second stage, when the defendant is in court, mental health dockets and assisted outpatient therapy can divert the defendant from prison to proper treatment. Finally it would be best if offenders with mental illness are not sent to prison in the first place because it will likely result in no treatment, costing them and society in more ways than one. There are many impressive alternatives to incarceration that would help people improve their mental health, save taxpayers money in the long term, and create a more efficient system overall for communities.

Recommendations

- There should be recurring crisis intervention training for all officers so they are better equipped to handle emergency calls related to mental illness crises, and so that unnecessary charges, incarceration, or criminalization of people with MI is avoided as much as possible.
- Crisis intervention teams should be created to assess communities' needs in relation to mental health and fulfill them.
- Funding for the creation and implementation of the "Marcus Alert" or "Marcus Alert System" should be provided as expediently as possible given the immense need for the system and the injustices that have occurred in its absence.
- Mental health dockets and courts should be created wherever possible.

- Virginia's state government should establish direct funding for mental health dockets.
- Assisted outpatient therapy should be created within existing courts.
- Defendants with mental illnesses should be diverted from incarceration when possible.
- The state of Virginia should increase funding to state hospitals to decrease wait times for beds and alleviate the current shortage of psychiatrists.
- Jails should investigate the adverse effects, if any, of switching their inmates to cheaper, generic mental health medications and stop the practice if evidence of such effects are found.
- Jails should provide a 30-to-45 day supply of medications that inmates with MI were taking while incarcerated to those people upon discharge.
- Jails should provide follow up case management upon discharging people with MI.

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