

*Mental Illness and
the Criminal
Justice System:
Clark County,
Nevada*



Nevada Division of Public and Behavioral Health

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Purpose

The purpose of this report is to understand the burden of forensic mental illness in Clark County, Nevada. This report is intended for use by leadership within public and mental health and law enforcement in order to direct program interventions and resources to best serve those with mental illness.

Summary

- Over 10 percent of 2011 Clark County Detention Center (CCDC) arrestees were Mental Health and Developmental Services (MHDS) clients.
- The number of males in CCDC with a mental illness was almost double that of females.
- The most common age groups of those arrested with a mental illness was 25 to 34 and 35 to 44 years of age.
- The most common race/ethnicity was White, non-Hispanic.
- Over 43 percent had a high school diploma or GED. Another 24 percent had at least some college education.
- Over 55 percent of this population was unemployed; slightly over 30 percent of those were looking for work. Only 11 percent were employed full- or part-time.
- Of 2,486 individuals admitted to an MHDS psychiatric hospital in 2011, 484, or 19.5 percent, were also detained at CCDC in the same calendar year.
- Of those MHDS clients who were detained at CCDC, 40.7 percent were detained on at least two occasions with 23.5 percent being detained twice, 8.4 percent detained three times, 4.0 percent detained four times, and 4.8 percent detained on five or more occasions.
- Among individuals who were both admitted to an MHDS psychiatric hospital and detained at CCDC in 2011, the most common criminal charge was trespassing, which accounted for 87.4 percent of all charges. Within the population of interest, 1.6 percent was charged with defrauding an innkeeper, 1.4 percent with battery, and 1.1 percent with domestic violence. Accounting for less than one percent of the charges in rank order were jaywalking, disorderly conduct, burglary, and obstructing a public officer. All other charges accounted for 6.4 percent of the total charges.

Introduction

Clark County is located in the southern region of Nevada and has a population of over 1.9 million people, representing 72 percent of Nevada's overall population. Clark County is the 12th largest county in the nation with the 8th busiest airport. It has over 42 million visitors per year.

About Clark County Detention Center

Clark County Detention Center (CCDC) provides adult detention for individual arrests in Clark County.

About the Division of Mental Health and Developmental Services

The Nevada Division of Mental Health and Developmental Services (MHDS) is the largest provider of mental health services in the state. MHDS provides services through eight major state agencies representing persons with mental illness, intellectual disabilities and substance

use/abuse disorders. These agencies also provide step down, community-based services through community partners and providers. In addition to serving consumers directly, MHDS works with many stakeholders including family members, advocates, service providers, legislators, law enforcement and the general public. As a result of stakeholders' diverse interests, the issues facing MHDS are complex and require input from many different perspectives. The unifying theme in this diversity, however, is the commitment of all stakeholders to have a system for mental health, developmental and substance use/abuse services that meet the needs of all Nevada's citizens. The eight agencies that provide services to Nevadans are:

Mental Health

- ✓ Southern Nevada Adult Mental Health Services (SNAMHS)
- ✓ Northern Nevada Adult Mental Health Services (NNAMHS)
- ✓ Rural Services (Mental Health)
- ✓ Lake's Crossing Center

Developmental/Intellectual Disabilities

- ✓ Desert Regional Center (DRC)
- ✓ Sierra Regional Center (SRC)
- ✓ Rural Services (Developmental/Intellectual Disabilities)

Alcohol and Substance Abuse

- ✓ Substance Abuse Prevention and Treatment Agency (SAPTA)

About the Data

Mental health and criminal justice data available from 2011 was cross-matched and analyzed at the Nevada State Health Division in order to assess the prevalence of mental illness among persons detained at CCDC in 2011. Frequencies, rates and patterns of detention of mentally ill individuals at CCDC were evaluated and compared to findings related to inpatient and outpatient care provided by the Division of Mental Health and Developmental Services. Data was also compared to county, state, and national data wherever possible.

The number of mentally ill individuals involved with the criminal justice system and detained in jails and prisons continues to grow in Clark County, throughout Nevada, and nationwide. This significant increase is attributed in most part to a severe lack of resources available for appropriate services and timely case management for this chronically ill population.

Background

Mental illness is the most prevalent cause of disability in the United States and other developed countries. It contributes to the largest proportion of morbidity, disability, mortality - more than any other group of illnesses including heart diseases, cancer, and stroke. High rates of co-occurrences with other prevalent associated risk factors such as alcohol and drug abuse in addition to a significantly increased chance of co-morbidity with chronic/communicable diseases – that are oftentimes inadequately or never addressed- makes mental illness a public health priority at the state and local levels.

It is estimated that between 5 and 20 percent of the population in the United States and Nevada is afflicted with a diagnosable mental illness. Recent Centers for Disease Control and Prevention (CDC) reports estimate that about 25 percent of all adults in the United States report having a

mental illness. This significant proportion of the population is frequently monitored, evaluated, and analyzed in several national mental health and criminal justice programs. Together, the criminal justice and the behavioral and public health systems are experiencing a common problem involving the alarming increase in arrests of persons with mental illness. Arresting behaviorally-impaired individuals in place of referring them to appropriate healthcare facilities and providers can lead to delayed and/or less effective treatment for their illnesses. It is clear that a joint partnership between both systems is required, vital, and overdue. Jails and prisons are not set up to ameliorate the force of mental illness, and a vicious cycle often results creating high rates of recidivism and less than optimal treatment outcomes.

It has become increasingly commonplace for mentally ill individuals exhibiting troublesome behaviors to be sentenced to criminal custody rather than receive placement in psychiatric institutions. Unfortunately, the public and media frequently regard jails and prisons, rather than psychiatric facilities, as the *de facto* institutions responsible for the care of people with mental illness. Criminalization hypothesis emerged as an explanation for the increasing numbers of people with mental illness found in jails and prisons. Criminalization hypothesis states that as a result of deinstitutionalization, shorter inpatient hospital stays and stricter criteria for civil commitment without an adequate match in mental health spending, the criminal justice system became responsible for controlling individuals with mental illness. Criminalization theory is based on the assumption that law enforcement officers might be forced to inappropriately recourse to criminal arrests in order to resolve encounters with mentally disordered suspects, especially when community support systems are inadequate. Appearance, behavior, age, gender, and race/ethnicity may play a role in the decision to arrest suspect individuals.

The public health evidence suggests a strong relationship between deinstitutionalization and the increasing prevalence of mentally ill individuals in the correctional system. Deinstitutionalization, coupled with a severe lag in case management efforts, has led to a significant increase in arrests of people with mental illness. Ideally, public health and the healthcare systems and facilities, not jails, are the most appropriate places to care for the ill, regardless of the nature of illness; mental, physical, or both.

Arresting mentally ill individuals as a means of handling troublesome behaviors can be seen as a compassionate gesture. Such arrests can also appear to be based on the common belief that people with mental illness could be more violent than the general population and may pose a danger to themselves and their communities. It is extremely challenging to define predictive factors, dangerous behaviors, specific traits or even special characteristics that can plausibly and reliably identify mentally ill individuals who might pose threats to themselves and/or their communities; describe those who could be considered at high risk to commit violence, and those who exhibit alarming potentials and/or display strong tendencies to commit mass shooting. There have been several highly publicized examples of fatal shooting perpetrated by individuals with histories of mental illness and psychiatric treatment. However, there has been very little research in which the relationship between mental illness and the risk of firearm-related violence and mass shooting were properly evaluated.

The scarcity of data, the shortage in peer-reviewed published studies, and the variety of controversial research results could be attributed to a complex set of poorly understood risk

factors and social determinants of mental illness. Additionally, legal, political, and economic factors coupled with a severe shortage in the medical and social case-management, poorly explained pharmaceuticals/drug side effects, and other infrequently evaluated contributing factors could be to blame for the lack of clear guidelines to control this very prevalent illness.

The increasing reliance on law enforcement is perhaps best exemplified by the need to adopt specific police strategies to address this relatively newly emerging socioeconomic and behavioral phenomenon. Crisis intervention teams were designed, developed and successfully utilized to enhance police response to mentally ill individuals. It is important to emphasize that law enforcement officers do not interact with mentally ill individuals exclusively due to troublesome behaviors on the part of the mentally ill individual, but also in a variety of other situations, including police-initiated contacts such as routine traffic stops, enforcement of court orders, transport for emergency hospitalization, and in response to inappropriate behaviors, or harmful and criminal activities. Additionally, individuals who exhibit more than one mental illness including substance abuse (co-occurring diagnosis) may interact with police due to illegal behaviors that could be related to drug seeking, selling, and soliciting. Individuals with mental illness, particularly those with *Axis I Disorders*, exhibit high prevalence of substance use and/or abuse.

It is estimated that law enforcement officers spend approximately 10 percent of their time in situations involving mentally ill individuals. Such individuals may enter the criminal justice system after being arrested for a variety of crimes, ranging from simple misdemeanor offenses to serious violent crimes. Little is known about the elements that shape encounters between police and people with mental illness. Criminal justice literature, current research, and several recent studies focus exclusively on analyzing the role of mental illness as a factor in the process and decision to arrest an individual. These proximate factors are important but only partially represent the context of the arrest decision. Literature reviews suggest that for every type of crime, law enforcement tends to under-identify mental illness among the individuals they arrest, and tend to arrest people with mental illness more frequently than others without such illnesses. Additionally, factors traditionally predictive of an arrest could be overshadowed by mental illness. Troublesome behaviors resulting from drug use and/or psychiatric symptoms can bring people with mental illness to the attention of law enforcement officers. Furthermore, studies show that people with mental illness compared to their counterparts without such illnesses may act or appear more disrespectful to law enforcement officers.

When law enforcement officers respond to an incident, practically-speaking, they are considered to be “out-of-service.” Transporting a mentally ill individual and seeking psychiatric care at a hospital or a mental health clinic may present a hurdle for police officers who could be pressured to return to the “in-service” or active status so that they can respond to urgent calls and keep the community safe. In most areas, an arrest takes substantially less time to process than an involuntary hospitalization especially when healthcare facilities are unprepared to properly handle and manage such cases, or are unwilling to admit such patients. No action or an informal disposition can take less time than transportation to a mental health facility or even an arrest.

The context in which law enforcement interacts with a person with mental health issues can influence outcomes. Law enforcement officers typically handle mentally ill individuals in

communities where resources are unavailable differently from the way they are handled in communities where public/mental health resources are adequate and effective. Criminal justice literature indicate that law enforcement officers never hesitate to bring a person with mental illness for a timely assistance, especially when alternatives to arrest are available and adequate mental healthcare facilities or resources are perceived to be efficient.

Socioeconomic factors such as poverty, transience, lack of healthcare coverage, and substance abuse are likely contributors to the over-representation of mentally ill individuals in the criminal justice system. Crisis team interventions to reduce arrests among mentally ill people such as training police officers and facilitating clinical access to appropriate health services often fail to consider underlying unfavorable socioeconomics that might have contributed to the arrests. As such, the effectiveness of all such interventions must be tested and validated through the practical application of a wider range of measures and indicators during police encounters with mentally ill individuals.

After deinstitutionalization, individuals with mental illness became more susceptible to neighborhood influences, and tended to gravitate more toward disadvantaged areas so the deviance in their behaviors would not elicit significant attention. Such underserved communities usually serve as homes of last resort. Additionally, people with mental illness, substance abuse problems, and a criminal history become more challenging to treat and therefore could be excluded from certain programs offered by the already overwhelmed mental health system. In the absence of viable treatment options for such chronically ill individuals, families and neighbors are frequently forced to rely on the police rather than on appropriate mental health or community-based programs and social services to address troublesome or inappropriate behaviors.

As is the case in several states, many Nevada cities and towns lack appropriate mental health services, thus explaining and probably “justifying” the relatively high numbers of people with mental illness in the criminal justice system. Law enforcement may use arrest to respond to acute manifestations of mental illnesses, but the extent to which this response represents a “criminalization” of mental illness is yet unclear, and needs further empirical development. Regardless of the reasons, it appears that jails and prisons have become our most enduring asylums.

Early diagnosis and medical interventions can reduce the likelihood of further demands on public resources by persons with active mental illness who may be unable to sustain full-time employment or self-maintain independently. Evidence suggests that less reliance on the criminal justice system to handle persons with active mental illness frees up critical resources for pursuing the criminal justice basic task to prevent societal harm caused by criminal activities. Subsequently, proper diversion interventions and case management for non-violent individuals with mental illness and timely referral to effective treatment would be a common goal. More studies are needed to identify practical approaches in order to provide effective interventions and treatment in jails and prisons. Such interventions should be practical during parole and probation also and should help facilitate community reentry and integration. Reducing the number of persons with mental illness in the criminal justice system will depend largely on the willingness

of mental health providers and managers in both systems to understand and collaborate with each other.

Criminal justice, public health, and mental health professionals and advocates strongly recommend diversion efforts to link offenders with mental health issues to community-based services in order to break their continued cycling through criminal justice, mental health, and substance abuse programs; and to reduce the number of detained mentally ill individuals. However, at present there is no definitive model for integrating efforts to coordinate criminal justice with mental health diversion programs. Additionally, little is known about the efficiency, feasibility, and effectiveness of available interventions, especially for detainees with co-occurring disorders (mental illness combined with chemical dependency); or whether such interventions actually benefit targeted recipients, especially in terms of symptom stabilization, reduced recidivism, higher levels of community adjustment, and stable participation in community mental health and substance abuse treatment services.

Jail diversion strategies focus on identifying individuals who, at some point in the arrest process, should be diverted to mental health services. Ideally, individuals with mental illnesses could be identified for diversion - before, during, or after an arrest - from the criminal justice system at any point including pre-booking interventions (before formal charges are brought), post-booking interventions (after an individual has been arrested and jailed), during, and after the conviction process. Diversion strategies could include screening detainees already in the criminal justice system for the presence of mental disorder. Jail diversion strategies require that mental health professionals evaluate the detainees and, if needed, link clients to appropriate community-based mental health services. Diversion may include planning for release from jail and instant referrals to community services, thus preventing extended incarceration. Diversions to mental health court can be operated by law enforcement, pre-trial services, and the jail system.

The following four key elements or activities are essential to ensure success of a jail diversion program:

- Active ongoing case management and participation of mental health experts
- Early and full involvement of agencies such as the behavioral and public health, mental healthcare facilities, substance abuse treatment programs, and criminal justice agencies
- Regular meetings of key personnel from these various agencies
- Strong leadership and close coordination of services

Such activities are shown to be very promising for diverting mentally ill people from jails, reducing recidivism, integrating them back into community, and facilitating access to ongoing treatment. While increasing the quality of life for mentally ill detainees, diversion programs from jails to community mental health and substance abuse services are proven to be cost-effective and essential to reducing negative health outcomes such as poor psychosocial functioning and repeated psychiatric hospitalizations.

Some incarcerated persons with mental illness will require treatment in jail or prison. Other persons will be referred to treatment by their probation or parole officer. Still others will complete their jail or prison term and will need to be reconnected to their community mental

health systems for ongoing case management. All of these crossroads between criminal justice and mental health may present additional challenges and potential opportunities for improving outcomes for people with mental illness and their families. In order to reduce the number of persons with mental illness in the criminal justice system while protecting the public, the degree of criminal justice involvement should be directly proportional to the extent to which an individual poses a danger to self and/or society. Crisis intervention teams have consistently improved engagement in treatment and the prevention of criminal recidivism among persons with serious mental illness. Therefore, two compatible goals can be stated as follows:

- Individuals with mental illness who are considered non-dangerous and do not pose a threat to self or others should be diverted to effective interventions and treatment at the earliest practical stage of the criminal justice process
- Individuals with mental illness who are considered dangerous and may pose a threat to self or others should be provided humane care and treatment during incarceration with an explicit linkage to community-based case-management and treatment upon release

There is an increase in the number of people with serious mental illness in the criminal justice system. The system is being overwhelmed by the burden of providing humane care and management for persons with mental illness. Integrating the Nevada state public health and mental health divisions provides a unique opportunity to improve the efficiency and effectiveness of treating and case-managing tens of thousands of persons who suffer mental illness, and who may become involved in the criminal justice system.

Currently there are no established standards to determine why mentally ill individuals are disproportionately represented in the criminal justice system and whether such high rates of detainment are the direct result of their illness.

The following data was analyzed to better understand forensic mental health in Clark County to be used to more appropriately direct resources and reduce recidivism and the burden on the criminal justice system.

2011 Prevalence of Detainees with a History of Mental Illness at CCDC

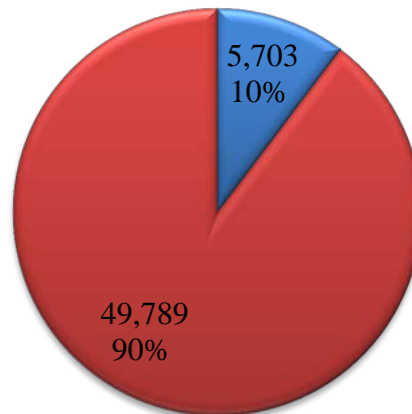
In 2011, 55,492 individuals were detained at least once at CCDC. Of these detainees, 5,703 individuals had at some point in their lifetimes sought services from the Nevada State Division of Mental Health and Developmental Services (MHDS) for issues related to mental illness. This group accounted for 10.3 percent of all 2011 CCDC detainees. In comparison, 4.6 percent of adults in Nevada’s general population have been diagnosed with a serious mental illness (McKnight, 2012). National estimates indicate that 7 to 16 percent of incarcerated individuals may have a serious mental illness and the prevalence of mental illness at CCDC fits comfortably within this estimated range (Osterweil, 2011). Further research has shown that there is a high likelihood (over 72 percent) that this population has a co-occurring disorder of mental illness and substance abuse (Osterweil, 2011).

10.3%

Of CCDC detainees were MHDS clients

Figure 1. Prevalence of Detainees with a History of Mental Illness at CCDC, 2011

■ History of Mental Illness ■ No History of Mental Illness

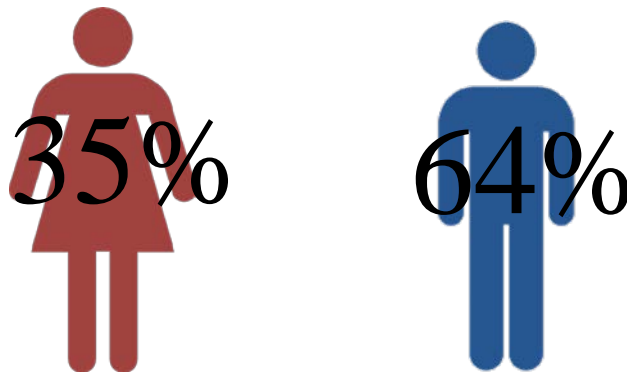


The proportion of detainees with a history of mental illness detained at CCDC appears to compare favorably to the proportion detained at the Carson City Jail and the Washoe County Detention Center in Northern Nevada for which reports similar to this one have been published. Of the 2,285 inmates detained at the Carson City Jail, 527 had received MHDS services at some point in their lives and accounted for 23.1 percent of the total 2011 jail population. In the same year, 15,458 individuals were detained at the Washoe County Detention Center, 2,676 of who had been diagnosed with a mental illness by an MHDS agency. The prevalence of mental illness at the Washoe County Detention Center in 2011 was 17.3 percent. Potential reasons for the lower rates of mental illness at CCDC include the availability of other detention centers in Clark County and underrepresentation of mentally ill individuals due to high rates of tourism and transiency, which may lead to an increased amount of individuals without mental illness being detained at CCDC. Other potential reasons for this difference may include the diversion of a

higher rate of mentally ill individuals via Legal 2000 in Clark County or lower rates of arrest due to differences in police officer to population ratios.

2011 Detainees with a History of Mental Illness at CCDC by Sex

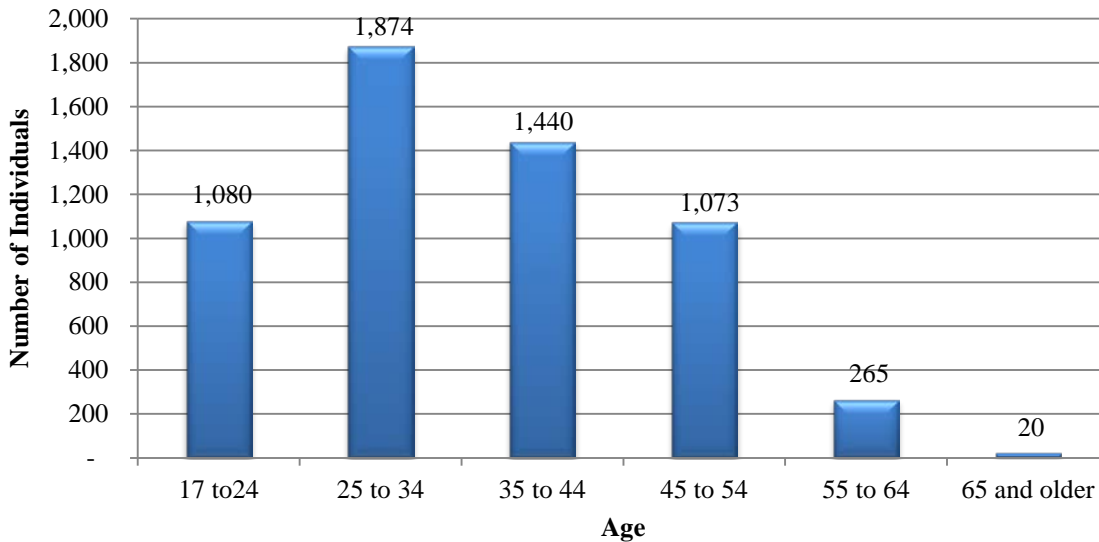
Males with a history of mental illness accounted for nearly two times the number of females incarcerated at CCDC at least once in 2011. A total of 3,655 men with a history of mental illness were detained at CCDC in 2011 and accounted for 6.6 percent of the entire population of CCDC detainees. At 64.1 percent of the mentally ill CCDC detainee population, males with a history of mental illness were overrepresented in comparison to the proportion of males in Clark County in 2010, which stood at 50.3 percent. National estimates indicate that mentally ill men are four times more likely to be incarcerated than those without mental illness (Osterweil, 2011). Females with a history of mental illness represented 3.6 percent of the entire 2011 detainee population at CCDC. In total, females accounted for 1,972 or 34.6 percent of the total population of 5,703 individuals diagnosed with mental illness by an MHDS agency and were underrepresented in comparison to 2010 Clark County demographics. National estimates show an even greater risk of incarceration for females with mental illness, who are eight times more likely to be incarcerated than the general population (Osterweil, 2011). Of the total, 71 inmates did not have the sex documented in their record.



2011 Detainees with a History of Mental Illness at CCDC by Age

Inmates with a history of mental illness at CCDC in 2011 ranged in age from 17 to 70 years old, with a median age of 33 years. Incarceration rates peaked within the 25 to 34 age range, which represented 32.9 percent of the total population. The most common age of incarceration was 27 years of age. The proportion of detainees diagnosed with a mental illness steadily declined with advancing age to a low of 0.4 percent for the 65 and older category. Those ranging in age from 35 to 54 years old accounted for 44 percent of incarcerated individuals with a history of mental illness and were overrepresented in comparison to the 2010 general population of Clark County, of which 28.4 percent of individuals fell in this age range (United States Census Bureau (USCB), 2010). In contrast, those 55 and older were underrepresented at 5.0 percent of CCDC population in comparison to 22.3 percent countywide in 2010 (USCB, 2010).

Figure 2. Detention of Individuals with a History of Mental Illness at CCDC by Age Group, 2011

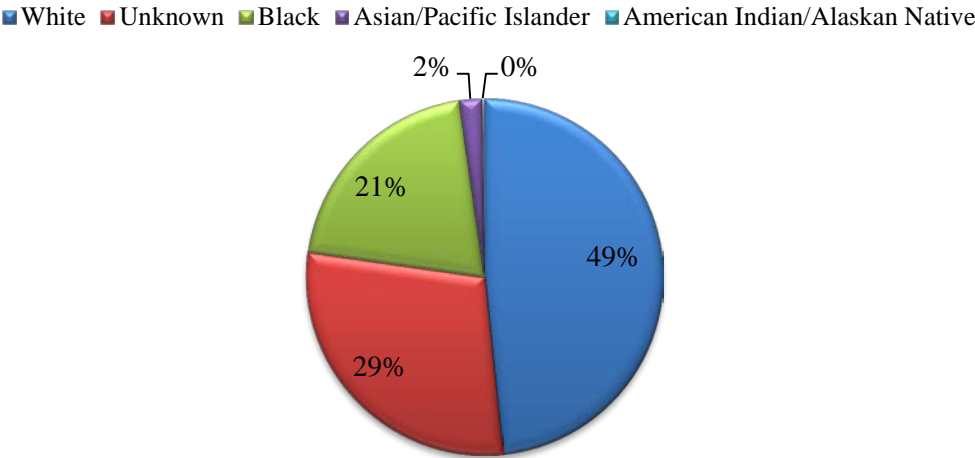


2011 Detainees with a History of Mental Illness at CCDC by Race and Ethnicity

In 2011, the majority of individuals who were detained at CCDC, and had at some point in time accessed MHDS services, were White. Of the total population of 5,703 individuals, 49.1 percent were classified as White. Blacks represented the largest minority group at 20.8 percent of the population and were distantly followed by Asians/Pacific Islanders, who comprised 2.1 percent of the population and American Indians/Alaskan Natives, who represented just 0.2 percent. The race was unknown for 29.3 percent of the population.

Prevalence rates for race are quite different among the general population of Clark County with the exception of Whites, which are similar to countywide rates. If those of unknown racial origin are excluded, Black persons with a history of mental illness account for 28.8 percent of CCDC’s mentally ill population, while Blacks represent just 12 percent of the Clark County general population (USCB, 2010). Prevalence rates for Blacks with a history of mental illness in CCDC are 2.4 times that of the general Black population in Clark County. Asians/Pacific Islanders who have accessed MHDS services are underrepresented at 2.9 percent of the 2011 CCDC population, excluding those of unknown race, in comparison to 12 percent of the countywide Asian/Pacific Islander population (USCB, 2010). American Indians/Alaskan Natives are similarly underrepresented at 0.3 percent at CCDC in comparison to 1.5 percent of the Clark County population (USCB, 2010).

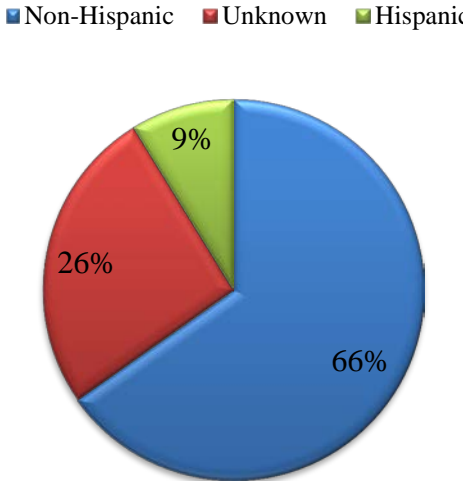
Figure 3. Detention of Individuals with a History of Mental Illness at CCDC by Race, 2011



The majority of persons incarcerated at CCDC who have also accessed MHDS services are of non-Hispanic ethnic origin and account for 66.2 percent of the total. In contrast, Hispanic persons with a history of mental illness who were detained at CCDC amount to just 8.9 percent of the population. The remaining 26.4 percent of the population is of unknown ethnicity.

According to the 2010 U.S. Census, 29.1 percent of the Clark County population is of Hispanic or Latino ethnicity (USCB, 2010). If those of unknown ethnic origin are excluded, Hispanics comprise 8.9 percent of the 2011 CCDC detainees with a history of mental illness, which indicates that this group is underrepresented at CCDC.

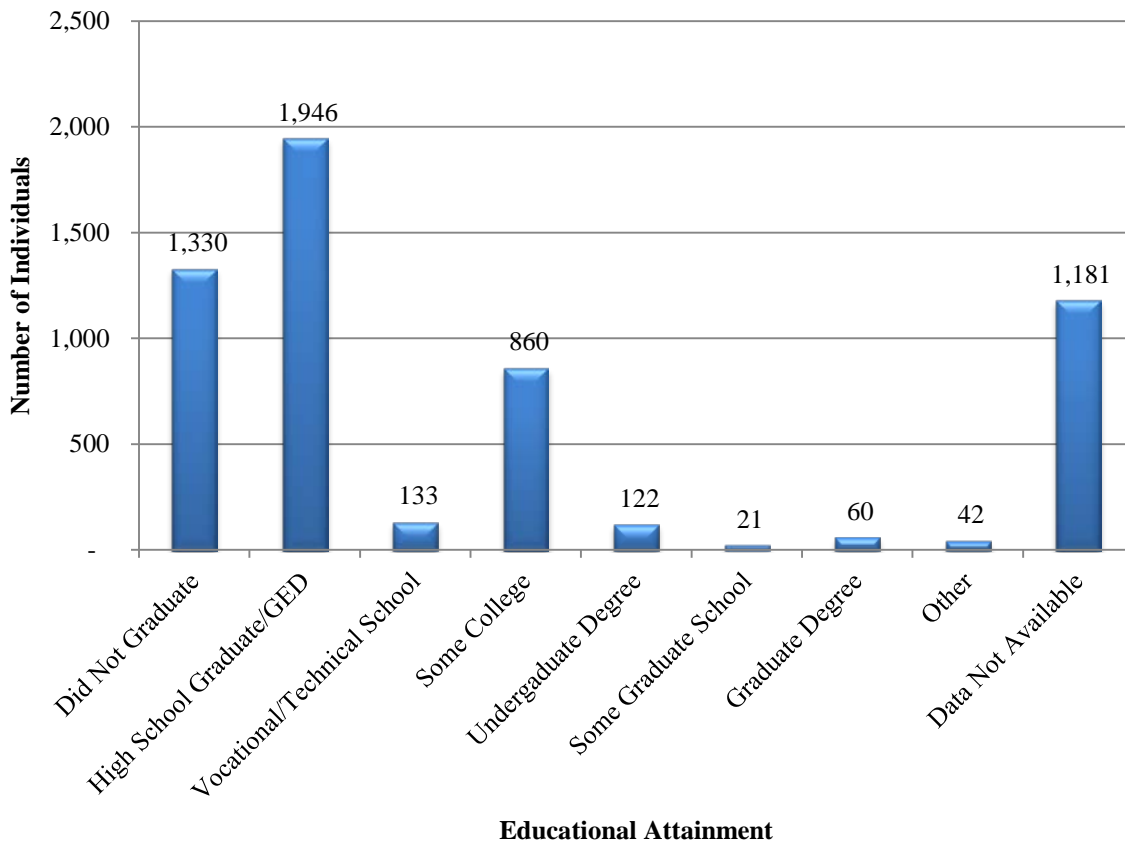
Figure 4. Detention of Individuals with a History of Mental Illness at CCDC by Ethnicity, 2011



2011 Detainees with a History of Mental Illness at CCDC by Educational Attainment

The population of 2011 CCDC detainees with a history of mental illness was underrepresented in terms of higher education. Data on educational attainment was not available for 1,181 individuals and this data were omitted from the total for purposes of comparison to rates in the Clark County general population. Rates for Clark County include only those 25 years of age and older. Over 29.4 percent of CCDC population diagnosed by MHDS with a mental illness, a total of 1,330 persons, did not graduate from high school. In comparison, the general Clark County population of persons 25 and older had a much lower dropout rate of 16.5 percent (USCB, 2010). Of the 2011 CCDC population with a diagnosis of mental illness, 43.1 percent had graduated from high school or received a GED in comparison to just 29.9 percent of the general population (USCB, 2010). For higher education, 19.1 percent of the incarcerated population with a history of mental illness had at least some college experience, while 24.8 percent of those persons 25 and older countywide had attended college, but had not graduated (USCB, 2010). Only 3.2 percent of individuals with a mental illness history detained at CCDC possessed an undergraduate degree in stark contrast to the 14.5 percent rate of the population countywide (USCB, 2010). Finally, 1.3 percent of the population of interest earned a graduate degree in comparison to 7.2 percent of the general population (USCB, 2010).

Figure 5. Detainees with a History of Mental Illness by Educational Attainment, 2011

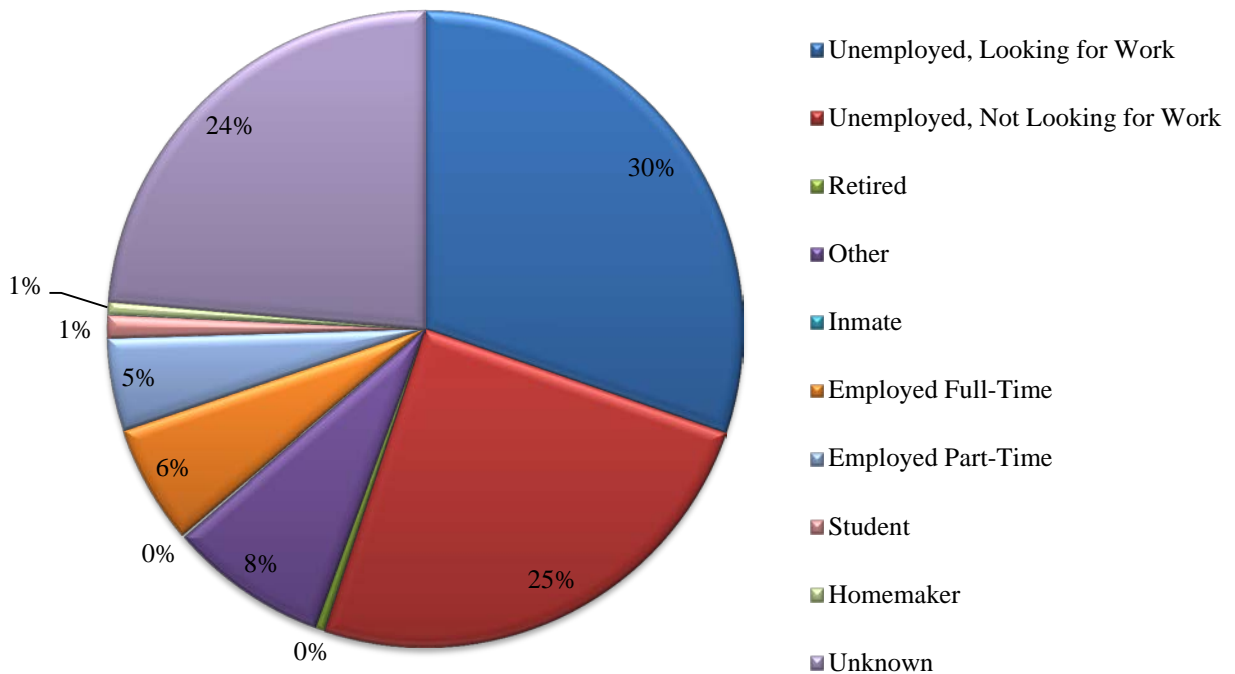


2011 Detainees with a History of Mental Illness at CCDC by Employment Status

The majority of 2011 CCDC detainees who had been diagnosed with mental illness were unemployed. Of those, 30.3 percent were looking for work, while 24.8 percent were not currently looking for work. For those employed (10.7 percent), those employed full-time slightly outnumbered those employed part-time. Students accounted for 1.2 percent of the population, homemakers 0.7 percent, and retirees 0.5 percent. The employment status of 8.0 percent was categorized as “other” and the employment status was unknown for 23.6 percent of the population.

Not including those for whom the employment status is not known, 72.2 percent of the detainee population with mental illness at CCDC was unemployed in 2011. This rate was more than five times the rate of statewide unemployment in mid-2011, which stood at 13.8 percent (YCharts, 2013).

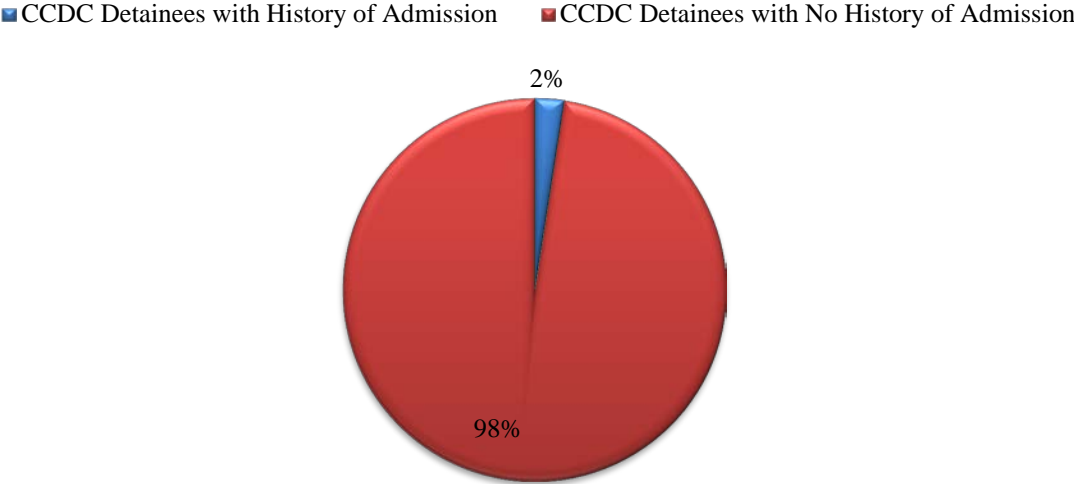
Figure 6. Detainees with a History of Mental Illness at CCDC by Employment Status, 2011



Prevalence of CCDC Detention and MHDS Psychiatric Hospital Admission

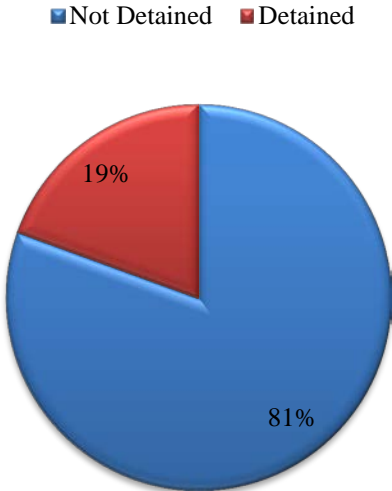
Of the 55,482 individuals detained by CCDC in 2011, 1,358 had been admitted to an MHDS psychiatric hospital at some point in their lives and accounted for 2.4 percent of the total detainees.

Figure 7. 2011 CCDC Detainees with a History of Admission to an MHDS Psychiatric Hospital



Out of a total of 2,486 individuals admitted to an MHDS psychiatric hospital in 2011, 484, or 19.5 percent, were also detained by CCDC in the same calendar year.

Figure 8. Prevalence of Clients Admitted to an MHDS Hospital and Detained at CCDC, 2011

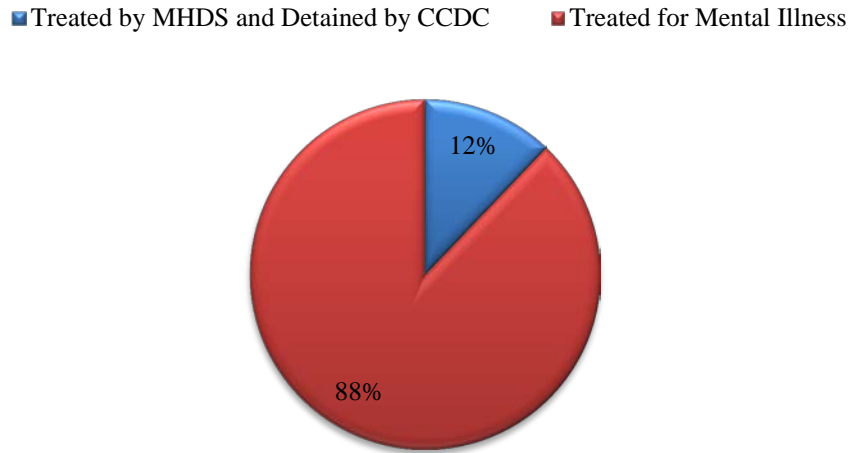


Individuals with a History of Mental Illness and Multiple Detainments at CCDC in 2011

In 2011, 17,668 clients were treated for mental illness by MHDS agencies. Of this number, 2,139 individuals were also detained at CCDC in 2011. In total, 12.1 percent of clients served by

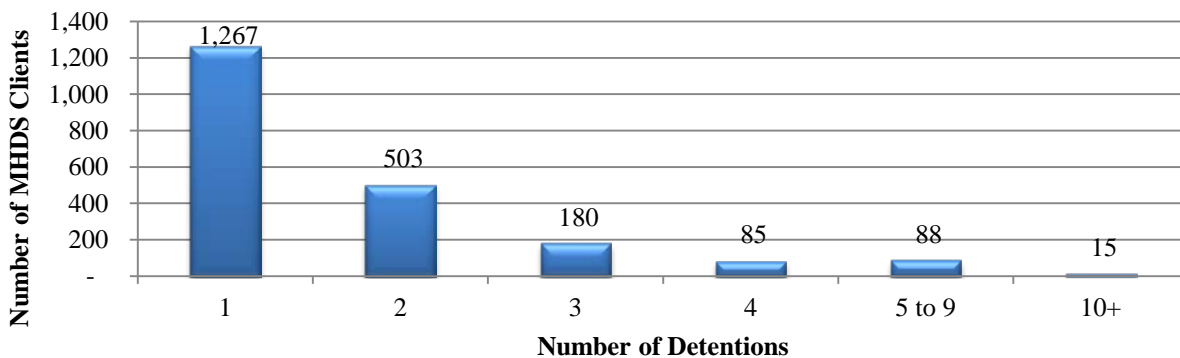
MHDS were also incarcerated at CCDC. The imprisonment rate for the nation, in contrast, was 500 per 100,000 U.S. residents in 2010 and accounted for just 0.5 percent of the total U.S. population (Guerino, Harrison, & Sabol, 2011).

Figure 9. Prevalence of MHDS Clients Detained by CCDC, 2011



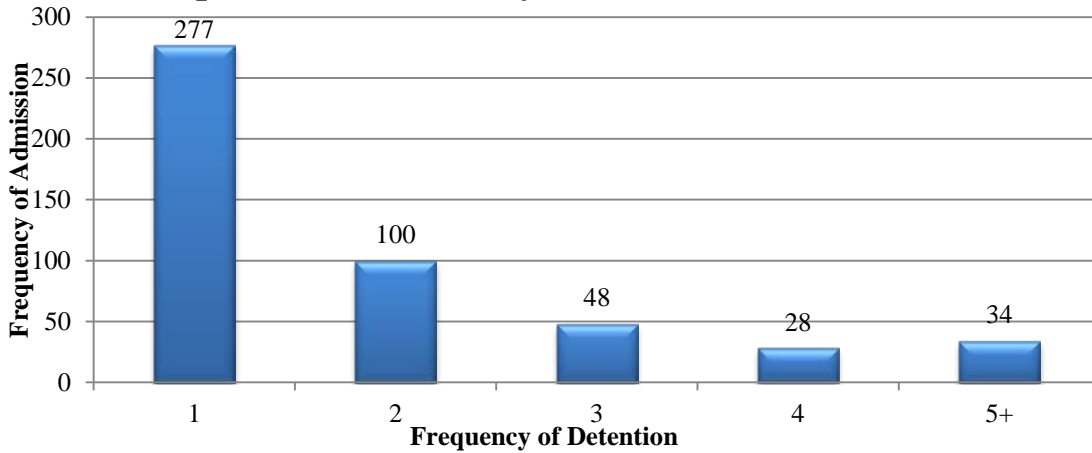
In 2011, 2,139 users of MHDS outpatient services were also detained at CCDC during the same year. Of those MHDS clients who were detained at CCDC, 40.7 percent were detained on at least two occasions with 23.5 percent being detained twice, 8.4 percent detained three times, 4.0 percent detained four times, and 4.8 percent detained on five or more occasions.

Figure 10. 2011 Users of MHDS Outpatient Services Who Were Detained by CCDC by Number of Detentions



Of the total 2011 MHDS admissions, 48 patients were also detained at CCDC at least once in 2011. Within this group, 43.4 percent were detained at least twice, with 9.9 percent having been detained thrice, 5.8 percent were detained four times, and 7.0 percent were detained on five or more occasions.

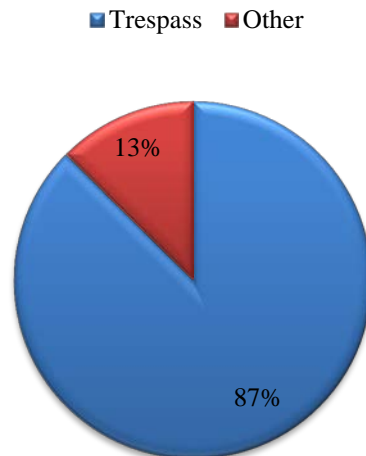
Figure 11. Individuals Who Were Both Admitted to a Hospital and Detained by CCDC at Least Once in 2011



Most Common Charges Against Clients Admitted to an MHDS Psychiatric Hospital and Detained at CCDC in 2011

Among individuals who were both admitted to an MHDS psychiatric hospital and detained at CCDC in 2011, the most common criminal charge was trespassing, which accounted for 87.4 percent of all charges. Within the population of interest, 1.6 percent was charged with defrauding an innkeeper, 1.4 percent with battery, and 1.1 percent with domestic violence. Accounting for less than one percent of the charges in rank order were jaywalking, disorderly conduct, burglary, and obstructing a public officer. All other charges accounted for 6.4 percent of all charges.

Figure 12. Charges Against Those with Multiple Admissions and Detentions in 2011



Relationship Between Number of Hospitalizations/Clinic Visits and Number of Detentions

Analyses were performed to determine whether or not correlations existed between the number of hospital admissions and number of detentions at CCDC, as well as, between the number of outpatient clinic visits and number of detentions at CCDC. Spearman's Rank Correlations for non-parametric data were run using SPSS9.0 for both data sets. The Spearman's rho revealed a statistically significant, though somewhat weak relationship between number of MHDS hospital admissions in 2011 and number of detentions at CCDC in the same year ($r_s[487] = .095, p < .05$) and a statistically significant, but weak relationship between number of MHDS outpatient visits in 2011 and number of 2011 detentions at CCDC ($r_s[2138] = .059, p < .01$).

These data can indicate that as the number of admissions or clinic visits increase, so do the number of CCDC detentions. Those persons with a high frequency of clinic visits, therefore, are in many cases the same individuals who are being frequently detained. It may be that this population would be better served by redirection to the outpatient clinics in an effort to support medication compliance, continuity of care, and provision of support services, rather than detaining them in the legal system, in which psychiatric care is not optimal. In addition, those MHDS clients who have a high frequency of detention for minor, non-violent offenses may benefit from more intensive, and less costly, case management services in lieu of repeated arrests.

Las Vegas Metropolitan Police Department Usage of Legal 2000, 72-Hour Legal Hold

In 2011, 5,989 72-hour legal holds, known more commonly as "Legal 2000s," were initiated by the Las Vegas Metropolitan Police Department (F. Castle, personal communication, March 12, 2013). This number increased slightly in 2012 to 6,185 Legal 2000s (F. Castle, personal communication, March 12, 2013). Included in these totals are a number of persons who were "legaled" on two or more occasions in the same calendar year and 248 individuals who were "legaled" from CCDC in 2012 (J. Gerson, personal communication, March 12, 2013). The number of Legal 2000s from CCDC for 2011 was not available. As noted above, 5,703 individuals with a history of mental illness were detained at CCDC in 2011. It may be that a number of these individuals could have been placed on a legal hold or routed to an outpatient clinic, rather than charged with a crime. While hospitalization may be more expensive on a day-to-day basis, a shorter stay in the hospital may be more cost-effective in the long run and would also be beneficial to the individuals in terms of level of care. More research into the routing of mentally ill individuals in Clark County should be undertaken in order to determine if current routing procedures lead to optimum health outcomes and cost savings or if more officer training in dealing with the mentally ill population is warranted.

Technical Notes

Several limitations must be considered in the evaluation of the above data. The prevalence of mental illness at CCDC is measured by cross-matching data with those who accessed MHDS services. This *does not* account for those individuals who sought out private services and this

may result in an underrepresentation of the actual prevalence of mental illness among detainees at CCDC.

Misclassification issues present another limitation for this study. In some cases, prevalence rates total over 100 percent. While this is a common problem as a result of rounding issues, it is further compounded in this study and has resulted in totals of over 100 percent, with at least one case as high as 101.5 percent. This may be due to misclassification of categorical variables, wherein one person may have been classified as Asian during one detainment and White at another.

It is possible that some of the persons included in the data are not currently experiencing severe acute mental illness issues. Much of the data includes individuals who have accessed MHDS services in the past, but may not be current utilizers of mental health services and may not be correctly classified as mentally ill. Care was taken to identify these persons as having a history of mental illness in order to avoid potential misclassification.

Prevalence rates are strictly based on detentions at CCDC. It is quite possible that MHDS clients were detained at prisons/jails other than CCDC and that the actual prevalence of incarceration among this population may be higher. Further studies on incarceration statewide are recommended and may provide a fuller picture of the true prevalence of incarceration for this population.

Recommendations

As stated above, this study would be strengthened by evaluating data from jails and prisons statewide. However, this study does shed light on the problem of criminalizing mental illness. Given that 87.4 percent of this population is charged with the relatively minor offense of trespassing, more appropriate care may be provided by redirecting those with mental illness to outpatient psychiatric care at one of the MHDS outpatient clinics. This may also present a more cost-effective alternative to the expense of incarceration.

According to a report prepared in 2001 by the Bureau of Justice Statistics, the annual operating costs per prisoner in Nevada were \$48.14 per day. A more recent estimate provided by the Las Vegas Metropolitan Police Department was \$144 per day. The cost of detaining a mentally ill individual is likely to be higher on average, given the clinical care required and the cost of medication. In comparison, the cost of admission to the Rawson Neal Psychiatric Hospital (MHDS facility) in Las Vegas was \$656.10 for the Fiscal Year 2012 (L. Espinoza, personal communication, March 15, 2013). It is obvious given the cost disparity that there is a financial incentive for the criminalization of mental illness. However, the cost of one visit to an outpatient medication clinic at Southern Nevada Adult Mental Health Services was only \$166.54 for the Fiscal Year 2012 (L. Espinoza, personal communication, March 15, 2013). In less than two days at the average incarceration costs, the cost of an outpatient clinic visit is covered, which makes the outpatient care option both more cost-effective and allows for more appropriate psychiatric care for the individual.

A study, conducted by the VERA Institute of Justice, found that states spent an average of \$76.03 per inmate per day in 2010 (Subramanian & Tublitz, 2012). The same study also found

that Nevada state spending on prison expenditures had increased by 9.39 percent during the period from 2006 to 2010, in spite of a 3.2 percent reduction between 2009 and 2010 (Subramanian & Tublitz, 2012). Redirection of mentally ill individuals to more appropriate outpatient care may also present a viable option to help ease the burden of rising prison expenditures in the state of Nevada

For those mentally ill individuals who are not rerouted to proper services and become incarcerated, it may be beneficial to provide transition services to outpatient care and case management services upon release from jail/prison as a preventive measure against recidivism. Furthermore, it may be of benefit to consider the reasons this population is being detained on multiple occasions in order to lower the number of detainments and increase access to mental health services for these individuals. It may also be advisable to focus on certain overrepresented populations within the mentally ill population detained at CCDC. For example, males, African Americans, persons between 25 and 44, those of lower educational attainment, and the unemployed are all overrepresented and intervention methods aimed at these high risk groups may lead to reductions in incarceration. There are a number of viable options that ought to be considered in efforts to reduce rates of incarceration and recidivism and in the redirection of mentally ill individuals to more appropriate services.

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