

Prevalence of Mental Illness in the Washoe County Criminal Justice System

Introduction

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.

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. 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% 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 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.

It is estimated that between 5% and 20% 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% 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 persons with mental illness. 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.

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 and ongoing case management and participation of mental health experts
- Full involvement, from the very beginning, of agencies such as the behavioral and public health, mental health facilities, substance abuse treatment programs, and criminal justice agencies
- Holding regular meetings of key personnel from the 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 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 treatment upon release

There is an increase in the number 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 an opportunity to improve the efficiency and effectiveness of treating tens of thousands of persons who suffer mental illness, and who may become involved in the criminal justice system.

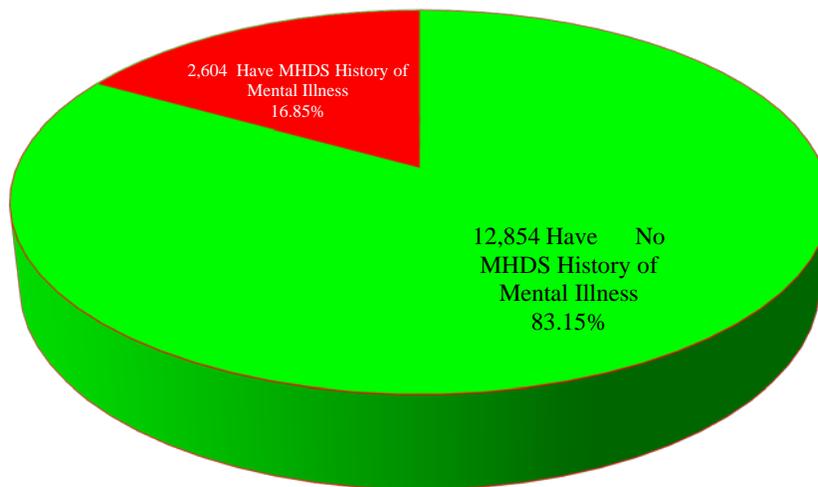
Currently there are no established standards to determine why mentally ill individuals are disproportionately represented in the criminal justice system and whether such high rates of detainment are the direct result of their illness.

Descriptive Analysis

Mental health and criminal justice data available from 2011 was cross-matched and analyzed at the Nevada State Health Division in order to assess prevalence of mental illness in the criminal justice system. Frequencies, rates, and patterns of detention of mentally ill individuals at the Washoe County Jail were thoroughly evaluated and compared to findings related to inpatient (admission/readmission) and outpatient care provided by the Division of Mental Health and Developmental Services. Categories of psychiatric diagnoses and levels of criminal charges were briefly described. Additionally, the effectiveness of Mental Health Court interventions was evaluated.

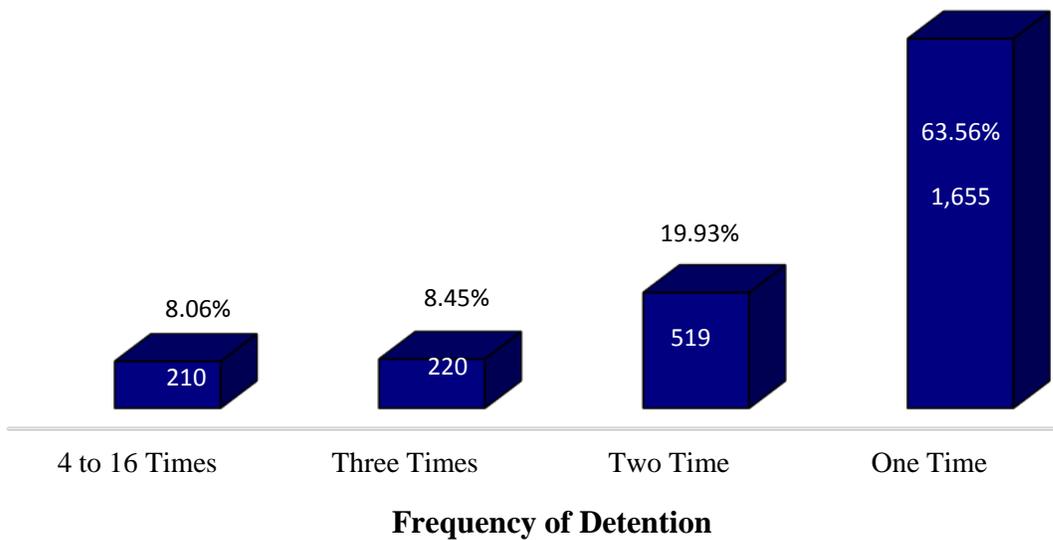
The number of mentally ill individuals involved with the criminal justice system and detained in jails and prisons continues to grow in Washoe County, Nevada and nationwide. This significant increase is attributed in most part to a severe lack in resources available for proper services and timely case-management for such unfortunate chronically ill individuals. In 2011, there were 15,458 individuals detained at least once at the Washoe County Jail, and of those, 2,604 had previously been served for a mental illness related problem. The prevalence of mental illness among persons admitted to Washoe County jails reached 16.85% percent in 2011, as illustrated in figure 1. It is also estimated that about 75% of these mentally ill individuals have a dual diagnosis or a co-occurring alcohol and/or drug use disorder.

Figure 1. Prevalence of Mental Illness in Washoe County Jail, Nevada 2011



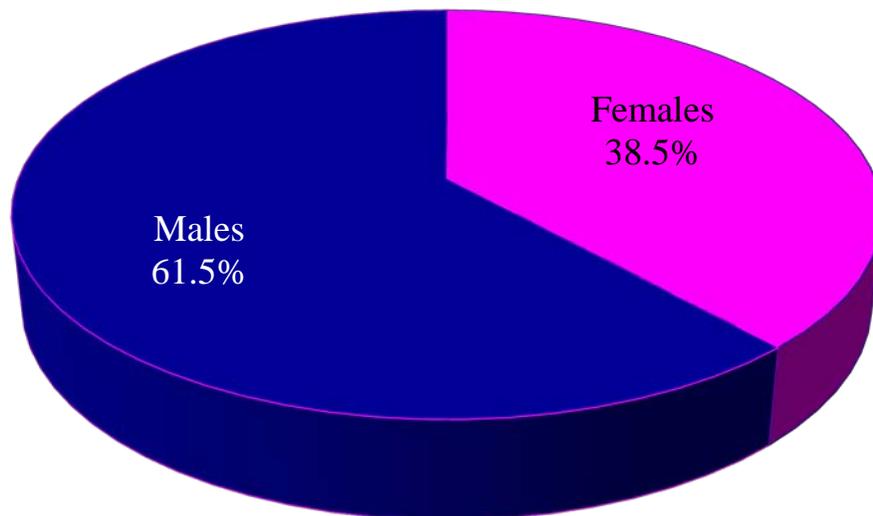
More than one-third of individuals (35.1%) with mental illness were repeatedly detained in Washoe County Jail in 2011. And, within a period of one year 210 individuals with mental illness were detained 4 to 16 times, 220 were detained three times, and 519 (about 1 in five) were detained twice in 2011 as illustrated in figure 2.

Figure 2. Individuals who Received Mental Health Services by Frequency of Detention at Washoe County Jail, Nevada 2011



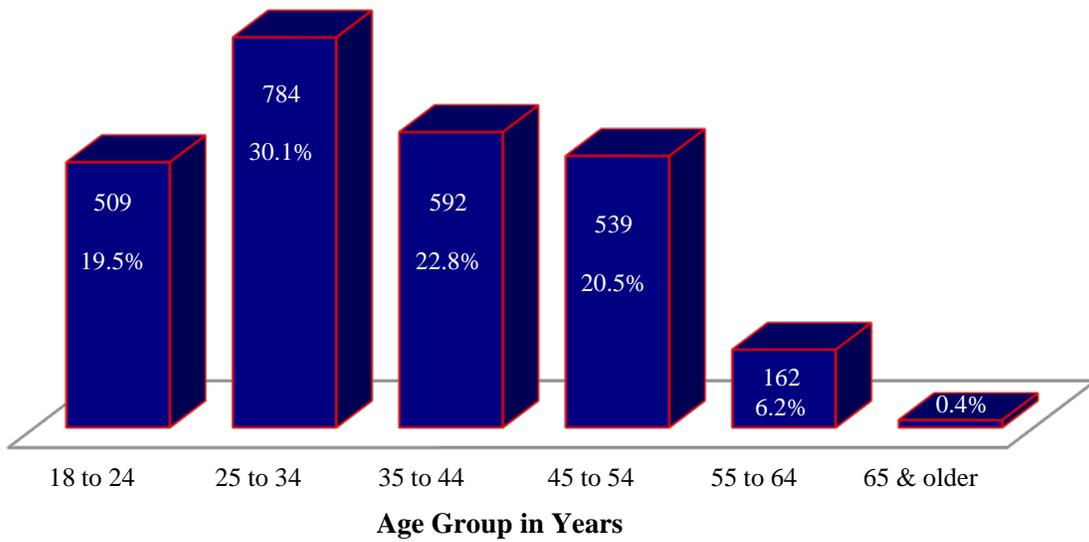
About two thirds of individuals with mental illness who were detained at least once in Washoe County Jail in 2011 were males as illustrated in figure 3.

Figure 3. Mentally Ill Individuals Detained at least once at Washoe County Jail by Gender - Nevada 2011



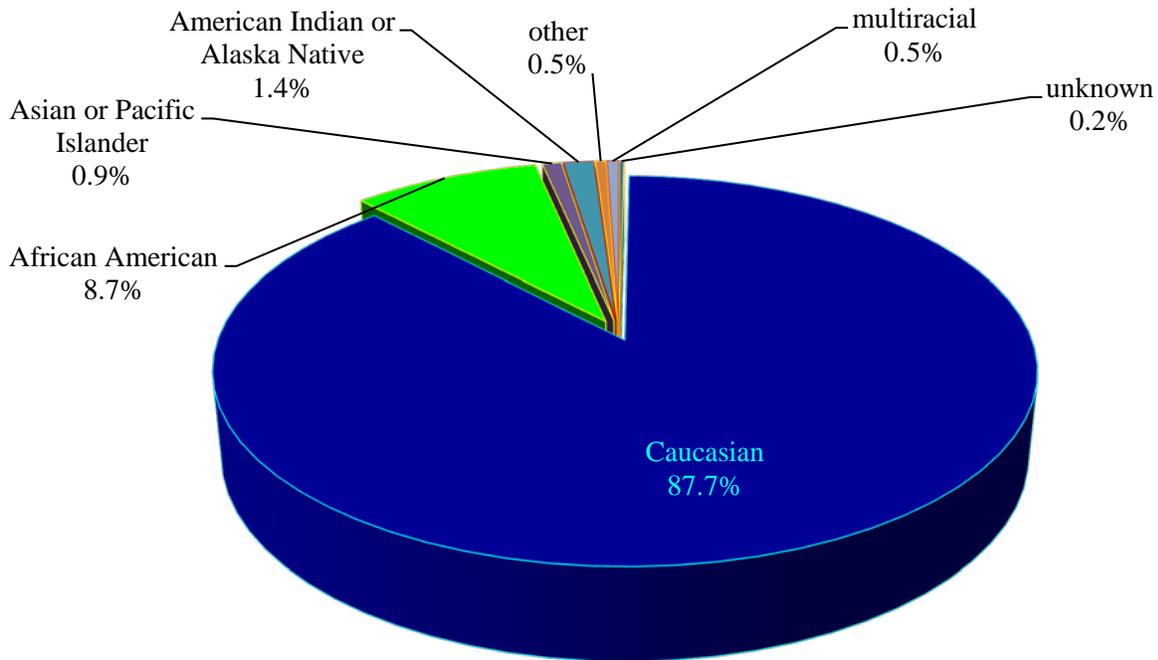
Age of mentally ill individuals detained at least once at the Washoe County Jail in 2011 ranged from 18 to 77 years with a median of 34. And, as illustrated in figure 4, among all age groups, those aged 25 to 34 years (784 mentally ill individuals) had the highest detention rate (30.1%).

Figure 4. Detention of Mentally Ill Individuals at Washoe County Jail by Age Group - Nevada 2011



The majority of mentally ill individuals who were detained at the Washoe County Jail in 2011 were Caucasian as illustrated in figure 5.

Figure 5. Detention of Mentally Ill Individuals at Washoe County Jail by Race, Nevada 2011

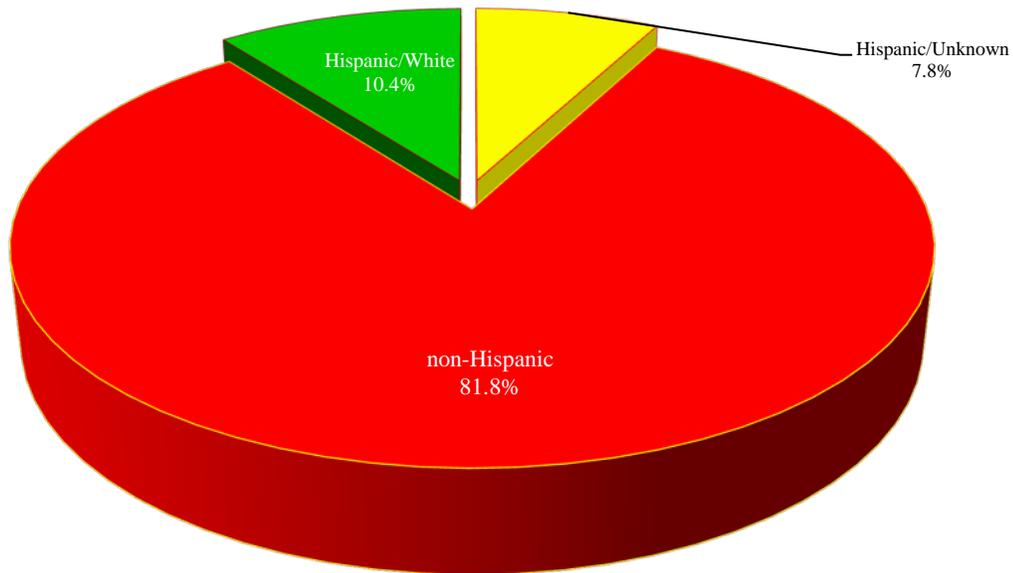


While the rate for mentally ill individuals among other racial minority groups was proportionate, similar to or comparable to overall rates in Washoe County, it is important to note that mentally ill Caucasian detainees

and mentally ill individuals of African American origin were over-represented in the Washoe County Jail. The rate of African American (8.7%) and Caucasian (87.7%) mentally ill detainees at the Washoe County Jail in 2011 significantly exceeded their overall rates in Washoe County, which are about 7% and 68% respectively.

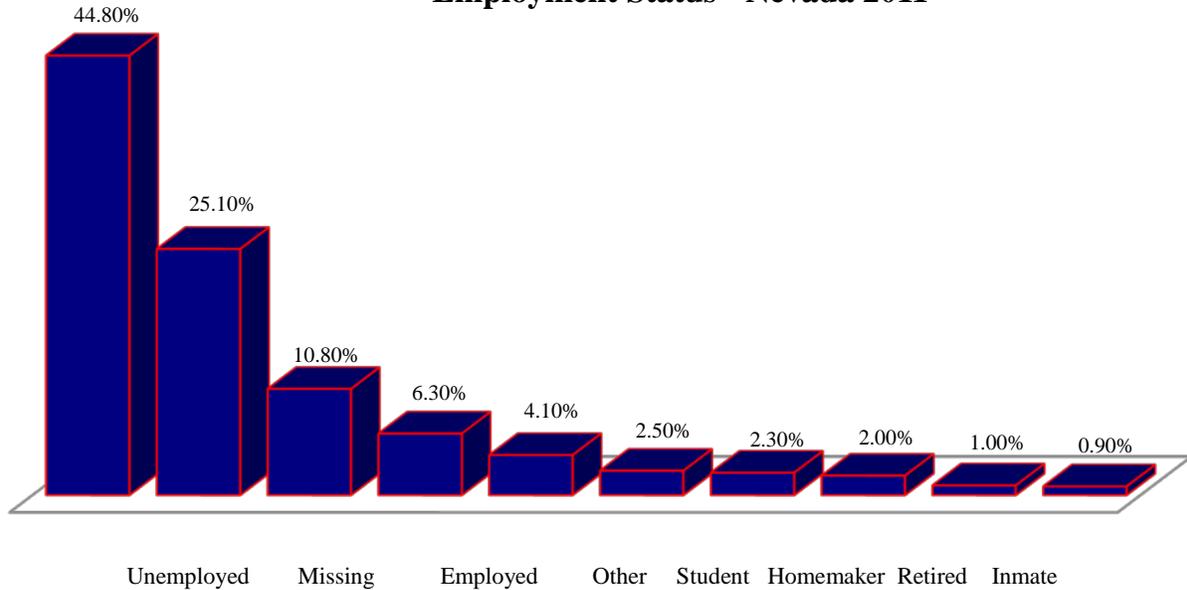
The percentage of mentally ill individuals of Hispanic origin who were detained at least once at the Washoe County Jail in 2011 was slightly lower than their overall rate in Washoe County. In 2011, 10.4% of mentally ill individuals detained in Washoe County Jail were Hispanic White, and 7.8% were Hispanics of unknown or undetermined racial origin. While about 25% of Washoe County residents are of Hispanic origin, a mere 18.2% of all mentally ill individuals detained at least once at the Washoe County Jail in 2011 were of Hispanic origin, as illustrated in Figure 6.

Figure 6. Detention of Mentally Ill Individuals at Washoe County Jail, Nevada 2011 by Ethnicity (all races)



As illustrated in figure 7, about half of mentally ill individuals detained at the Washoe County Jail in 2011 were unemployed seeking employment; one-quarter were unemployed and not seeking employment; 6.3% were full-time employed; and about 4.1% were part-time employed. Figure 7 also shows 2.3% as students; 2.0% as homemakers; 1% as retired; 0.1% as military; and 0.1% as inmates. Employment status was recorded as “unknown, other, or missing” for about 11% of the mentally ill detainees at the Washoe County Jail in 2011.

Figure 7. Mentally Ill Individuals Detained at Washoe County Jail by Employment Status - Nevada 2011



About one-fourth of individuals with mental illness detained at least once at the Washoe County Jail had a high school diploma; 17.0% had some college education; 16.9% had some general education; 4.6% had vocational school degrees; 2.4% had college degrees; and about 1.2% had graduate degrees, as illustrated in figure 8.

Figure 8. Mentally Ill Individuals Detained at Wahsoe County Jail by Education - Nevada 2011

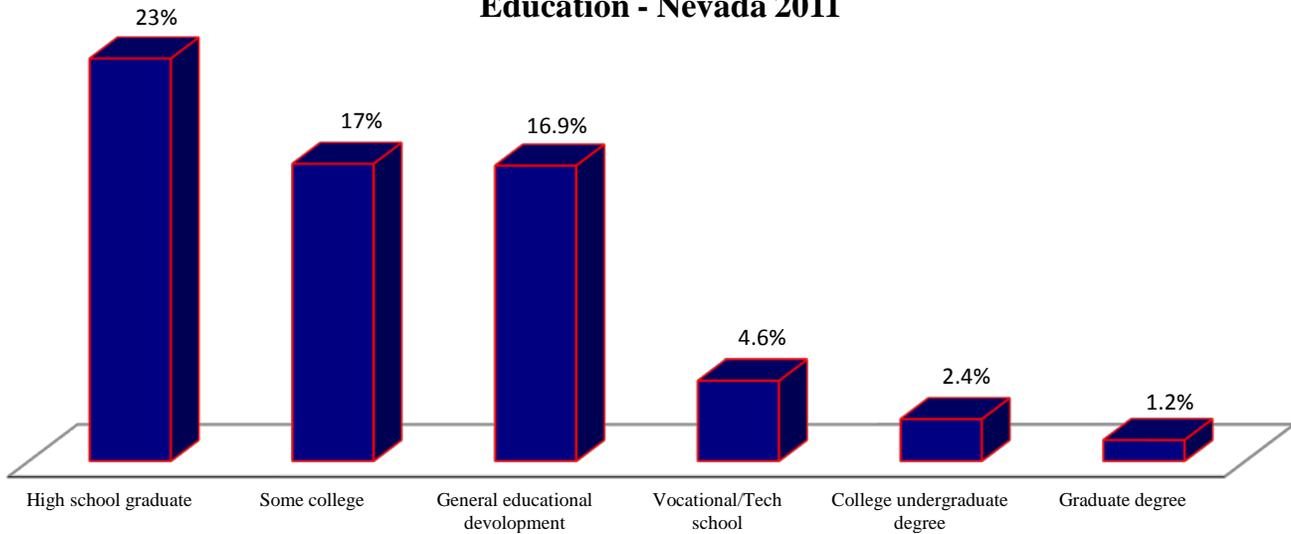
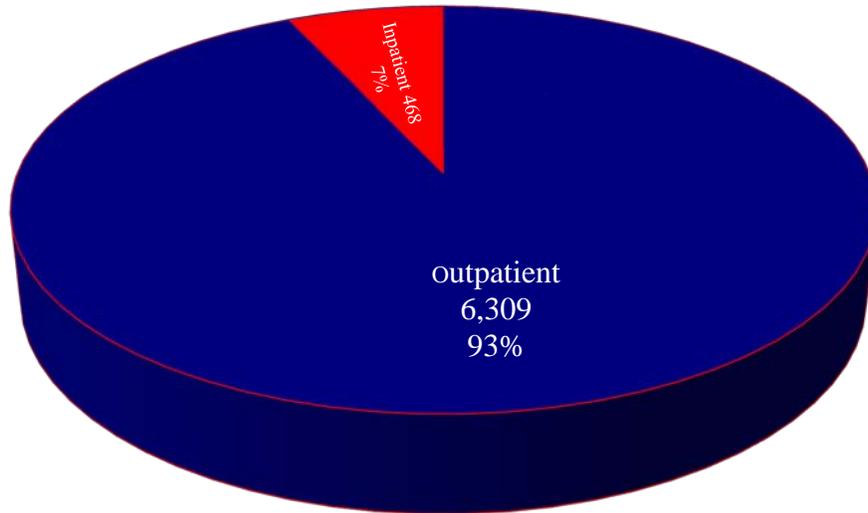


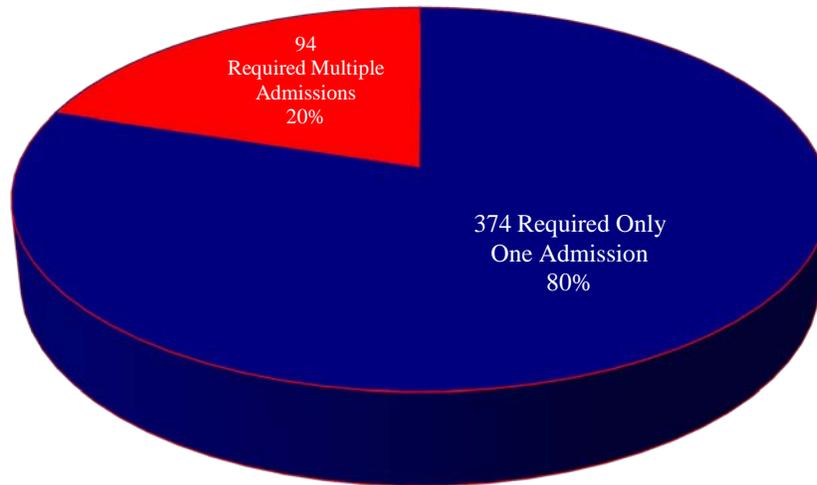
Figure 9 illustrates that there were 6,309 outpatient and 468 inpatients who received services at mental health facilities in 2011.

Figure 9. Mentally Ill Patients - Nevada 2011



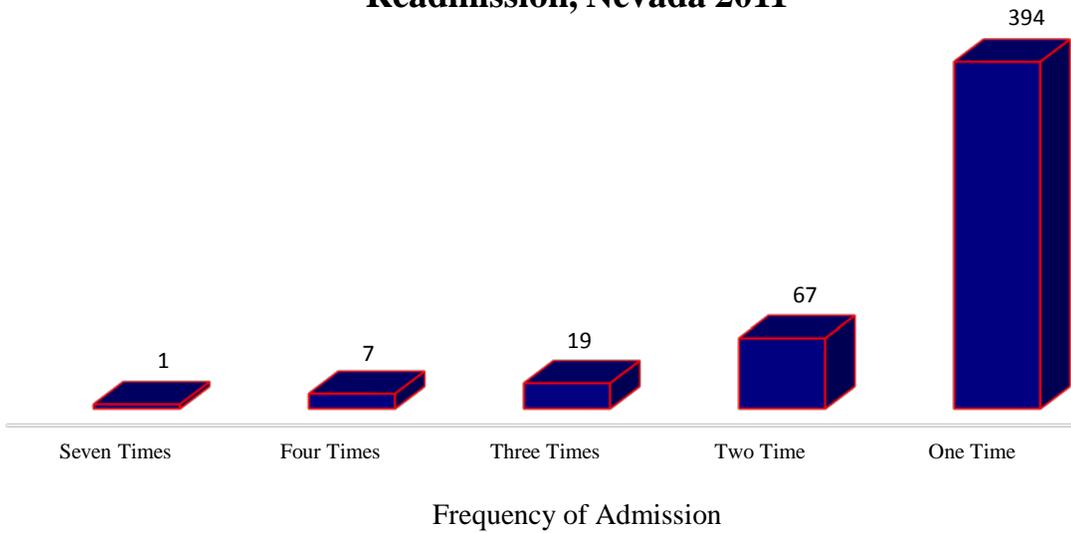
Hospital admission frequency ranged from one to seven times in 2011. One-fifth, 94 of the 468, of the mentally ill inpatient individuals required more than one admission for treatment in 2011 as illustrated in figures 10 to 15, and table 1.

Figure 10. Mentally Ill Inpatients who Required Multiple Hospital Admissions - Nevada 2011



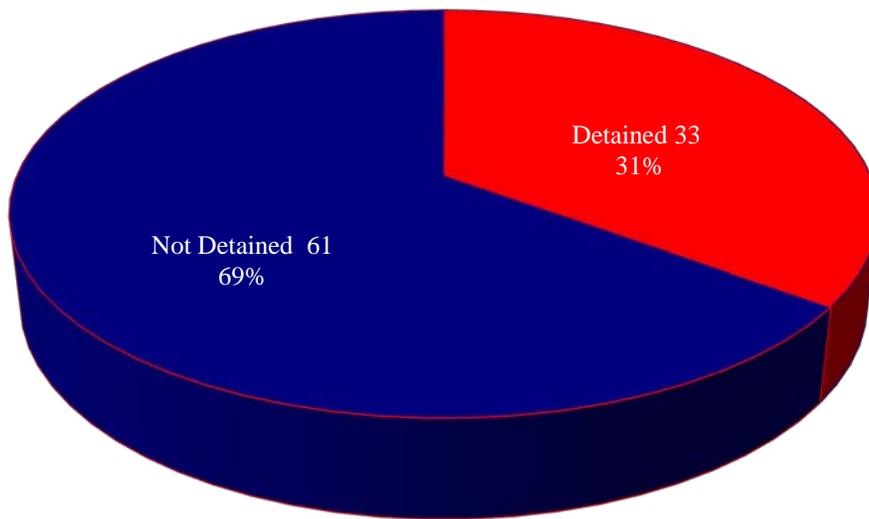
Of the 94 mentally ill individuals, one patient was admitted seven times; 7 patients were readmitted four times; 19 required three readmissions; and 67 required two readmissions, as illustrated in figure 11.

Figure 11. Mentally Ill Inpatients by Frequency of Hospital Readmission, Nevada 2011



Of the 94 mentally ill individuals who required two admissions or more, one-third was detained at least once at the Washoe County Jail in 2011 as illustrated in figure 12.

Figure 12. Mentally Ill Inpatients Detained at Washoe County Jail and Required Multiple Hospital Admissions - Nevada 2011



Of the 374 mentally ill inpatients who were admitted once to the hospital in 2011, about 17.9% were detained in Washoe County Jail as seen in figure13.

Figure 13. Mentally Ill Inpatients who were Detained at Washoe County Jail and Required One Hospital Admission - Nevada 2011

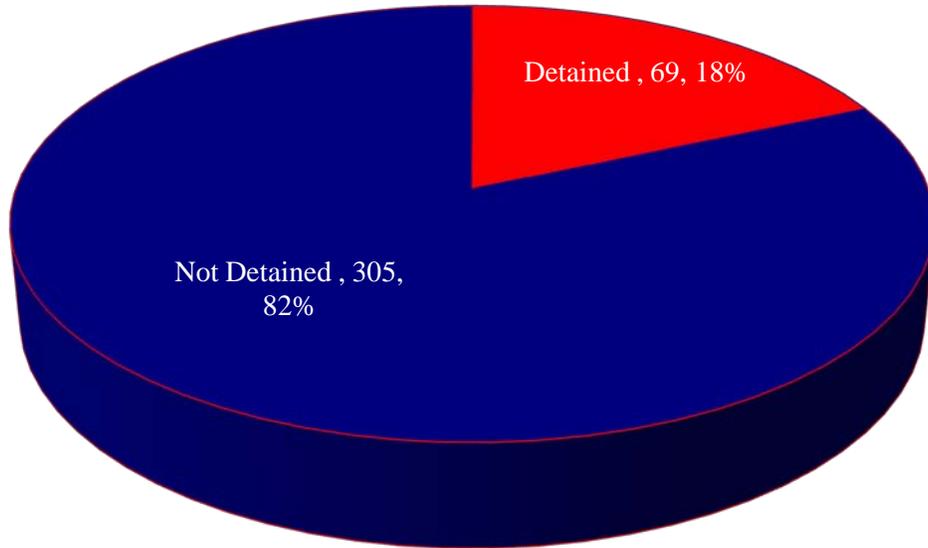
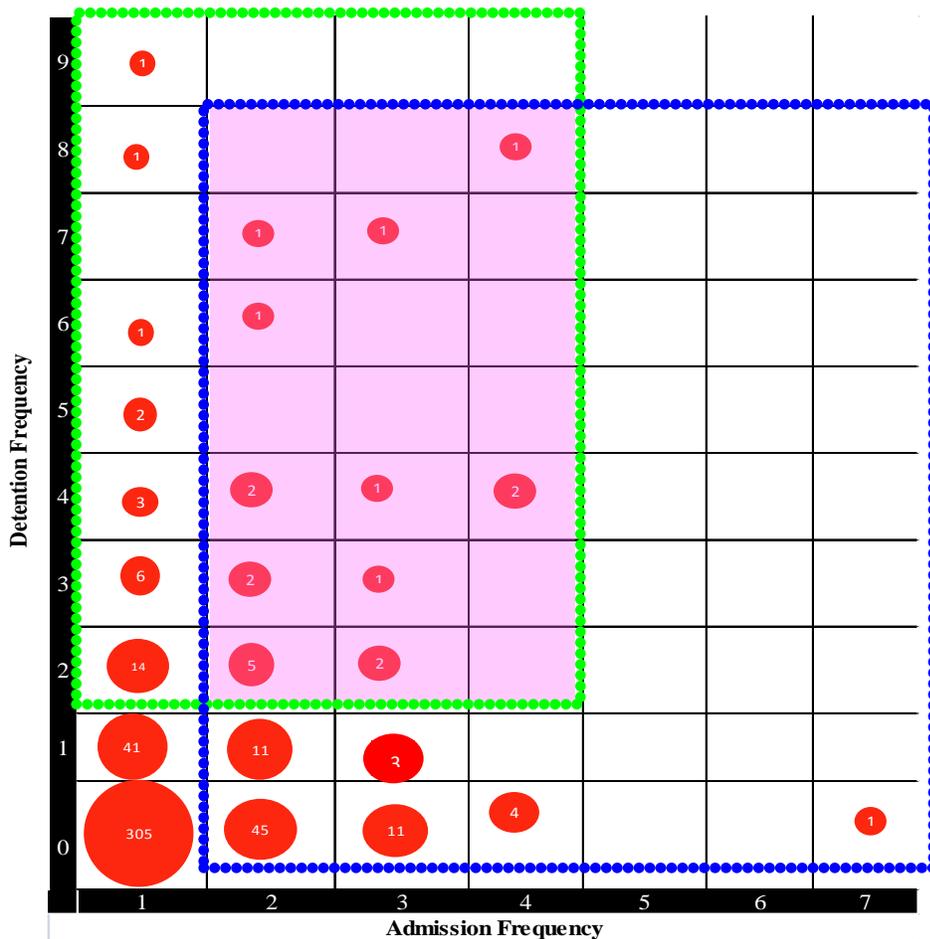


Figure 14.

Detention among Mentally Ill In-patients - Washoe County Jail, Nevada 2011



Blue Frame: 94 inpatients with multi admissions with or without detention

Green Frame: 47 inpatients with multi detention

Pink Area: 19 inpatients with multi admission & multi detentions

Of the 94 patients, 19 had multiple hospital admissions and multiple detentions at Washoe County Jail in 2011 as illustrated in figure 15.

Figure 15. Inpatients with Multiple Hospital Admissions and Detentions Washoe County Jail, Nevada 2011

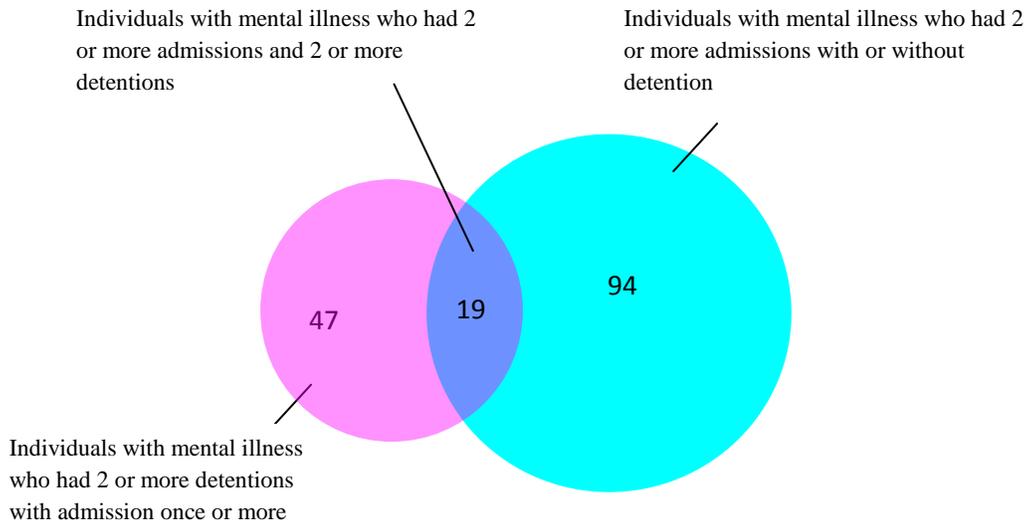


Table 1.

Admissions	Detentions	Total Patients
7	0	1
4	8	1
4	4	2
4	0	4
3	7	1
3	4	1
3	3	1
3	2	2
3	1	3
3	0	11
2	7	1
2	6	1
2	4	2
2	3	2
2	2	5
2	1	11
2	0	45
1	9	1
1	8	1
1	6	1
1	5	2
1	4	3
1	3	6
1	2	14
1	1	41
1	0	305

This significant rate of increased readmission correlated with a high rate of detention was probably related to insufficient case-management efforts and inadequate community resources to assist such high risk patients.

The 102 mentally ill inpatients who were detained once or more had a combined 217 detainments during 2011, with an average of about 2.21 detainments per patient, and a combined number of detainment days of 4,294 during 2011. The average number of detainment days per patient was 42 per year.

The frequency of hospital admission was similar or comparable to the frequency of jail detention in each of the following subgroups:

- Mentally ill patients with multiple admissions and multiple detentions
- Mentally ill patients with one admissions and multiple detentions
- Mentally ill patients with multiple admission with or without detention
- Mentally ill patients with one admission and one detention
- Mentally ill patients with one admission and no detention

The similarity in frequencies observed in both interventions is probably the result of a general tendency to utilize jail detention and/or hospital admission in an interchangeable manner. Nevertheless, it is important to emphasize that jails are not healthcare facilities, and are not ideal sites for treating patients regardless of the disease nature. While detentions are maybe perceived as a quick fix or temporary solution that can immediately address the problem, it is certainly not an ideal solution since it does not address or treat the chronic disease itself, which is mental illness. Detaining individuals with chronic mental illness is very costly and not effective, and it may delay or reduce the opportunity to obtain optimal outcomes that ultimately provide long-lasting solutions that could improve the quality of life for patients, their families and the community as a whole.

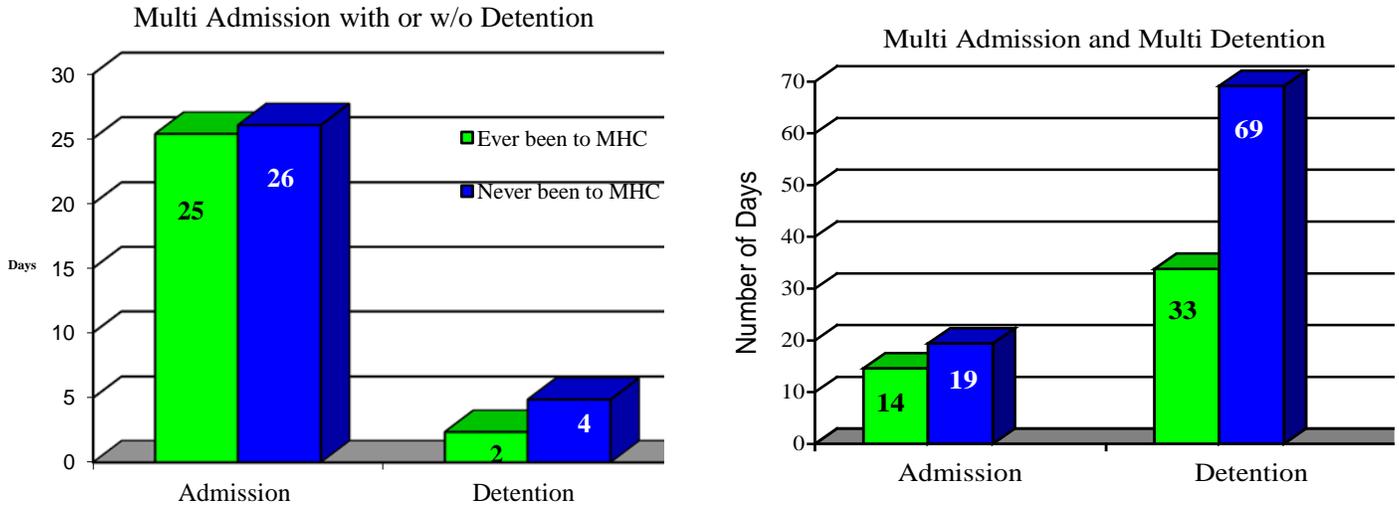
Only 51 out of 468 or 10.89% of all mentally ill inpatients were seen at the Mental Health Court in Northern Nevada during 2011. Data analysis of subgroups of mentally ill patients among the 94 with a history of multiple admission with or without multiple detention showed that mentally ill patients who ever been at the Mental Health Court exhibited significantly lower average/rate of admission days to hospital and lower detention days at the Washoe County Jail.

The average number of admission days for mentally ill patients who had multiple admissions with or without detention who were not seen at the Mental Health Court was 26 days and their average number of detention was 4 days. On the other hand the average number of admission days for mentally ill patients with multiple admissions with or without detention who were seen at the Mental Health Court was 25 days and their average number of detention was 2 days in 2011 as it is illustrated in figure 16a.

The average number of admission days for each of the 14 mentally ill patients with multiple admissions and multiple detentions who were not seen at the Mental Health Court was 19 days and their average number of detention days was 69 days. On the other hand the average number of admission days for each of the 5 mentally ill patients who were seen at the Mental Health Court was 14 days and their average number of detention days was 19 days in 2011 as it is illustrated in figure 16b.

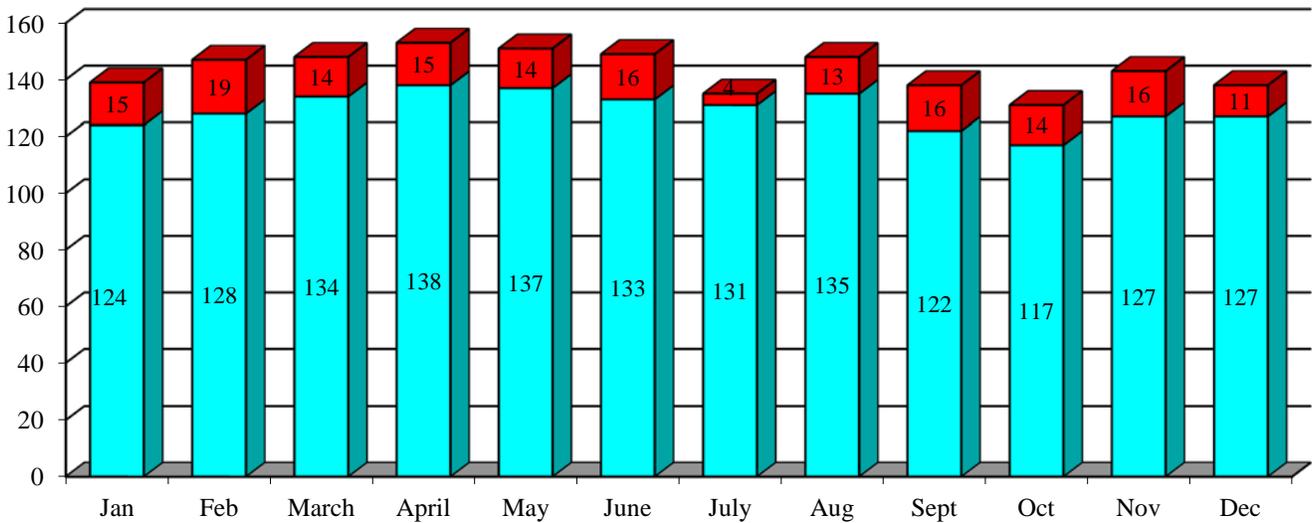
Mental Health Court interventions were effective in reducing the number of detention days. Additionally, the outcome of the court decisions resulted in a slight reduction in the admission days for mentally ill patients who were seen at the court in 2011.

Figure 16a and 16b - Average Days of Admission and Detention among Mentally Ill Patients who were Seen at the Mental Health Court - Northern Nevada 2011



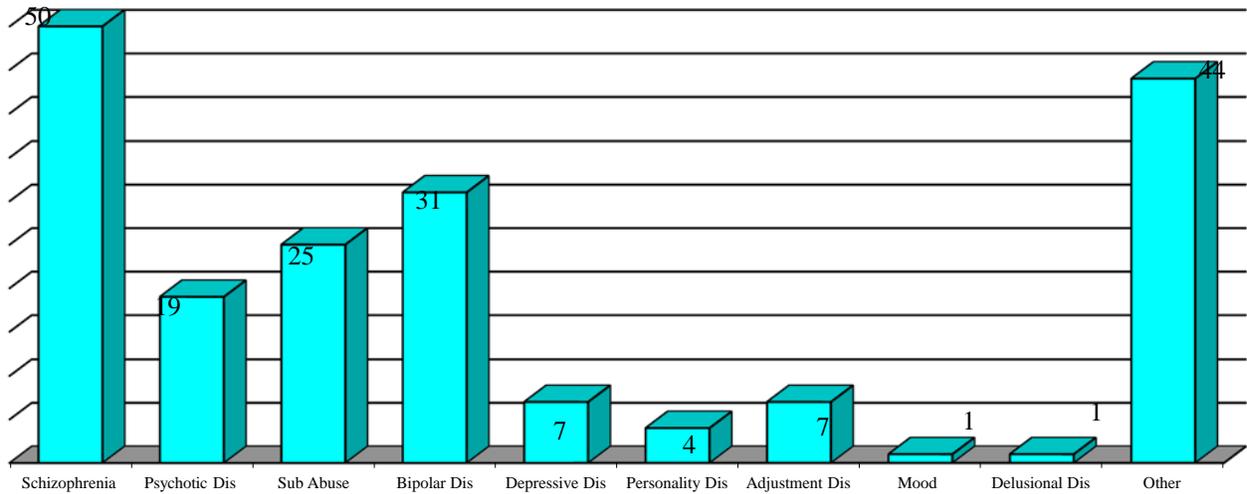
Of the 1,706 the Northern Nevada Adult Mental Health Services (NNAMHS) patients seen in 2011 at the Mental Health Court, 167 (9.8%) were referred for admission, as illustrated in figure 17. Such interventions could be very cost-effective in that patients with mental illness were properly referred to mental health facilities that are capable of providing appropriate treatment and needed case-management.

Figure 17. NNAMHS Patients seen at Mental Health Court - Nevada 2011



The most frequent diagnosis among NNAMHS patients who required multiple admissions during 2011 was schizophrenia/schizophreniform disorders. This was followed by bipolar disorder, substance abuse, psychotic, depressive and personality disorders as illustrated in figure 18. A sizable number of patients exhibited more than one psychiatric disorder, especially those with co-occurrence of mental health disorder and substance abuse.

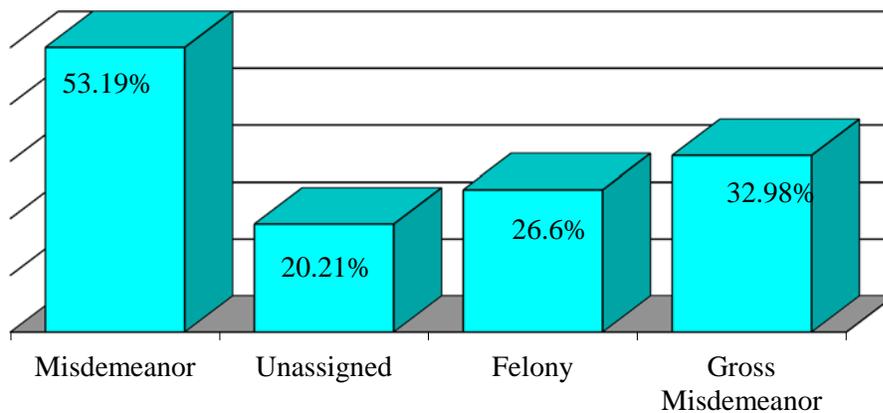
Figure 18 Diagnosis among NNAMS Patients with Multiple Admission Nevada 2011



n = 94

Data analysis of the NNAMHS demonstrated that the majority of crimes committed by mentally ill individual patients were not violent in nature. The most frequent charge among a subgroup of NNAMHS patients who had a history of multiple hospitalizations - with or without detention - was at the level of misdemeanor, followed by gross misdemeanor, and felony as illustrated in figure 19.

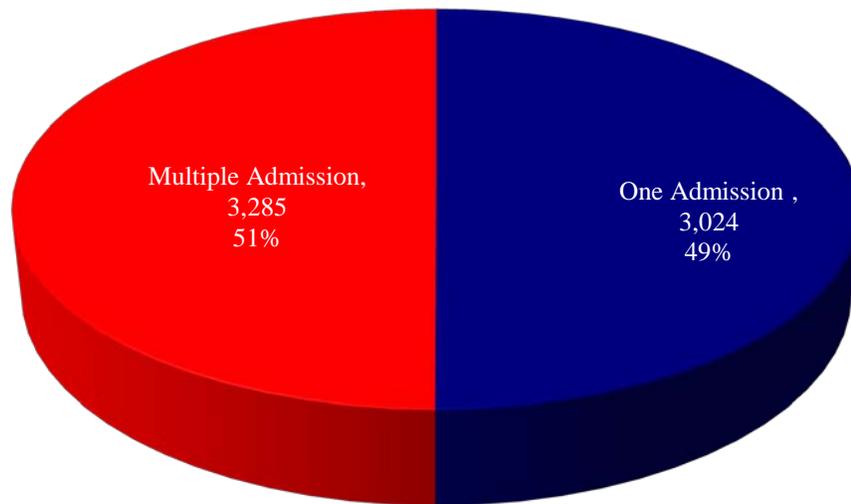
Figure 19. Charges among NNAMHS Patients with Multiple Admission Nevada 2011*



* Some of the NNAMHS patients may have more than one charge

The frequency of outpatient clinic visits ranged from one to 22 times in 2011, with a median of 14 visits per year. A little more than a half of all 6,309 mentally ill patients who visited the outpatient clinic in 2011 required multiple visits as illustrated in figure 20.

Figure 20. Mentally Ill Outpatients who Required Multiple Clinic Visits, Nevada 2011



Of all mentally ill patients who visited the outpatient clinic multiple times in 2011, 11.27% visited the clinic 8 to 22 times, 9.96% were seen 5 to 7 times, 10.21% of the outpatients were seen 4 times, 23.16% required 3 outpatient clinic visits, and 45.41% of all those who visited the outpatient clinic in 2011 were seen 2 times, as illustrated in figure 21.

Figure 21. Mentally Ill Outpatients by Frequency of Clinic Visits, Nevada 2011

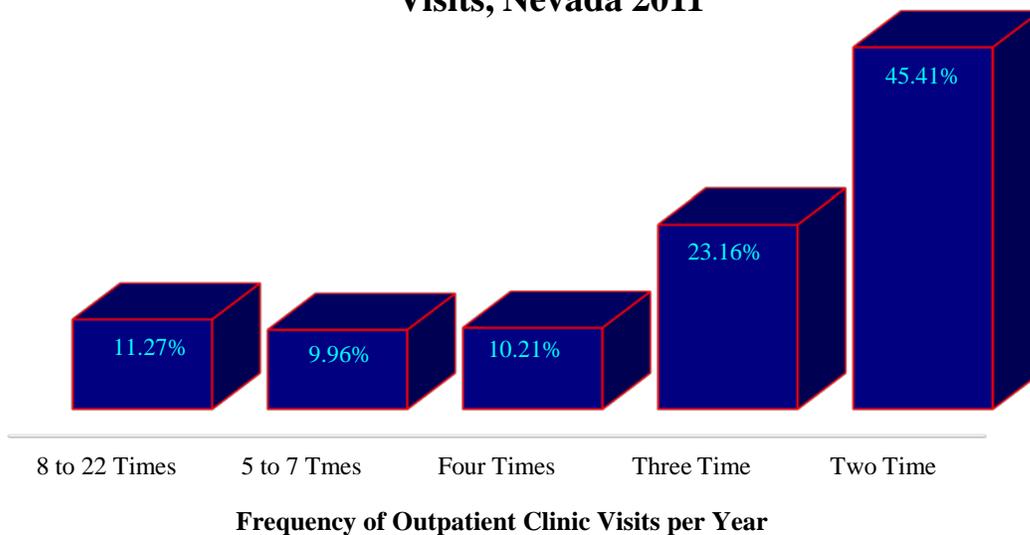
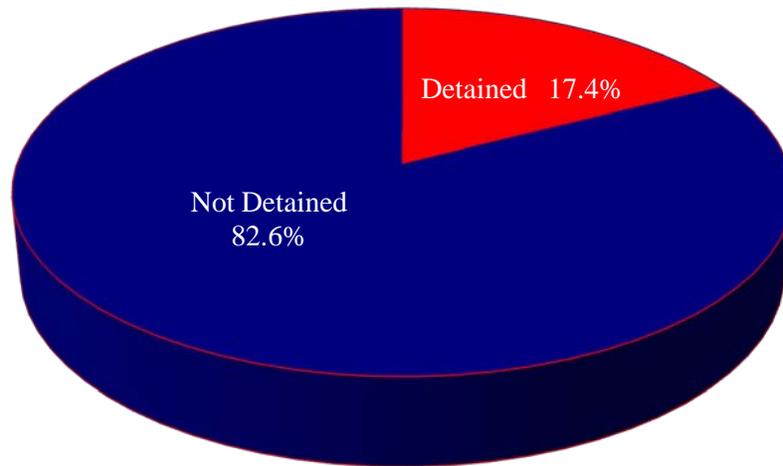
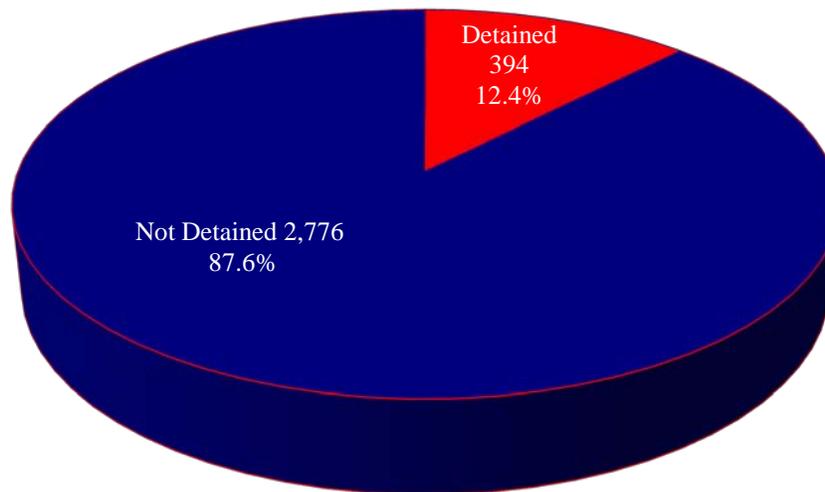


Figure 22. Mentally Ill Outpatients who Required Multiple Outpatient Clinic Visits and Were Detained at Washoe County Jail , Nevada 2011



Of the mentally ill patients who required at least two outpatient clinic visits, 17.4% were detained at least once at the Washoe County Jail in 2011 as illustrated in figure 22. And, of the mentally ill patients who were seen at the outpatient clinic only once in 2011, about 12.4% were detained in Washoe County Jail as seen in figure 23.

Figure 23. Mentally Ill Outpatients who Were Seen Once at the Outpatient Clinic and Detained at Least Once at the Washoe County Jail, Nevada 2011



Mentally ill patients who visited the outpatient clinic twice or more in 2011 seemed to have had a slightly higher rate of detention than those who visited the outpatient clinic only once in 2011. However, that difference was statistically insignificant.

Conclusion

In the United States, persons with mental illness are overrepresented in the criminal justice system. Additionally, persons in the U.S. with serious mental illness die 25 years earlier than persons in the general population, and those with a dual diagnosis of mental illness and substance abuse on average die nearly 32 years earlier than their fellow citizens outside of the public mental health system. Even individuals in the general population who self-identify as having a mental illness die nearly 9 years sooner than those who do not self-identify. To reverse the alarming trend of this major public health problem, aggressive national and state plans are needed to address this large segment of our society.

Technical Note

- Limited data sets consist of one year (2011) from Washoe County Jail and several years from the Nevada State Division of Mental Health and Direct Services were used
- Probabilistic data set matching was based on limited number of variables including social security and date of birth
- Figures and rates in this report are subject to change as recent and more complete data sets becomes available