

PROSECUTOR AS “Nurse Ratched”?

Misusing Criminal Justice as Alternative Medicine

By Gerald E. Nora

Too often today prosecutors are the new gatekeepers of our nation’s primary system for inpatient mental health care. When asked, “What are the nation’s three largest psychiatric facilities?” they know the answer: Los Angeles County Jail, Riker’s Island, and Cook County Jail.

Typically prosecutors undertake one of two roles with mental health issues. There is the traditional role as the “skeptical advocate”—one who contests forensic issues of competency, sanity, guilty but mentally ill, and factors in sentence mitigation. But some prosecutors are now accepting the new role as a “diversionary gatekeeper,” using mental health treatment programs as alternatives to criminal charges or traditional sentencing. Neither of these roles is sufficient to implement the prosecutor’s duty to promote a just society. Prosecutors must go beyond these roles and address a larger injustice that makes both our mental health and criminal justice systems a scandal. They must reverse their point of view and recognize that the criminal justice system is a general diversion mechanism for the mental health system.

Criminal justice as alternative medicine

In the wake of exposés in the 1950s and ’60s that related the horrible conditions in the nation’s mental hospitals, John F. Kennedy in 1961 urged more humane care of the

mentally ill, with comprehensive strategies that complemented inpatient care with outpatient treatment facilities, including halfway homes. Budgetary concerns thwarted the implementation of most of this vision; deinstitutionalization was radically implemented, but outpatient care was neglected. Civil libertarians accelerated this development with legislation in more than 40 states that seriously restricted the ability to involuntarily commit mentally ill patients. (*See sidebar, By the Numbers.*) Yet it would be incorrect to conclude that most of our new prisoner population should be in mental hospitals, or that those who should be in mental hospitals are now found in jail. The truth is more complex and cruel.

Multiple scientific studies that report consistent findings allow for generalizations about the different populations of criminal defendants and the seriously mentally ill, and how the populations overlap. In determining how many criminal defendants have serious mental illnesses, two problems encourage underreporting. First, many jails do not have the expertise and facilities to make an adequate diagnosis. Second, all jails will tend to limit their treatment and diagnosis to the most acutely ill and dysfunctional. They are not built to assess the functioning yet mentally ill inmate. Despite these limitations, the Bureau of Justice Statistics (BOJS) reported in 2006 that 7 to 9 percent of all jail inmates are medically diagnosed as suf-

fering serious mental illnesses. But these are only the prisoners who have been diagnosed. The study went on to state that, when asked, 45 percent of federal inmates, 56 percent of state inmates, and 64 percent of jail inmates report psychiatric symptoms. In 2000, a major policy paper for the National Institute of Justice reported a 1985 study showing that 15 percent of Philadelphia inmates had been previously diagnosed with either schizophrenia or bipolar disorder and a consistent finding by other researchers in 1998 that between 10 and 20 percent of all prisoners had serious mental illnesses. (Arthur Lurigio & James Swartz, *Changing the Countours of the Criminal Justice System to Meet the Needs of Persons With Serious Mental Illness*, POLICIES, PROCESSES AND DECISIONS OF THE CRIMINAL JUSTICE SYSTEM, NIJ 2000, at 67, 68.) Conservatively, then, more than 20 percent of all criminal defendants suffer from a serious mental illness, and nearly half of them have already been diagnosed.

There is as well a substantial, well-documented “co-morbidity” between drug abuse and mental illness, with the “co-morbidity” phenomenon also demonstrating that the drug war has been a significant factor in moving the mentally ill into the criminal justice system.

Drug addicts generally have a mental illness rate estimated between 25 and 50 percent; more than 90 percent of prison inmates addicted to alcohol or drugs are co-morbid for antisocial personality disorder, schizophrenia, or bipolar disorder. According to the Bureau of Justice Statistics, mentally ill state prisoners, including non-addicts, are 42 percent more likely than other inmates to have used illegal drugs in the month before their arrest.

An immediate implication of co-morbidity is that drug treatment programs are exercises in futility for many defendants until they are supplemented with effective mental health services. Another implication of co-morbidity is that many drug offenders are self-medicating their diseases. This raises the question: By providing these mentally ill offenders with mental health and drug treatment in jail, should we not be troubled by the fact that society rewards criminal conduct as the best means for finding a government treatment program? To the extent that the state reserves mental health interventions, including confinement, for active criminals, the law-abiding mentally ill are being unfairly repaid for their good behavior.

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Also, it is too easy to misapprehend the threats presented by the most dangerous offenders such as schizophrenics and bipolar disordered. Multiple studies cited in the BJS and NIJ reports indicate that these mentally ill individuals are four times as likely as the general population to be arrested for violent crimes, but they have the same arrest rates as the normal population when their illnesses are in remission. Simply put, 80 percent of violent crimes by schizophrenics and bipolar patients are committed while they are unmedicated and symptomatic.

This discloses a terrible consequence of our preference of prisons over mental hospitals. Innocent crime victims are paying for our cost savings.

It is clear that prosecutors must reevaluate the mental health issues in the criminal justice system. Fifty years ago, mentally ill patients feared their fates rested in the hands of some cruel character like Nurse Ratched in Ken Kesey's *One Flew Over the Cuckoo's Nest*. Now, many mentally ill patients are not admitted for treatment unless they commit a crime, and their admission charts are kept by prosecutors.

The prosecutor as “skeptical advocate”

Traditionally, the prosecutor has confronted mental health questions as forensic issues, not medical issues. Instead of being concerned with the symptoms and treatment modalities for bipolar disorder and paranoid schizophrenia, the prosecutor confronts legal issues of sanity, guilty but mentally ill, and factors in sentence mitigation.

Traditionally, it is the defense that puts the defendant's mental status at issue. Various privileges and privacy laws prevent the prosecutor from independently investigating the defendant's mental history, and the defendant's mental status will only act to mitigate, not enhance, culpability and punishment. Consequently, our rules consistently cast the prosecutor in the role of the skeptic, the party who attempts to undermine proof of mental illness. Other aspects of our system compound this situation. In the view of many prosecutors, mental health professionals (psychologists more than psychiatrists) share an unhappy resemblance to other social science expert witnesses. As Richard M. Weaver noted in his classic text, *Ethics of Rhetoric* (Lawrence Erlbaum, 1995), social scientists tend to mix two forms of rhetoric, the objective and the dialectic, as circumstances suit them. On the one hand, social scientists speak as though they are scientists, giving objective findings of illness and health. On the other hand, the social scientists also speak as advocates, adjusting their findings to support their moral assessments of a case.

Accordingly, prosecutors note many anomalies, such as a much greater likelihood that defendants will be diagnosed as having diminished capacity when they are accused of murder than when they are accused of armed

robbery. These court experiences undermine the credibility of the mental health profession generally, not just that of its expert witnesses. Also, one sees mental illness redefined from one edition of the American Psychiatric Association's *Diagnostic and Statistical Manual* to the next. These redefinitions are well-publicized subjects of political infighting among association members, and they hardly build confidence in the scientific validity of any mental health diagnosis. As a result, prosecutors are often misled into a biased and dangerously narrow view of mental health issues. What they need to understand is that the most serious mental diseases associated with violent crime—such as schizophrenia and bipolar disorders—are subject to objective diagnoses, are biological processes with known chemical components, and, most importantly, are amenable to both reliable diagnosis and effective treatment. Also, mental retardation and many of the mental diseases that will mitigate punishment are also susceptible to an objective diagnosis. Mental health medicine is scientifically reliable for the illnesses that are most relevant to public safety and criminal justice.

In addition, the skeptical prosecutor should sympathize with the predicament society has imposed upon the mental health professional. Mental health should be an objective science, but society has decided to shut down mental hospitals and divert patients to the streets, where some return as criminal defendants. The professionals who would treat these patients through the medical system now meet them in the criminal justice system, which is not objective, but dialectical—a system that is adversarial and operates through advocacy. We should not be surprised that this subverts mental health as a science.

Ending government's willful ignorance

At this point in our analysis, it is easy to argue that the prosecutor must take a more enlightened, active role respecting mentally ill defendants. An offender's mental health is a component of many crimes, yet prosecutors know virtually nothing about the average defendant's mental problems. Some prosecutors reflexively resist mental health surveys of defendants because the information tends to mitigate guilt or punishment. But reflecting on the true ends of justice should bring all to conclude that such information is needed because it *should* mitigate guilt or punishment. When E. Michael McCann, then-Milwaukee County district attorney, set up a mental health screening unit in 1981, a two-year survey of all county cases showed that a positive finding of mental illness consistently led to lower punishments, even for defendants with significant recidivism.

It is futile to sentence a defendant if the system remains willfully ignorant of the remedies that will rehabilitate the offender. Earlier we noted that the profoundly

mentally ill offender is four times more dangerous when the offender's illness goes out of remission. All such offenders should be ordered to undergo treatment and comply with medication orders. This can be done in the prison or as an order of probation.

The case for obtaining mental health histories is even more compelling when we look at the large number of drug defendants who are being diverted to treatment, either before charging or as a sentencing alternative. This treatment is useless for the many mentally ill, self-medicating drug abusers who are not receiving concurrent mental health evaluations and treatment.

The case for limiting the prosecutor's role

This raises the question of the prosecutor's responsibilities for making the system aware and responsive to mentally ill defendants. The ABA Standards and other canons remind us that the prosecutor is a "minister of justice." We should be cautious, however, before turning the prosecutor into a "minister of mental health." When it comes to mental health, there are many good reasons for keeping the prosecutor as a skeptical outsider.

"Justice" is a broad term that can fit whatever one might consider the "right thing to do." This causes every potential reform to be cast as a prosecutorial responsibility. But there are many "right things" that we do not want the prosecutor to do. "Justice" also means giving everything its proper due, and also putting everything in proper order.

Legal systems as diverse as Stalin's Soviet Union and Plato's ideal Republic have defined the person with a disordered mind as "unjust." When we move the diagnosis and treatment of mental illness into the coercive sphere of governmental justice we move into dangerous territory. We have already dumped the mentally ill in the criminal justice system, but it will be a significant change when we begin diagnosing or treating them.

As the criminal system's gatekeeper, the prosecutor will always possess great power to use the knowledge and negotiate the remedies the system has provided. Prosecutors must overcome our system's willful ignorance of the mental health issues, but the prosecutor should not be given any greater power with this information. The prosecutor should not have the power to investigate, initiate, or disclose any medical diagnosis. The prosecutor should not have the power to negotiate any medical treatment components of sentencing.

The criminal justice system, not the prosecution, must routinely assess defendants' mental health just as it assesses the defendants' physical health and other background. This information should be shared with defense counsel during the guilt phase, and defendants can share it as their interests dictate with the court and prosecution. During sentencing, the information and appropriate treatment

alternatives should be routinely obtained and disclosed with other presentence information. This will enlighten the courts, enable justice, and avoid giving the government inappropriate information and power.

Two types of reforms

Most jurisdictions lack the resources for setting up “mental health courts” and other diversion programs for mental health treatment. These boutique experiments receive much deserved publicity, but they can distract us from another, more important reform that every jurisdiction can implement.

Ninety percent of cases are resolved through guilty pleas. Virtually every defendant who enters a guilty plea will undergo a presentence investigation that will explore pertinent parts of the defendant’s social, criminal, and health histories. Those who plead guilty will be subjected to boilerplate conditions of probation that will enforce basic norms of good citizenship, such as paying child support and finding employment.

Where a defendant has a mental health history, pretrial investigators should determine whether the patient has dropped out of a treatment plan, is subject to a current treatment plan, or needs a new evaluation. The defendant’s conditions of probation should require appropriate compliance, and a routine consent form will enable surveillance by the defendant’s probation officer. Virtually all defendants with a prior mental health history can receive treatment under Medicaid, Medicare, or insurance plans that funded their previous diagnosis and treatment.

This simple reform would do much to overturn the criminal justice system’s current regime of willful ignorance. It would also force the probationer to follow a plan for which the probationer already has obtained the diagnosis and means of treatment. The reform can be implemented as a routine screening protocol for all probationers, preventing it from becoming subject to any discretionary abuses.

In most jurisdictions, this practice would be a substantial new intrusion in the defendant’s privacy. On the other hand, it is unrealistic (and unfair to the defendant) to impose other intrusive conditions of probation where a necessary component of rehabilitation is omitted.

This condition of probation would also create a new type of “technical” violation of probation and will thus cause some resistance from overworked probation officers. But it is counterproductive (as well as unjust) to hold mentally ill probationers accountable for other conduct when we do not hold them accountable for taking their medication. Short-term, intermediate sanctions have proven effective for mental health court defendants; they should be employed for all mentally ill probationers. Compliance with medical plans will reduce noncompli-

ance with other conditions of probation. Probation will be more successful, not more difficult, when mental health conditions are enforced.

Prosecutors should also encourage parole agencies to implement the same reforms for paroled inmates. Most defendants return to the community, and, unlike the mental hospitals it replaced, the criminal justice system returns the mentally ill without requiring improvements in their health. We can mitigate this failure by requiring a mental health assessment and plan for probationers and parolees.

BY THE NUMBERS

Although many Americans believe that the country started incarcerating more of its citizens between 1960 and 1990, this is false. Both the confinement rate and the number of confined persons declined in this period. When we compute involuntary confinements we should count the populations in mental hospitals, not just those in prisons and jails. When we correctly identify “incarcerated” Americans as those who are confined to mental hospitals as well as prisons, we find some surprises.

When the numbers are correctly defined as including individuals institutionalized in prisons and mental hospitals, the numbers and rates for all incarcerated Americans fell from 1960 to 1990 when the numbers “recovered” due to the war on drugs. It was during this same time that mental hospitals and prisons traded the role of the nation’s primary caretaker of confined Americans. Criminal justice professionals saw their prisons growing while mental health professionals saw their hospitals closing and many patients moving into prisons.

The number of persons confined to prisons and mental hospitals fell from 685,000 in the mid-1950s to 533,000 in 1970 and 436,000 in 1980; it rose to 863,000 in 1990. The rate of incarceration was 0.38 percent of Americans in 1960; it fell to 0.26 percent in 1970 and 0.19 percent in 1980. The incarceration rate rose in 1990 to 0.35 percent—or 3.5 individuals per 1,000 population—with the advent of the war on drugs in the late 1980s.

The relative caseloads of American mental hospitals and prisons flipped during these same years. Of the 685,000 incarcerated Americans in the mid-1950s, prisons accounted for 185,000 or 27 percent. In 1970, American prisons held 196,000 inmates, or 37 percent of the incarcerated population. In 1980, 304,000 American prisoners comprised 70 percent of the total incarcerated individuals. And, in 1990, 773,000 prisoners accounted for more than 89 percent of our confined population. (Allen Liska et al., 104 (No. 6) *Modeling the Relationship Between the Criminal Justice and Mental Health Systems*, AMER. J. SOC. 1744-1775, (May 1999).)

SUGGESTED READING

- *Mental Health Problems of Prison and Jail Inmates*, U.S. Department of Justice, OJP/BJJ, 9/06 NCJ 213600, available at www.ojp.usdoj.gov/bjs.
- “Changing the contours of the criminal justice system to meet the needs of persons with serious mental illness” by Arthur J. Lurigio and James A. Swartz in *NIJ 2000 Series: Policies, Processes, and Decisions of the Criminal Justice System*, (J. Homey, ed.) (Vol. 3) (pp. 45-108); Washington, DC: National Institute of Justice.
- “Reinventing Mental Health Care” by E. Fuller Torrey in *City Journal* (Autumn 1999), available at www.city-journal.org.
- “Modeling the Relationship Between the Criminal Justice and Mental Health Systems” by Allen E. Liska, Fred E. Markowitz, Rachel Bridges Whaley & Paul Bellair in *The American Journal of Sociology*, Vol. 104, No. 6 (May 1999), p. 1744.
- “Criminal Prosecution of the Mentally Disordered” by Ellen Hochstedler in *Law & Society Review*, Vol. 20, No. 2 (1986), p. 279.

Mental health courts

Inspired by pioneering efforts in Broward County, Florida, and King County, Washington, more than 100 mental health courts have been established in the last decade. Without exception, these courts have demonstrated that mental health treatment can do much to rehabilitate mentally ill offenders, especially those who commit simple drug and nuisance-type misdemeanors. Nationwide, these courts share important characteristics.

Mental health courts are collaborative enterprises involving every criminal justice agency as well as drug, medical, and mental health treatment providers. Each agency in a successful program provides professionals who are personally dedicated to the court’s mission.

The prosecutor is a necessary partner, and frequently instigates a mental health court’s establishment. Nevertheless, the prosecutor appropriately surrenders leadership once the program is established. The “first among equals” in each mental health court is the judge, but the primary hallmark of a successful drug court is that it is no longer an adversarial forum. It is a collaborative enterprise among all of its partners.

Four judges led the establishment of the first mental health court in Cook County, Illinois. Chief Judge Timothy Evans and Presiding Judge Paul Biebel organized a partnership with the prosecutor, public defender, Cook County Probation Department, Cook County Sheriff’s Department, the Chicago Police Department, the Illinois Department of Mental Health, TASC (the primary state drug treatment

provider), and others. This collaboration built upon other successes, including the Cook County Circuit Court’s drug court, the state’s attorney’s drug diversion school, and the Cook County Jail’s excellent mental health unit. The court was then implemented under the leadership of two judges, Judge Lawrence Fox, who hears female defendant cases, and Judge Clayton Crane, who hears male defendant cases. (Cook County’s results show female defendants have much higher success rates when their cases are not heard in the presence of male mental health defendants.)

Many criminal defendants are not appropriate for the kinds of specialized treatment and release programs administered in mental health courts. Prominent successes such as Broward and King counties targeted nonviolent misdemeanors. The misdemeanor cases typically concerned public nuisance crimes, such as urinating in public, sleeping in airports, and harassing people in front of stores or restaurants.

Cook County’s mental health court hears felony cases. Most of its defendants, however, committed felonies or graduated to felony status through repeated misdemeanor convictions. Significantly, Cook County Jail’s mental health experts initially identify potential mental health court defendants. Every candidate already had an open state department of mental health case. In addition to a diagnosed mental illness and an open mental health case, each candidate-defendant must:

1. Have a pending nonviolent felony with no civilian victims;
2. Have no recent history of violent or sex crimes; and
3. Understand and consent to the program’s conditions.

After this initial screening, defendants give informed consent through their lawyers, and then they undergo additional screening by the court, state’s attorney, probation department, and treatment providers.

As in those in other jurisdictions, most Cook County mental health court defendants have been “nuisance” offenders who have a high incidence of drug co-morbidity, treatment plan noncompliance, and recidivism. Their high recidivism rate and the problem of severe jail overcrowding made the mental health court experiment especially attractive to some county policy makers.

Thus far, the court has proved remarkably effective in reducing recidivism. The average participant had four arrests and two convictions in the year prior to admission. After admission, 76 percent of participants have no arrests, 89 percent no convictions, and 97 percent no felony convictions. In the year prior to admission, the average participant spent 130 days in the county jail. The average participant will spend 21 days in jail during the year after admission, usually as a sanction for program noncompliance, not for a new offense.

The program is serving other justice needs besides relieving jail overcrowding. Seventy percent of the partici-

pants successfully complete the program. The mental health professionals are especially heartened that most of the graduates have been reunited with their families. Few of them lived with family before the program, and living apart from family is a leading indicator for those mentally ill who will be arrested for future offenses.

Mental health courts achieve success through detailed, individualized treatment plans and rigorous oversight and enforcement. The typical treatment plan in Cook County involves 24 months of graduated care that is split into four periods of gradual reduction in oversight and treatment.

The first and most aggressive phase will typically include:

1. Weekly personal or phone reports to probation officer;
2. Active cooperation with a mental health case manager and either a psychosocial rehabilitation (PSR) programming or assertive community treatment (ACT) team program;
3. Daily medication monitoring and/or ongoing mental health assessments;
4. Attending alcohol/drug counseling or 12-step meetings as directed up to seven days per week;
5. Submitting to random urinalysis or BAC (blood alcohol content) tests as directed by the probation officer, TASC case manager, or treatment provider;
6. Monthly status reports to the mental health court judge;
7. Weekly meetings with drug treatment case manager; and
8. Successful completion of a residential substance abuse program as needed.

In its final phase, these requirements are typically relaxed to the following:

1. Monthly reports to a probation officer;
2. Attending treatment sessions as individually prescribed;
3. Submitting to random urinalysis or BAC tests;
4. Mental health court status hearings every three months;
5. Twelve-step program meetings, up to twice a week;
6. Participation in education or job training as directed by treatment team; and
7. Twice weekly reports to drug case manager.

To graduate from this program, a probationer must meet the following objectives:

1. Six months of sobriety from prescription drug abuse, illicit drugs and/or alcohol;
2. Six months of daily productive activity;
3. Successful completion of all court-ordered treatment;
4. Ongoing, regular 12-step meeting attendance as directed;
5. Completion of high school diploma or GED, job skills training, unless excused by the mental health court team;

6. Ongoing compliance with medication and other treatment prescriptions;
7. Stabilized income and housing; and
8. No new arrests or criminal complaints.

The Cook County initiative is an unusually serious probation program that truly tests its participants while giving them meaningful guidance.

Using existing resources, Cook County implemented a mental health court call that served 25 defendants per year. With a three-year, \$1.2 million federal grant to cover the costs of treatment, Cook County expanded its service to 75 defendants annually. These costs and service levels resemble those in other mental health courts. (For more on mental health courts, see the article in this issue, *The Promise of Mental Health Courts*, page 24.)

Difficult truths

The mental health courts present society with some difficult truths. First, some mentally ill defendants can be successfully treated and crime can be reduced when the criminal justice system supplements confinement alternatives with aggressive mental health care. Second, the mental health courts are replicating the types of services for which society used to depend upon mental hospitals. Third, mental health courts require an extensive investment of resources from legal professionals to enable the work of mental health professionals who, before “deinstitutionalization,” did not need courtrooms to do their work. Fourth, mental health courtrooms require highly dedicated, collaborative partnerships on objective medical problems with legal professionals who normally work in an adversarial system that weighs the probabilities of innocence and guilt. There is insufficient data to predict the effects of burnout, staff turnover, and the loss of charismatic, founding leaders. One of the oldest and most prominent mental health courts has publicly posted comments requesting advice on burnout.

The bottom line is that mental health courts are heroic efforts to bring some justice to a severely underserved population. It is society’s failure, not the criminal justice system’s failure, if these courts continue to be the brightest candles in the darkness we have imposed upon the mentally ill. We are prosecuting the mentally ill as criminals. And many mental health workers are prevented from doing their jobs unless they are partnered with lawyers, probation officers, and court orders. And our preferred patients are those who commit crimes. We let the law-abiding suffer alone.

Our recent experience with DNA technology teaches us that the future will have enough surprises about things we are not doing well. On mental health issues, we will have no excuses. If we persist in prosecuting mentally ill defendants in willful ignorance of their medical problems, our system will stand as an asylum whose keepers are as deluded as the inmates. ■