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Note

PRISONS: THE NEW MENTAL HEALTH SYSTEM

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By the middle of the twentieth century, the United States was in crisis: over half a million Americans were in state mental hospitals. Several changes, including the development of effective anti-psychotic medications and increased funding for the establishment of community mental health centers, made deinstitutionalization—the movement of the mentally ill from state hospitals to community-based programs—possible. Although a good plan in theory, deinstitutionalization quickly became one of the main reasons for the substantial increase in mentally ill individuals in prisons. Many of the originally considered community mental health centers were never developed, leaving such individuals with nowhere to turn for treatment.

This Note suggests that it was deinstitutionalization in conjunction with a number of other factors—including changes in civil commitment laws, lack of training for police officers, “mercy bookings,” lack of proper support systems, and societal attitudes—that created the gap that prisons soon came to fill. This Note discusses how three states, comparable in size and located throughout the United States, have addressed the needs of the mentally ill in their prison systems. This Note ultimately argues that because of the limited treatment available to the mentally ill, prisons have become the new mental health system. Likewise, despite the successes seen in some states, there is still work to be done. Finally, it proposes solutions for remedying this situation and reducing the number of mentally ill individuals in the criminal justice system.

NOTE CONTENTS

I. INTRODUCTION.....	1727
II. THE TRAGIC STORY OF TIMOTHY PERRY.....	1729
III. THE NEED FOR AND DEVELOPMENT OF A MENTAL HEALTH SYSTEM IN PRISONS.....	1731
A. CHANGES IN CIVIL COMMITMENT LAWS	1735
B. LACK OF PROPER TRAINING FOR POLICE OFFICERS.....	1735
C. "MERCY BOOKINGS"	1736
D. LACK OF PROPER SUPPORT SYSTEMS TO HELP WITH REINTEGRATION	1737
E. SOCIETAL ATTITUDES	1738
IV. CHARACTERISTICS FREQUENTLY SEEN WITHIN THE MENTALLY ILL POPULATION	1739
A. HOMELESSNESS	1739
B. LOST ACCESS TO MEDICAID BENEFITS	1740
C. CO-OCCURRING DISORDERS	1740
D. STIGMA	1741
V. CONNECTICUT PRISONS.....	1742
A. THE DEVELOPMENT OF A MENTAL HEALTHCARE SYSTEM IN CONNECTICUT PRISONS AND THE DESIGNATION OF GARNER CORRECTIONAL INSTITUTION AS A MENTAL HEALTH FACILITY	1743
B. CONNECTICUT'S DIVERSION PROGRAMS	1744
VI. A BRIEF LOOK AT OTHER STATE PRISON SYSTEMS	1753
A. WISCONSIN PRISONS.....	1754
B. WASHINGTON PRISONS	1757
VII. THE FUTURE: WHAT MORE CAN BE DONE.....	1759
A. INCREASE FUNDING	1759
B. ADDRESS THE CRIMINALIZATION OF AND CHARACTERISTICS COMMON TO THE MENTALLY ILL	1760
C. FOCUS ON DIVERSION	1762
VIII. CONCLUSION	1762



PRISONS: THE NEW MENTAL HEALTH SYSTEM

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I. INTRODUCTION

By the mid-twentieth century, the United States was in crisis: over half a million Americans were in state mental hospitals.¹ With new developments on the horizon—including the introduction of effective anti-psychotic medications and increased funding for the establishment of community mental health centers—deinstitutionalization, or the movement of the mentally ill from hospitals to community-based treatment programs, became a real possibility.² That movement, however, in conjunction with a number of other factors—changes in civil commitment laws, lack of training for police officers, “mercy bookings,” lack of proper support systems, and societal attitudes—limited the *treatment* available to these individuals and created a gap that prisons would soon come to fill.³

Several important characteristics are common among the mentally ill population. First, a large portion of the mentally ill population is homeless, and a mentally ill homeless person is twice as likely to be arrested as a non-mentally ill homeless person.⁴ Second, people lose access to their Medicaid benefits when incarcerated; as such, many of these

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¹ RISDON N. SLATE & W. WESLEY JOHNSON, *THE CRIMINALIZATION OF MENTAL ILLNESS: CRISIS & OPPORTUNITY FOR THE JUSTICE SYSTEM* 28 (2008); Sasha Abramsky & Jamie Fellner, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, HUMAN RIGHTS WATCH 19 (Joseph Saunders & James Ross eds., 2003), available at <http://www.hrw.org/sites/default/files/reports/usa1003.pdf>.

² Abramsky & Fellner, *supra* note 1, at 19–20 (listing some of the factors that made deinstitutionalization possible); see also SLATE & JOHNSON, *supra* note 1, at 29–30 (explaining how initially people thought Thorazine, the first effective anti-psychotic medication, may be a “cure for mental illness”); E. FULLER TORREY ET AL., *CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS* 52–53 (1992) (summarizing some of the major events that made deinstitutionalization possible).

³ In general, this Note uses the term “prison” to refer to both state and federal prisons, but does distinguish between the two when necessary.

⁴ DORIS J. JAMES & LAUREN E. GLAZE, *BUREAU OF JUSTICE STATISTICS SPECIAL REPORT: MENTAL HEALTH PROBLEMS OF PRISON & JAIL INMATES* 4 (2006), <http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf>; see also SLATE & JOHNSON, *supra* note 1, at 46 (describing how “homelessness has been determined to be directly related to higher crime rates and arrests for violent crime”); Abramsky & Fellner, *supra* note 1, at 25 (“Just as it is poor and homeless mentally ill individuals who have the greatest difficulty obtaining the mental health treatment they need, so it is poor and homeless mentally ill individuals who are disproportionately incarcerated.”).

individuals do not have access to treatment when released from prison.⁵ Third, a large percentage of the mentally ill population also suffers from substance abuse disorders.⁶ Finally, the mentally ill are stigmatized, which affects their employment options, chances of getting housing, and access to treatment.⁷ This Note argues that the number of mentally ill individuals in prison would decrease if these four characteristics were addressed.

As an example, Connecticut addressed these issues by forming an alliance with the University of Connecticut Health Center, which now handles all of the Connecticut Department of Correction's health services.⁸ Connecticut has one designated prison for all adult male offenders with severe mental illness and has shifted its focus to diversion—programs that seek to keep the mentally ill out of prison when possible—because these individuals fare better in community-based programs than in prison.⁹ Alternatively, states such as Wisconsin and Washington have achieved similar “success” in the area of prison mental healthcare by focusing their efforts on the care provided within the prisons and assisting inmates with reintegration.¹⁰

Despite these efforts to help the mentally ill, tragic events occur in prisons throughout the United States. Few stories are more compelling than that of Timothy Perry. Timothy was a mentally ill twenty-one year old who was transferred from a mental hospital to a Connecticut correctional center because of his aggressive behavior—a symptom of his mental illness.¹¹ On his twelfth day in prison, Timothy acted out and had

⁵ NAT'L ASS'N OF MENTAL HEALTH PLANNING & ADVISORY COUNCILS, JAIL DIVERSION: STRATEGIES FOR PERSONS WITH SERIOUS MENTAL ILLNESS 5 (2006), <http://www.namhpac.org/PDFs/01/jaildiversion.pdf>; SLATE & JOHNSON, *supra* note 1, at 38–39.

⁶ FORENSIC TASKFORCE OF THE NAMI BOARD OF DIRECTORS, DECRIMINALIZING MENTAL ILLNESS: BACKGROUND AND RECOMMENDATIONS 12 (2008); *see also* TORREY ET AL., *supra* note 2, at 83 (noting that one characteristic common to mentally ill offenders is alcohol or drug abuse).

⁷ Patrick W. Corrigan & Petra Kleinlein, *The Impact of Mental Illness Stigma*, in ON THE STIGMA OF MENTAL ILLNESS: PRACTICAL STRATEGIES FOR RESEARCH AND SOCIAL CHANGE 11, 18–19 (Patrick W. Corrigan ed., 2005).

⁸ *CT Prisons Facing Increase in Mentally Ill Inmates*, CORRECTIONS REP. (Mar. 25, 2011), <http://www.correctionsreporter.com/2011/03/25/ct-prisons-facing-increase-in-mentally-ill-inmates/>.

⁹ *See Accomplishments in 2003*, STATE OF CONN. DEP'T OF CORRECTION, <http://www.ct.gov/doc/cwp/view.asp?a=1493&q=265206> (last modified July 11, 2005) (listing some of Connecticut's accomplishments in 2003, including the consolidation of mental health services for adult male offenders at Garner Correctional Institution and the adoption of a new Mission Statement); *History of the Connecticut Department of Correction*, STATE OF CONN. DEP'T OF CORRECTION, <http://www.ct.gov/doc/cwp/view.asp?a=1500&q=378460> (last modified Aug. 3, 2010) (reviewing how Connecticut's Department of Correction evolved).

¹⁰ *See infra* Part VI.

¹¹ Complaint for Damages at 9–11, *R. Bartley Halloran Adm'r of the Estate of Timothy Perry v. Armstrong et al.* No. 3:01 CV 582 (D. Conn. 2001); *see also* Mary Beth Pfeiffer, *Changing of the Guards: A Prison Breaks from Convention in Treating the Mentally Ill*, LEGAL AFF. 50, 51 (July–Aug. 2005), http://www.legalaffairs.org/issues/July-August-2005/feature_pfeiffer_julaug05.msp (“In April

to be restrained.¹² Two hours after he was placed in four-point restraints and given a sedative, Timothy was found dead in his cell.¹³ While tragic, Timothy's story is not uncommon; in fact, it accurately represents what is currently happening in prisons across the United States.

This Note begins with Timothy's story to illustrate not only why mental healthcare in prisons is needed, but also why, despite the steps taken in states such as Connecticut, there is still work to be done. Part III examines the development of mental healthcare in prisons and how they have become the new mental health system. Part IV discusses four characteristics common to the mentally ill population that, if addressed, could help decrease the number of individuals that enter or reenter the criminal justice system. Part V focuses on the mental healthcare system in Connecticut prisons—how it developed and the programs the state has implemented. Part VI addresses the number of mentally ill individuals in United States prisons and discusses what Wisconsin and Washington have done to approach the issue. Part VII describes what more can be done to improve the mental healthcare system in United States prisons, and finally, Part VIII concludes.

II. THE TRAGIC STORY OF TIMOTHY PERRY

Timothy Perry's mother gave birth to him when she was fifteen years old.¹⁴ It is assumed that Timothy's father was in his fifties, but very little is known about him.¹⁵ In the eighteen-month period immediately before Timothy turned three, Timothy and his mother moved thirteen times.¹⁶ Timothy's mother also displayed signs of her own mental instability. When he turned three, his mother threw herself down the stairs and sprained her ankle.¹⁷ She also took Timothy to the roof of a building and threatened to people on the sidewalk that she would jump and commit

1999, when [Timothy Perry] assaulted two staff members, Cedarcrest officials gave up. To teach him a lesson, they pressed charges, and he was sent to Hartford Correctional Center.”)

¹² Complaint for Damages, *supra* note 11, at 12; *see also* Pfeiffer, *supra* note 11, at 50 (“In his twelfth day at Hartford Correctional Center, [Timothy] erupted in a day room while waiting for a nurse He refused repeated orders to return to his cell and charged a member of the staff [A]t least six guards took ten minutes to wrestle Perry to the floor.”).

¹³ Abramsky & Fellner, *supra* note 1, at 88; *see also* Complaint for Damages, *supra* note 11, at 18 (explaining how a nurse noticed through the window of his cell that “Timothy’s feet were discolored and that he was in the exact same position that he had been in two hours earlier”); Pfeiffer, *supra* note 11 (describing the type of restraints Timothy was placed in).

¹⁴ Pfeiffer, *supra* note 11, at 50 (“From the start, Perry’s life was bleak. His mother repeatedly told social workers of her having been raped and sexually abused, once by strangers, other times by family friends.”).

¹⁵ *Id.*

¹⁶ *Id.* at 51.

¹⁷ *Id.*

suicide with her son.¹⁸ Timothy's mother was a diagnosed paranoid schizophrenic and lost her parental rights soon after the incident on the roof.¹⁹ At the hearing, a social worker commented, "I believe that [she] is likely to kill . . . Timothy if left in her care," and the court found that she was an unfit parent.²⁰ A family in Middletown, Connecticut, adopted Timothy, but he misbehaved and was kicked out of school at age ten; he was soon removed from the home of his adoptive parents after he claimed that they had abused him.²¹ At age eleven, Timothy was diagnosed with schizoaffective disorder and committed to Cedarcrest Hospital in Newington, Connecticut.²² Timothy was being treated at Cedarcrest Hospital before he was sent to Hartford Correctional Center in April 1999.²³

When Timothy was readmitted to Cedarcrest Hospital in January 1999, he was diagnosed with "schizophrenia, schizoaffective disorder, impulse control disorder, borderline personality disorder with anti-social features, major depression and oppositional defiant disorder."²⁴ He had also been diagnosed as suffering from "neuropsychological dysfunction and impairment, with a borderline level of intellectual functioning and [an] IQ of 76."²⁵ Timothy's illness caused him to be assaultive, impulsive, and aggressive.²⁶ By April 1999, Timothy had been restrained fifteen times and accused of inappropriately touching several women.²⁷ When he then assaulted two staff members, the hospital pressed charges and had him sent to prison.²⁸

Timothy was twenty-one years old when he went to Hartford Correctional Center.²⁹ On his twelfth day in prison, April 12, 1999, Timothy began acting aggressively—pacing wildly, banging on windows, standing on tables, refusing to obey orders, and finally charging at a staff member.³⁰ It took six correction officers at least ten minutes to wrestle Timothy to the floor.³¹ When he was finally under control, the correction

¹⁸ *Id.* (describing how a passing cab driver had to talk Timothy's mother down from the ledge).

¹⁹ *Id.* at 50 ("Court records say Perry's mother suffered frequent hallucinations and was diagnosed as 'retarded and paranoid schizophrenic.'").

²⁰ Pfeiffer, *supra* note 11, at 51.

²¹ *Id.* (explaining that although Timothy claimed he was abused by his adoptive parents, charges were never filed).

²² *Id.* (defining schizoaffective disorder as a mental illness "marked by mood swings and distorted thinking").

²³ *Id.*

²⁴ Complaint for Damages, *supra* note 11, at 9.

²⁵ *Id.*

²⁶ *Id.*

²⁷ Pfeiffer, *supra* note 11, at 51.

²⁸ *Id.*

²⁹ *Id.* at 50.

³⁰ *Id.*

³¹ *Id.*

officers held him facedown, cuffed him, and placed a towel over his head as they carried him facedown to a cell.³² As Timothy was being transferred, a doctor was called and ordered that Timothy be sedated and tied to his bed.³³ When they reached the cell, even though Timothy was no longer resisting, the correction officers stripped him, turned him on his back, replaced his handcuffs with four-point restraints, and had the nurse administer the sedative.³⁴ Two hours later, a nurse noticed, through the window of his cell, that not only were Timothy's ankles blue, but he was also in the same position he had been in two hours earlier.³⁵ Timothy was dead—at the age of twenty-one.³⁶

Timothy's severe mental illness should have kept him out of prison, where he was never going to receive the help and treatment that he needed. In fact, his mental illness only brought him more negative attention. Timothy's case serves as a prime example of why prisons are ill suited to care for mentally ill individuals. The corrections officers at Hartford Correctional Center could not differentiate Timothy's disruptive behavior from the disruptive behavior of a non-mentally ill inmate. Even though Connecticut has made great strides in the area of mental healthcare in prisons, there is still significant room for improvement. The case brought by Timothy's estate settled for \$2.9 million—the largest wrongful death settlement ever paid out by the State of Connecticut in the death of a single man with no children.³⁷

III. THE NEED FOR AND DEVELOPMENT OF A MENTAL HEALTH SYSTEM IN PRISONS

Timothy's story is a sad but accurate representation of what occurs in prisons around the country. This is not, however, a recent problem. At the start of the twentieth century, mental health care was based almost exclusively on institutional care.³⁸ By 1955 there were over half a million Americans in state mental hospitals.³⁹ The steady and substantial increase raised concerns about the need for change.

³² Complaint for Damages, *supra* note 11, at 13 (“[The Correction Officers] carried Timothy face down and handcuffed from cell 10 to cell 24, a 4-point restraint cell.”); Pfeiffer, *supra* note 11, at 50.

³³ Complaint for Damages, *supra* note 11, at 13.

³⁴ *Id.* at 15; see also Abramsky & Fellner, *supra* note 1, at 88 (“[The correction officers] even accused him of continuing to resist, despite the fact that, as established by subsequent investigations, he was either already dead at this stage, or, at the very least, comatose.”).

³⁵ Complaint for Damages, *supra* note 11, at 18.

³⁶ *Id.* at 18 (“[The nurse] had Timothy's cell door opened, and . . . discovered that Timothy had no pulse, that he was cold, stiff and not breathing, and that he had been dead for some time.”).

³⁷ Abramsky & Fellner, *supra* note 1, at 88.

³⁸ Abramsky & Fellner, *supra* note 1, at 19; see also SLATE & JOHNSON, *supra* note 1, at 28 (explaining how the number of patients in state mental hospitals increased from 145,000 at the beginning of the twentieth century to 559,000, “its highest point in America[n history],” in 1955).

³⁹ SLATE & JOHNSON, *supra* note 1, at 28; Abramsky & Fellner, *supra* note 1, at 19.

Deinstitutionalization, the “mass exodus from the residential mental health system” that took place during the mid-to-late twentieth century,⁴⁰ was the result of several key changes. First, the development of effective anti-psychotic medications made earlier ideas of treatment outside of hospitals real possibilities.⁴¹ Second, successful lawsuits brought by people confined in these state mental hospitals made it more difficult for individuals to be involuntarily committed.⁴² The new involuntary commitment standard emerging from this litigation required a showing that the person was mentally ill and a danger to himself or others prior to commitment.⁴³ Third, the federal government provided three billion dollars to build and staff community mental health centers (“CMHCs”) that would provide treatment to those previously in state mental hospitals.⁴⁴ Fourth, the mentally ill were “made eligible for federal programs such as Medicaid, Medicare, Supplemental Security Income, Social Security Disability Insurance, food stamps, and federal housing subsidies.”⁴⁵ Finally, the federal government substantially increased funding for psychiatrist, psychologist, and social worker training.⁴⁶ These were the professionals who, it was believed at the time, would care for the mentally

⁴⁰ SLATE & JOHNSON, *supra* note 1, at 28; *see also id.* (describing how from 1960 to 1980 the number of patients in mental hospitals “plunged [from 559,000] to less than 100,000” and how by the start of the twenty-first century, “[only] approximately 55,000 persons with mental illness [were] housed in state mental hospitals”); TERRY A. KUPERS, REPORT ON MENTAL HEALTH ISSUES AT LOS ANGELES COUNTY JAIL 3 (2008), http://www.aclu.org/files/pdfs/prison/lacountyjail_kupersreport.pdf (discussing how mental health experts also refer to deinstitutionalization as “‘trans-institutionalization’ . . . [because society] transferred the population that once resided in psychiatric hospitals into the jails and prisons”); E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA’S MENTAL ILLNESS CRISIS 8–9 (1997) (“In effect, approximately 92 percent of the people who would have been living in public psychiatric hospitals in 1955 were not living there in 1994.”).

⁴¹ Abramsky & Fellner, *supra* note 1, at 19; *see also* SLATE & JOHNSON, *supra* note 1, at 29–30 (“The contention was that Thorazine would improve the conditions of persons with mental illnesses who were currently institutionalized so that they could be released into the community . . .”).

⁴² Abramsky & Fellner, *supra* note 1, at 19 (“Litigation increased due process safeguards in mental hospital involuntary commitment and release procedures . . .”).

⁴³ H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVICES 483, 487 (1998). This change in the commitment standard meant “far fewer people could be committed or kept in the hospitals against their will.” Abramsky & Fellner, *supra* note 1, at 19.

⁴⁴ TORREY ET AL., *supra* note 2, at 52. The funding for these CMHCs was provided by the 1963 Community Mental Health Centers Construction Act and its subsequent amendments. David Hartley et al., *The Role of Community Mental Health Centers as Rural Safety Net Providers* 4 (Maine Rural Health Research Center, Working Paper No. 30, 2002). These CMHCs were supposed to provide “five core elements of service: outpatient, inpatient, consultation/education, partial hospitalization, and emergency/crisis intervention.” *Id.*

⁴⁵ TORREY ET AL., *supra* note 2, at 52.

⁴⁶ *See id.* (explaining how this support led to an increase in the “total number of psychiatrists, psychologists, and psychiatric social workers . . . from approximately 9,000 in 1940 to over 200,000 in 1990”).

ill in the CMHCs.⁴⁷

Many supported deinstitutionalization because they believed that the mentally ill would benefit from being released from the state hospitals.⁴⁸ They believed that with the assistance of anti-psychotic medications, the mentally ill would be able to live independently in the community and that the CMHCs would provide the additional care, treatment, and follow up services.⁴⁹ Deinstitutionalization promised care outside of state mental hospitals in the form of “half-way houses, community residences, outpatient clinics, in-home psychiatric providers, and other alternatives”⁵⁰

Although a good plan in theory, deinstitutionalization quickly became one of the main reasons for the substantial increase in mentally ill people in jails and prisons.⁵¹ Patients were ejected from state mental hospitals at a substantially faster rate than community mental health programs were created.⁵² In addition, although more stringent standards for involuntary commitment meant fewer unnecessary commitments, it also made it substantially harder to get someone committed.⁵³ Furthermore, although money was appropriated for both deinstitutionalization and the development of CMHCs, frequently it would not be allocated because of the “not in my back yard” mentality—a problem often seen with prison construction.⁵⁴ Many residents did not support the development of these facilities for criminals and the mentally ill in their communities.⁵⁵ Once

⁴⁷ *Id.*

⁴⁸ Abramsky & Fellner, *supra* note 1, at 20 (“Deinstitutionalization freed hundreds of thousands of mentally ill men and women from large, grim facilities to which most had been involuntarily committed and in which they spent years, if not decades or entire lives, receiving greatly ineffectual, and often brutal, treatment.”).

⁴⁹ See TORREY ET AL., *supra* note 2, at 52 (explaining that there was “agreement that most mentally ill people do not need long-term hospitalization, and are entitled to live in the community as normally as possible”); Abramsky & Fellner, *supra* note 1, at 20 (describing what supporters of deinstitutionalization envisioned).

⁵⁰ SLATE & JOHNSON, *supra* note 1, at 33.

⁵¹ See E. FULLER TORREY, AARON D. KENNARD, DON ESLINGER, RICHARD LAMB & JAMES PAVLE, MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 2 (2010) (discussing how deinstitutionalization was “one of the most well-meaning, but poorly planned social changes ever carried out in the United States”).

⁵² TORREY ET AL., *supra* note 2, at 51. Connecticut prison officials who responded to Torrey’s survey stated, “[i]t is nearly impossible to get [seriously mentally ill individuals] placed into a hospital for the mentally ill” and complained that “[l]ocal mental health agencies pick and choose those they will follow after release.” *Id.*

⁵³ See, e.g., *id.* at 53 (providing the example of a woman that tampered with her neighbor’s mail during the day and cut their shrubs at night, and was arrested when her neighbors reported her to the district attorney after the local outpatient clinic said that she could not be involuntarily committed because she was not dangerous).

⁵⁴ SLATE & JOHNSON, *supra* note 1, at 33.

⁵⁵ See *id.* (“[C]ommunity residents want prisoners and persons with mental illness out of sight and out of mind and are therefore resistant to facilities in their communities.”).

deinstitutionalization began, governments provided less funding, and in some instances terminated funding completely, for CMHCs.⁵⁶ CMHCs also “failed to accept responsibility for the most seriously mentally ill individuals, [and] instead focus[ed] their resources on individuals with less serious problems.”⁵⁷ The grand plan to create “half-way houses, community residences, out patient clinics, in home psychiatric providers, and other alternatives . . . never materialized.”⁵⁸ Finally, the fact that the mentally ill were now eligible for federal funding once they were released from state mental hospitals created an incentive for state governments to discharge patients without considering what might happen to them.⁵⁹

Prisons and jails quickly became the largest mental healthcare providers because the mentally ill were not receiving the treatment they needed and were deteriorating to the point where they committed crimes.⁶⁰ For example, when Timothy Perry acted out at Cedarcrest Hospital, it was not because he was a criminal, it was because aggression and impulsive behavior were symptoms of his mental illness.⁶¹ Deinstitutionalization, however, is only one of several factors that ultimately led to the need for a mental healthcare system in prisons, and what one scholar termed “the criminalization of the mentally [ill].”⁶² These other factors included changes in civil commitment laws, lack of proper training for police officers, “mercy bookings,” lack of proper support systems and programs

⁵⁶ See Abramsky & Fellner, *supra* note 1, at 20 (explaining that “[t]he federal government did not provide ongoing funding for community services” and “states cut their budgets for mental hospitals, [but] did not make commensurate increases in their budgets for community-based mental health services.”); see also TORREY ET AL., *supra* note 2, at 52 (“But the policy as implemented—or more accurately, the fact that it was *never really implemented at all*—has been a disaster for seriously mentally ill people, and has contributed to their increasing numbers in city and county jails.”).

⁵⁷ TORREY ET AL., *supra* note 2, at 53.

⁵⁸ SLATE & JOHNSON, *supra* note 1, at 33.

⁵⁹ TORREY ET AL., *supra* note 2, at 53.

⁶⁰ See Jamie Fellner, *A Corrections Quandary: Mental Illness and Prison Rules*, 41 HARV. C.R.-C.L. L. REV. 391, 393 (2006) (“Left untreated and unstable, people with serious mental illnesses—particularly those who are also poor, homeless, and suffering from untreated alcoholism or drug addiction—may break the law and then enter the criminal justice system.”); see also TORREY ET AL., *supra* note 2, at 50 (“America’s jails are rapidly becoming surrogate mental hospitals.”).

⁶¹ See *supra* Part II (discussing how Timothy was diagnosed with schizophrenia, schizoaffective disorder, impulse control disorder, borderline personality disorder with anti-social features, major depression, and oppositional defiant disorder which caused him to be assaultive, impulsive, and aggressive).

⁶² M. F. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 HOSP. & COMMUNITY PSYCHIATRY 101, 105 (1972); see also Lamb & Weinberger, *supra* note 43, at 484 (“[Abramson] observed that persons with mental disorders who engaged in minor crimes were increasingly subject to arrest and prosecution”); SLATE & JOHNSON, *supra* note 1, at 34 (“[A]s state hospitals are downsized or closed, more and more individuals with mental illness are drifting into the streets and encountering the criminal justice system—a system that is often ill-equipped to deal with their needs.”).

to help the mentally ill reintegrate, and societal attitudes.⁶³

A. *Changes in Civil Commitment Laws*

Several changes were made to the civil commitment laws in the 1970s. The laws were changed substantively so that specific criteria must be met—for example, the person must be mentally ill and a danger to himself or others—to be committed.⁶⁴ Likewise, the duration of commitment went from “indeterminate and extensive periods to determinate and brief periods.”⁶⁵ Lastly, the laws were changed to provide faster access to courts.⁶⁶ These changes made it more difficult to commit people with serious mental illnesses to mental health hospitals and increased the number of mentally ill who turned to crime.⁶⁷

B. *Lack of Proper Training for Police Officers*

Police officers are normally the first to arrive at the scene of a crime and are, therefore, the first to deal with the mentally ill who commit crimes.⁶⁸ Police officers are “gatekeepers” in this respect. They have the power to determine an individual’s fate.⁶⁹ they decide whether an individual enters the mental health system or the criminal justice system.⁷⁰

Historically, police officers were not trained to deal with the mentally ill.⁷¹ Police officers are not mental health professionals and, therefore, cannot always identify easily when a person is exhibiting symptoms of a

⁶³ See Lamb & Weinberger, *supra* note 43, at 486–88 (describing factors that caused the mentally ill to be placed in the criminal justice system—deinstitutionalization, more restrictive civil commitment standards, lack of access to treatment, the role of the police in the lives of the mentally ill, and society’s attitudes).

⁶⁴ See *id.* at 487.

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ See *id.* at 486–87 (listing “more formal and rigid criteria for civil commitment” as a reason why more mentally ill persons are being placed in the criminal justice system).

⁶⁸ See H. Richard Lamb et al., *The Police & Mental Health*, 53 *PSYCHIATRIC SERVICES* 1266, 1266 (2002) (“The police are typically the first and often the sole community resource called on to respond to urgent situations involving persons with mental illness.”).

⁶⁹ FORENSIC TASKFORCE OF THE NAMI BOARD OF DIRECTORS, *supra* note 6, at 4.

⁷⁰ See *id.* (explaining how police officers have become “‘street-corner psychiatrist[s]’ by default,” which many criticize because police officers do not receive proper mental health training).

⁷¹ Lamb & Weinberger, *supra* note 43, at 488; see also Lamb et al., *supra* note 68, at 1269 (“At a minimum, training for the police officers should include becoming familiar with the general classification of mental disorders used by mental health professionals; learning and demonstrating skills in managing persons with mental illness, including crisis intervention; knowing how to gain access to meaningful resources less restrictive than hospitalization; and learning the laws pertaining to persons with mental illness, in particular the criteria specified for involuntary psychiatric evaluation and treatment.”).

mental disorder.⁷² Because an individual suffering from delusions or some other symptoms can be particularly sensitive, situations can escalate—with unfortunate results—if police officers are not trained properly.⁷³ This lack of training is cited as one of the reasons more mentally ill end up in prison.⁷⁴

Police officers have the option of taking a person they suspect to be suffering from a mental illness to the psychiatric emergency room, but they do not often exercise this option because of the potential consequences.⁷⁵ That is, in many jurisdictions police officers are required by law to wait with the mentally ill individual until he or she is evaluated and a decision is made on whether to admit or release him or her.⁷⁶ This often takes a long time, which keeps the police officer from other work.⁷⁷ Moreover, a medical professional may disagree with the police officer and think the person is not suffering from a mental illness.⁷⁸ That person would then be released after the police officer waited all that time.⁷⁹ Police officers, therefore, prefer charging mentally ill offenders with misdemeanors, because they know how the individual will be treated, and believe that process is more reliable.⁸⁰

C. “Mercy Bookings”

“Mercy bookings” have also contributed to the increase in mentally ill people in prisons.⁸¹ Some officers book mentally ill individuals for low-level crimes when they believe there are no appropriate community mental

⁷² See SLATE & JOHNSON, *supra* note 1, at 82 (“Many officers have difficulty in recognizing the signs and symptoms of mental illness, as, without proper training, they are essentially laypersons.”); Lamb et al., *supra* note 68, at 1267 (“A person who seems to be mentally ill to a mental health professional may not seem so to the police officers—who, despite their practical experience, have not had sufficient training in dealing with this population.”).

⁷³ See SLATE & JOHNSON, *supra* note 1, at 79 (“We all come to each encounter as a culmination of our past experiences . . . Unfortunately, the traditional tactics, i.e., to quell disturbances and subdue bad guys may serve to escalate police encounters with persons with mental illness, sometimes resulting in tragedy.”).

⁷⁴ See Lamb & Weinberger, *supra* note 43, at 488 (describing how police officers feel comfortable referring psychiatric cases to the criminal justice system, because the mentally ill are dealt with in a “more systematic way”).

⁷⁵ See *id.* (describing some of the “problems and irritants” that arise when police officers take individuals to the psychiatric emergency room); see also TORREY ET AL., *supra* note 2, at 85 (explaining that problems often arise because “most psychiatric emergency services have full waiting rooms and/or are understaffed”).

⁷⁶ TORREY ET AL., *supra* note 2, at 85.

⁷⁷ *Id.* (“It is not uncommon for this wait to last two to four hours, thereby tying up the officers so that they are not available for other law enforcement duties.”).

⁷⁸ Lamb & Weinberger, *supra* note 43, at 488.

⁷⁹ *Id.*

⁸⁰ TORREY ET AL., *supra* note 2, at 85.

⁸¹ Lamb et al., *supra* note 68, at 1267.

health services available and that the individual could benefit from treatment in prison.⁸² This practice has become known as “mercy booking”⁸³ and is supported by the fact that most of the mentally ill who end up in prison are charged with minor crimes.⁸⁴ As Lamb and Weinberger stated, “the criminal justice system [has] become[] the system that ‘can’t say no.’”⁸⁵

This practice exemplifies the shortcomings of deinstitutionalization. There was a valid argument to be made during the early twentieth century that people were involuntarily committed that should not have been, that people who were not mentally ill were locked away in mental hospitals.⁸⁶ Deinstitutionalization was, in fact, implemented to correct that wrong. Unfortunately, it was only ever implemented halfway. While the goal of decreasing the number of state mental hospitals was accomplished, a sufficient number of community service programs never materialized to treat those with debilitating mental illnesses.⁸⁷ The mentally ill, left with few resources, largely turned to petty crime, ending up in prison because there were no better alternatives.⁸⁸ These individuals need mental healthcare and treatment. However, as this Note argues, placing them in prison because they will receive more care there than they would outside of prison (even if it is still inadequate), is not a sound justification for the current state of the mental healthcare system.

D. Lack of Proper Support Systems to Help with Reintegration

Beyond institutional aid, the mentally ill population also lacks proper social support systems to help them recover and reintegrate once released from prison.⁸⁹ These individuals need their families, friends, and other social networks. Without the proper support systems in place, the mentally

⁸² See *id.* (“[L]aw enforcement officers may be more inclined to charge persons with mental illness with a misdemeanor and take them to jail if they think that no appropriate alternatives are available . . .”).

⁸³ See SLATE & JOHNSON, *supra* note 1, at 88 (explaining how some police officers prefer to book the mentally ill because they will at least have their basic necessities met).

⁸⁴ Assault and battery, theft, disorderly conduct, alcohol or drug related charges, and trespassing are the five most common offenses the mentally ill are charged with. TORREY ET AL., *supra* note 2, at 46.

⁸⁵ Lamb et al., *supra* note 68, at 1267.

⁸⁶ See, e.g., GERALD N. GROB, MENTAL ILLNESS AND AMERICAN SOCIETY, 1875–1940, at 181–85 (1983) (discussing the rise in use of mental hospitals as “old-age homes” for the elderly who may or may not have been mentally ill).

⁸⁷ See *supra* notes 54–58 and accompanying text.

⁸⁸ See *infra* Section IV.A.

⁸⁹ See FORENSIC TASKFORCE OF THE NAMI BOARD OF DIRECTORS, *supra* note 6, at 12 (describing how the social support needed by the mentally ill can be found not only in family and friends, but also “religious affiliations, social clubs, advocacy and peer support organizations, recreational facilities, and social service agency programs”).

ill stop treating themselves, fall back into bad habits, and come back through the “revolving jail door.”⁹⁰ “Proper support systems” means not only family and friends who are there to help the individual reintegrate, but also family and friends who understand the specific treatment and care these individuals need. In some cases, these support groups have helped the mentally ill person go or return to prison because they believe it is the best place for the individual to receive treatment.⁹¹ Mental health reform must address this misconception as well.

E. Societal Attitudes

Finally, societal attitudes have also contributed to the increase of mentally ill individuals in prison. Society as a whole wants criminals to be held accountable for their actions and their crimes, mentally ill or not.⁹² Something that is often overlooked, however, is that most of the mentally ill population is not violent. In fact, experts note that there are certain factors that help predict the risk of violence amongst the mentally ill population.⁹³ Three “primary predictors of violence” are a history of past violence, alcohol or substance abuse, and noncompliance with treatment.⁹⁴ Three additional factors considered good indicators of potential violent behavior are neurological impairment, paranoid delusions, and command hallucinations.⁹⁵ Although very few of these individuals are actually violent, the acts of a small number of mentally ill persons have stigmatized the majority of mentally ill individuals.⁹⁶ Society feels little sympathy for these individuals and wants them to be punished like every other criminal.

⁹⁰ TORREY ET AL., *supra* note 2, at 81.

⁹¹ TORREY, *supra* note 40, at 40 (“The mentally ill also are sometimes jailed because their families find it is the most expedient means of getting the person into needed treatment.”).

⁹² See Lamb & Weinberger, *supra* note 43, at 488 (“The public has traditionally believed that any sentence other than prison is too lenient for serious offenders, even if they are mentally ill.”) see also TORREY ET AL., *supra* note 2, at 87 (“American society has traditionally cherished the rights of the individual as long as such rights do not interfere with the rights of others.”); Corrigan & Kleinlein, *supra* note 7, at 20 (“The growing intolerance of offenders in general has led to harsher laws and hampered effective treatment planning for mentally ill offenders.”).

⁹³ See SLATE & JOHNSON, *supra* note 1, at 51 (“[L]ess than one percent of persons with mental illnesses ever exhibit violent behavior.”); see also TORREY, *supra* note 40, at 49 (“[T]he mentally ill as a group account for only a small fraction of the violence in our communities. America is a violent society and within this broad landscape, the total contribution of the mentally ill is not large.”).

⁹⁴ SLATE & JOHNSON, *supra* note 1, at 51; TORREY, *supra* note 40, at 49–51.

⁹⁵ TORREY, *supra* note 40, at 52. For example, tests have revealed that violent schizophrenics have a significantly higher number of neurological abnormalities. *Id.*

⁹⁶ See *infra* Section IV.D (discussing how the media’s focus on the small subsection of violent mentally ill individuals adds to the stigmatization of mental illness).

IV. CHARACTERISTICS FREQUENTLY SEEN WITHIN THE MENTALLY ILL POPULATION

There are four characteristics common to the mentally ill population that, if addressed, could help decrease the number of these individuals in prison, and thus ensure that tragic stories like that of Timothy Perry are not repeated.

A. Homelessness

One of the unintended consequences of deinstitutionalization was that over the second half of the twentieth century thousands of individuals were shifted from state mental hospitals to the streets and from the streets to prisons.⁹⁷ There are approximately 744,000 homeless people in the United States today, and one-third to one-half of that population is believed to suffer from mental illness.⁹⁸ In addition, a mentally ill homeless person is twice as likely as a non-mentally ill homeless person to be arrested and put in jail.⁹⁹ Not knowing if you will have a meal and warm place to sleep at night is stressful for anyone, yet even more so for those with mental illness.¹⁰⁰ The sad reality is that certain individuals are considered “‘regulars’ who rotate through the jail on a regular and predictable basis, knowing and known to jail officials on a first name basis.”¹⁰¹ Most prison officials provide mentally ill individuals with information about the closest shelters because they are aware that many will otherwise be on the streets.¹⁰² With no place to go and no family or friends, it should come as no surprise that many mentally ill homeless people commit misdemeanor crimes in search of warm place to stay.¹⁰³

⁹⁷ See TORREY, *supra* note 40, at 14 (“More and more very sick people were living on the streets and in public shelters. Many of them were being arrested for misdemeanors associated with not receiving treatment and were ending up in city and county jails.”).

⁹⁸ JAMES & GLAZE, *supra* note 4, at 4; SLATE & JOHNSON, *supra* note 1, at 46.

⁹⁹ Abramsky & Fellner, *supra* note 1, at 25; see also SLATE & JOHNSON, *supra* note 1, at 46 (“With treatment beds non-existent and friends and family as caretakers unavailable, the aberrant behavior of homeless persons with mental illnesses is pushed into the streets where it is more likely to come to the attention of the authorities and result in criminal justice sanctions.”).

¹⁰⁰ TORREY, *supra* note 40, at 19 (“Living in shelters or on the streets is likely to be difficult, even for a person whose brain is working normally. For those with a severe mental illness, this kind of life is often a living hell.”) (emphasis added).

¹⁰¹ TORREY ET AL., *supra* note 2, at 82.

¹⁰² See *id.* (“Shelters and jails . . . comprise an institutional system between which many of the most seriously ill individuals in the United States regularly migrate.”).

¹⁰³ SLATE & JOHNSON, *supra* note 1, at 46 (“[L]ack of housing becomes an integral avenue for pushing one’s actions into the crime category when long-term psychiatric inpatient care is not available.”); see also NAT’L ASS’N OF MENTAL HEALTH PLANNING & ADVISORY COUNCILS, *supra* note 5, at 4 (“Nearly half of the inmates with mental illness in prison were incarcerated for committing a nonviolent crime. Many have been incarcerated for minor offenses such as trespassing, loitering, disorderly conduct and other symptoms of untreated mental illness.”) (emphasis omitted).

B. *Lost Access to Medicaid Benefits*

Studies have shown that for the most part, mentally ill individuals are compliant and take their medications when in prison, but, once released, many stop taking their medication.¹⁰⁴ One explanation is that once released, mentally ill individuals lose the structure and support they had in prison.¹⁰⁵ A second explanation is that in many states, people lose access to Medicaid benefits once they are incarcerated.¹⁰⁶ Unless special efforts are made to ensure that a mentally ill individual's Medicaid benefits will be available upon his or her release, many do not have access to their benefits and to the care and treatment they need when released.¹⁰⁷ Individuals must reapply for Medicaid benefits once terminated, and many prisons do not have the resources to ensure that every mentally ill person reapplies and has access to benefits before they are released.¹⁰⁸ This may seem like a small step, but for those mentally ill individuals who lack support systems, or who are homeless, this can present a significant hurdle. In addition, approval and reinstatement of an individual's benefits can take an inordinate amount of time. An individual with a serious mental illness may already be on his or her way back to prison before he or she can even apply for benefits.¹⁰⁹

C. *Co-occurring Disorders*

Mental health professionals in the criminal justice system also estimate that "at least 75 percent of [the mentally ill population in prison] meet the . . . criteria for drug and/or alcohol abuse or dependence."¹¹⁰ Despite this high percentage and the establishment of the Substance Abuse and Mental Health Services Administration ("SAMHSA") in 1992, there are still too few integrated mental health and substance abuse treatment

¹⁰⁴ TORREY ET AL., *supra* note 2, at 83.

¹⁰⁵ *Id.*

¹⁰⁶ SLATE & JOHNSON, *supra* note 1, at 38. Federal law denies Medicaid benefits to individuals in prison. NAT'L ASS'N OF MENTAL HEALTH PLANNING & ADVISORY COUNCILS, *supra* note 5, at 5. Although the states control when an individual is eligible for benefits, many states agree with the federal law and assert that the prison population is not eligible for benefits. *Id.*

¹⁰⁷ SLATE & JOHNSON, *supra* note 1, at 38-39; NAT'L ASS'N OF MENTAL HEALTH PLANNING & ADVISORY COUNCILS, *supra* note 5, at 5.

¹⁰⁸ See NAT'L ASS'N OF MENTAL HEALTH PLANNING & ADVISORY COUNCILS, *supra* note 5, at 5 ("[I]t is unlikely that [Medicaid benefits] will be available to persons with mental illness upon discharge from correctional facilities unless special efforts have been made to reapply for benefits during the pre-release phase.").

¹⁰⁹ See *id.* ("Denying individuals the financial resources they need to survive in the community seriously undermines the effectiveness of post-release jail diversion programs.").

¹¹⁰ FORENSIC TASKFORCE OF THE NAMI BOARD OF DIRECTORS, *supra* note 6, at 12; see also TORREY ET AL., *supra* note 2, at 83 ("The other characteristic is that many of these individuals also abuse alcohol or drugs and it is the combination of their untreated mental illness plus alcohol [or] drugs that leads them to break laws and therefore be jailed.").

programs to make an impact on the mentally ill population. Some mental health programs refuse to admit individuals with substance abuse problems because they do not know how to treat those individuals, and fear that admitting such individuals will only disturb those whom they know how to treat.¹¹¹ Many states, however, are moving toward integrated treatment. In Connecticut, for example, although statewide-integrated treatment is not yet available, many mental health clinicians are now also trained in the treatment of substance use disorders.¹¹² To successfully treat someone's mental illness, his or her co-occurring drug or alcohol abuse problem must also be treated.

D. Stigma

Finally, mentally ill individuals must face the challenge of stigma. Although the mental illnesses themselves cause significant impairments—and are the main reason for the day-to-day struggles these individuals face—the stigmatization of mental illness in no way helps and, not surprisingly, in many ways negatively affects these individuals' lives.¹¹³ Studies have shown that unemployment rates are three to five times higher amongst the mentally ill.¹¹⁴ The stigma that attaches to individuals labeled “mentally ill” also affects their chances of getting housing, verified by the fact that a large portion of the mentally ill population is either homeless or living in inadequate housing.¹¹⁵ Landlords prefer to rent to other low-income groups over the mentally ill because they are “more suitable tenants.”¹¹⁶ Additionally, police officers are often the first to respond to a scene and the first to deal with mentally ill persons.¹¹⁷ A police officer's approach to a scene is often influenced by the public nature of, and

¹¹¹ Abramsky & Fellner, *supra* note 1, at 22; see also *About the Agency*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION, <http://www.samhsa.gov/about/> (last visited Mar. 15, 2012) (providing SAMHSA's mission statement and initiatives).

¹¹² Linda Frisman et al., *Connecticut's Criminal Justice Diversion Program* 3 (2000), <http://www.ct.gov/dmhas/LIB/dmhas/publications/jaildiversion.pdf>.

¹¹³ See Corrigan & Kleinlein, *supra* note 7, at 19 (“Many people with serious mental illness lack the social and coping skills to meet the demands of the competitive work force and independent housing. Nevertheless, the problems of many people with psychiatric disability are exacerbated by labels and stigma.”).

¹¹⁴ *Id.*

¹¹⁵ *Id.*; see also *supra* Section IV.A (discussing how one of the unintended consequences of deinstitutionalization was the movement of mentally ill individuals from state mental hospitals to the streets).

¹¹⁶ Corrigan & Kleinlein, *supra* note 7, at 18.

¹¹⁷ Lamb et al., *supra* note 68, at 1266; see also *supra* Section III.B (discussing how police officers are considered gatekeepers because they determine whether these individuals will enter the mental health system or the criminal justice system).

public's reaction to, an event.¹¹⁸ This fact presents a strong argument for de-stigmatization because people's unfounded stereotypes of mental illness should not affect the treatment the mentally ill receive.¹¹⁹

The mentally ill who commit crimes face additional burdens. They are stigmatized not only for their illness, but, like all criminals, for the crime or crimes they commit as well.¹²⁰ Even those individuals who have not committed a crime are sometimes stigmatized as dangerous and violent because of the horrific actions of a small subsection of the mentally ill population on which the media focuses.¹²¹ If society were to completely de-stigmatize mental illness, it would motivate more individuals to seek the treatment they need and affect the number of individuals that end up in prison.

V. CONNECTICUT PRISONS

As of July 2011, there were over 17,000 people incarcerated in Connecticut prisons and 3232 people in halfway houses, transitional supervision, placement programs, or on parole.¹²² The most recent annual report showed that 3500 inmates, or eighteen percent of the prison population in Connecticut, are receiving mental health treatment.¹²³ Put differently, "about one in five prisoners in Connecticut receiv[es] mental health treatment."¹²⁴ This percentage reflects an increase in the number of individuals receiving care; only thirteen percent of the population was receiving care in 2003.¹²⁵ Additionally the report showed that 221,699 visits were made to social workers, psychologists, and psychiatric nurse clinicians, 22,175 visits were made to psychiatrists, and 22,014 visits were made to advanced practice registered nurses in 2010.¹²⁶

These numbers reflect the relative success Connecticut has had in the

¹¹⁸ See SLATE & JOHNSON, *supra* note 1, at 81 (describing a study that found "the more public an event, the more likely an arrest will follow in a law enforcement officer's encounter with a person with mental illness").

¹¹⁹ *Id.* ("With the public's influence on the behavior of police officers in mind, the need for public education and de-stigmatization regarding mental illness is of paramount concern.").

¹²⁰ See *id.* at 50 ("For persons with mental illnesses who have experienced the humiliation of arrest, it is as if a double whammy occurs. They are stigmatized for their mental illnesses and they are stigmatized for being processed by the criminal justice system.").

¹²¹ The Virginia Tech shooter is an example of a mentally ill individual who added to the stigmatization of the mentally ill population. *Id.* at 52. There is still little consensus today as to why the shooter killed thirty-two fellow students and faculty members. *Id.*

¹²² *July 1, 2011 Statistics*, STATE OF CONNECTICUT DEP'T OF CORRECTION, <http://www.ct.gov/doc/cwp/view.asp?a=1505&q=482638> (last visited Mar. 16, 2012).

¹²³ UNIV. OF CONN. HEALTH CTR. CORR. MANAGED HEALTH CARE, JULY 2009–JUNE 2010 CMHC ANNUAL REPORT 4 (2010) [hereinafter CMHC ANNUAL REPORT].

¹²⁴ *CT Prisons Facing Increase in Mentally Ill Inmates*, *supra* note 8.

¹²⁵ *Id.*

¹²⁶ CMHC ANNUAL REPORT, *supra* note 123, at 4.

area of prison mental healthcare. Beyond care offered in prisons though, Connecticut has shifted its primary focus to diversion. Its programs aim to keep mentally ill individuals out of prison when possible, allowing those individuals to receive the treatment they need in much more appropriate settings.¹²⁷ These programs also provide those individuals who cannot be diverted with more opportunity to receive treatment in prison because the number of people seeking institutional care is decreased.¹²⁸

The pertinent issue, then, is how Connecticut developed a mental health care system in its prisons, and what programs the state has implemented.

A. The Development of a Mental Healthcare System in Connecticut Prisons and the Designation of Garner Correctional Institution as a Mental Health Facility

The Connecticut Department of Corrections approached the University of Connecticut Health Center (“UConn Health Center”) in 1996 with a proposal that the medical center handle all of the department’s health services.¹²⁹ The UConn Health Center established the Correctional Managed Health Care program in 1997 and has since become the provider of healthcare and mental health services to the incarcerated population of the state of Connecticut.¹³⁰ The UConn Health Center provides mental health services at every prison and jail in Connecticut, but has comprehensive programs available at Osborn, York, Manson Youth, and Garner correctional institutes.¹³¹

Garner Correctional Institution in Newtown, Connecticut opened in 1992.¹³² Garner is a level four, high-security prison that initially housed a large portion of Connecticut’s gang population.¹³³ One of the major changes Commissioner Theresa C. Lantz made during her administration—date-to-date—was the consolidation of Connecticut’s prison mental health treatment program.¹³⁴ In August 2003, Lantz announced that all adult male offenders with significant mental illnesses

¹²⁷ See *infra* Section V.B (discussing Connecticut’s attitude toward diversion and four diversion programs the state has implemented).

¹²⁸ *Id.*

¹²⁹ See *CT Prisons Facing Increase in Mentally Ill Inmates*, *supra* note 8 (discussing how Connecticut established a managed health care system).

¹³⁰ *Id.*; see also CMHC ANNUAL REPORT, *supra* note 123, at 4 (“Mental health services include access to care and outreach, screening and assessment, identification, treatment planning, classification, provision of distinct levels of service and continuity of care upon discharge to the community.”).

¹³¹ CONN. DEP’T OF CORR., UNIVERSITY OF CONNECTICUT HEALTH CENTER CORRECTIONAL MANAGED HEALTH CARE (CMHC) OVERVIEW 1 (2005).

¹³² *Garner Correctional Institution*, STATE OF CONNECTICUT DEP’T OF CORRECTION, <http://www.ct.gov/doc/cwp/view.asp?a=1499&q=265410> (last modified July 5, 2011).

¹³³ *Id.*

¹³⁴ *Accomplishments in 2003*, *supra* note 9.

would be brought to Garner.¹³⁵ Today, Garner remains the designated prison for individuals with severe mental illness.¹³⁶ Because of its collaboration with UConn Health Center, Garner is able to provide individual treatment plans, extensive programming, and one-on-one and group therapy.¹³⁷ Along with consolidation, the way correction officers interact with inmates changed as well. At Garner, the mental health staff determines whether a mentally ill individual should be punished for the disruptions he causes.¹³⁸ The staff examines the individual and determines why he caused the disruption.¹³⁹ The staff also determines whether the individual could have controlled his behavior or whether it was a result of his mental illness.¹⁴⁰

By consolidating adult male mentally ill inmates into one prison, Connecticut was able to focus its efforts on providing an effective corrections environment for those mentally ill individuals who cannot be diverted away from the criminal justice system. The increased responsibilities of the mental health staff at Garner ensures that more attention is placed on treatment rather than punishment. Garner is still, however, a correctional facility, and the “gap between guards and mental health professionals is a major challenge”¹⁴¹ Some argue that Garner should be run completely by mental health professionals, but as of 2005 there was only one prison in the United States run by a state agency other than a corrections department, which suggests that efforts are best spent ensuring that mental health professionals play as active a role as possible in the correctional system.¹⁴²

In addition to this specially designated mental health prison, Connecticut also has a number of programs in place to help mentally ill persons receive the care and treatment they need outside of prison.

B. Connecticut's Diversion Programs

Connecticut initially implemented diversion programs, which represent an alternative to incarceration, as a way to deal with the problem of prison

¹³⁵ *Id.*; *History of the Connecticut Department of Correction*, *supra* note 9.

¹³⁶ *Garner Correctional Institution*, *supra* note 132.

¹³⁷ *Garner Correctional Institution*, *supra* note 132; *see also* CONNECTICUT DEP'T OF CORRECTION, OFFENDER PROGRAMS & VICTIM SERVICES UNIT: ALPHABETIC LISTING OF PROGRAMS FOR GARNER CI, ALL AUSPICES, ALL TYPES (2011) (showing that there is a total of sixty different mental health programs available at Garner).

¹³⁸ Pfeiffer, *supra* note 11, at 52 (“At Garner, clinicians are supposed to determine whether discipline is appropriate and to avoid the punishment of behavior that is illness-related.”).

¹³⁹ *Id.*

¹⁴⁰ *See id.* (“In prison, correctional staff members do not normally negotiate with inmates to get them to cooperate. At Garner, guards are supposed to do that and more by asking a counselor to speak with an agitated inmate before they use force against the prisoner, for example.”).

¹⁴¹ *Id.*

¹⁴² *Id.*

overcrowding.¹⁴³ These programs, however, serve a dual purpose;¹⁴⁴ they both help with prison overcrowding and allow the mentally ill to be treated much more effectively in community programs and halfway houses.¹⁴⁵

Generally speaking, there are two major types of diversion programs—pre-arrest and post-arrest.¹⁴⁶ Police officers are often the first to arrive at the scene of an incident and the first to have contact with mentally ill criminals.¹⁴⁷ For pre-arrest diversion programs to be implemented successfully, police officers have to be “knowledgeable about the nature of mental illness, de-escalating crisis situations, and providing options for mental health treatment alternatives to incarceration that are available in the community.”¹⁴⁸ Police training, crisis response teams available to provide assistance to the police, and the transportation of the mentally ill to community mental health programs rather than prisons are some examples of pre-arrest diversion programs.¹⁴⁹ Post-arrest diversion programs, which involve screening an individual to determine whether he or she is suffering from a mental illness and negotiating with prosecutors to get the person less prison time and more mental health treatment, are more common across the United States.¹⁵⁰ An example of a post-arrest diversion program is mental health courts.¹⁵¹

The Connecticut Department of Mental Health and Addiction Services (“CDMHAS”) has been at the forefront of providing resources to people with mental illness and is continually building alternatives to incarceration and mental health programs.¹⁵² Four of the numerous diversion programs Connecticut implemented are diversion teams, jail re-interview programs,

¹⁴³ See RUSS IMMARIGEON & JUDITH GREENE, *DIVERSION WORKS: HOW CONNECTICUT CAN DOWNSIZE PRISONS, IMPROVE PUBLIC SAFETY & SAVE MONEY WITH A COMPREHENSIVE MENTAL HEALTH & SUBSTANCE ABUSE APPROACH* 9–10 (2008) (“A new consensus is emerging that community-based options are more likely than civil or criminal confinement to achieve [the twin objectives of increasing public safety and reducing recidivism].”).

¹⁴⁴ *Id.* at 10.

¹⁴⁵ *Id.*

¹⁴⁶ NAT’L ASS’N OF MENTAL HEALTH PLANNING & ADVISORY COUNCILS, *supra* note 5, at 6.

¹⁴⁷ Lamb et al., *supra* note 68, at 1266.

¹⁴⁸ NAT’L ASS’N OF MENTAL HEALTH PLANNING & ADVISORY COUNCILS, *supra* note 5, at 7.

¹⁴⁹ *Id.*

¹⁵⁰ *Id.* at 8.

¹⁵¹ *Id.*

¹⁵² *About DMHAS*, STATE OF CONNECTICUT DEPARTMENT OF MENTAL HEALTH & ADDICTION SERVICES, <http://www.ct.gov/dmhas/cwp/view.asp?a=2899&q=334082> (last modified Feb. 22, 2012). CDMHAS’s mission is “to improve the quality of life of the people . . . by providing an integrated network of comprehensive, effective and efficient mental health and addiction services.” *Id.* CDMHAS provides programs for a number of people, not just those involved in the criminal justice system. *Id.*; see also IMMARIGEON & GREENE, *supra* note 143, at 8 (“Connecticut has been building a relatively rich and comprehensive continuum of alternatives to incarceration and mental health programming for pretrial and sentenced populations in the state’s criminal justice system.”).

mobile crisis teams, and crisis intervention teams.¹⁵³ Connecticut also provides transitional services that offer assistance with reintegration.¹⁵⁴

1. *Connecticut's Diversion Team Program*

Connecticut's Diversion Team Program was designed to address the problems experienced in the Geographic Area (G.A.) courts with respect to mentally ill defendants.¹⁵⁵ Everyone—judges, public defenders, and states attorneys—agreed that these individuals were not receiving proper treatment.¹⁵⁶ The courts only had the power to order competency evaluations, which many times ultimately led to treatment but was an inefficient use of the state's resources.¹⁵⁷ In response to these issues, CDMHAS created diversion teams and put them to work in the courts.¹⁵⁸ CDMHAS started with this diversion program in only six mental health centers covering only nine G.A. courts.¹⁵⁹ In 2001, however, CDMHAS received \$3.1 million to expand the diversion program and it is now available on site at all twenty-two Connecticut G.A. courts.¹⁶⁰ Each program has at least one licensed clinician on site at the court, a forensic case manager, and a transitional or respite bed.¹⁶¹

Diversion teams consist of one to three clinicians who assist mentally ill individuals with arraignments, pleas, or sentencing.¹⁶² The professionals on these teams are employees of the mental health centers, not the court.¹⁶³ They function as mental health staff and must, therefore, obtain consent to work on behalf of the individual and receive permission to discuss their case with the court.¹⁶⁴ Every morning the arraignment list is faxed to these clinicians so that they can cross-reference it against CDMHAS's database of individuals currently receiving assistance from the mental health

¹⁵³ IMMARIGEON & GREENE, *supra* note 143, at 8. All of these programs seek to provide the court with the critical information needed to make an informed decision. *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ Frisman et al., *supra* note 112, at 1.

¹⁵⁶ *See id.* ("No one . . . felt that justice was done by imprisoning offenders whose mental disorders were more serious than their crimes.").

¹⁵⁷ *See id.* (providing a description of the process and how it was inefficient).

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

¹⁶⁰ Frisman et al., *supra* note 112, at 4.

¹⁶¹ *Id.*

¹⁶² *Id.* at 2. Although these clinicians can provide their assistance at any phase of the court case, they primarily focus on arraignments. *Id.*

¹⁶³ *See id.* at 1–2 ("These mental health centers recognized the value of having staff members who are knowledgeable about the criminal justice system, and the efficiency of basing clinicians in courts . . .").

¹⁶⁴ *Id.* at 2 (explaining that because these clinicians are employed by mental health centers, "[t]hey follow the rules of the mental health center[s] with respect to the goals of their work (to assist the client, and not the court) and the rules of treatment consent and confidentiality").

system.¹⁶⁵ This list determines (for the most part) which individuals will receive assistance on any given day, but the clinicians will also assist individuals recommended to them by court officials.¹⁶⁶ The clinician often performs a brief assessment in the lockup area to determine what, if any, symptoms the individual is experiencing, whether he or she is taking medication, and whether the individual has ever received treatment.¹⁶⁷

Clinicians on these diversion teams provide their opinion on the options in a case to the court.¹⁶⁸ They rely on their observations, and consider “the seriousness of the charge, the treatment plan indicated for the [individual], the risk posed by the [individual], and the extent to which the offense was related to the mental disorder.”¹⁶⁹ In Connecticut, diversion is not automatic.¹⁷⁰ The judge has discretion and ultimately decides who will be diverted.¹⁷¹ If an individual is diverted, he or she then works with the diversion team to create a treatment plan,¹⁷² which includes periodically checking in with the court to ensure that he or she is following the treatment plan.¹⁷³ At these checkups, it is the diversion clinician who reports whether the individual is keeping up with treatment.¹⁷⁴ If the individual fails to follow his or her treatment plan, his or her case is returned to the regular docket and proceeds as if diversion had not been attempted.¹⁷⁵

At the end of the day, not every mentally ill individual can be diverted. These diversion teams do try to ensure, however, that the mentally ill individuals going to prison receive the best treatment they can. Diversion teams call prisons to make sure the mental health staff is aware of an individual’s issues.¹⁷⁶ They give prisons their opinions on the medication and treatment for these individuals, and may also recommend that certain individuals be placed in Department of Correction specialty programs.¹⁷⁷

Other states, such as Pennsylvania and Ohio, have mental health courts in which all the courtroom personnel, including judges, prosecutors, and

¹⁶⁵ *Id.* (describing how “clients generally have a serious mental disorder, such as schizophrenia, bipolar disorder, or major depression”).

¹⁶⁶ Frisman et al., *supra* note 112, at 2.

¹⁶⁷ *Id.*

¹⁶⁸ *See id.* (“The diversion team does not make the decision to divert; rather, it offers options to the judges.”).

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *See id.* 2–3 (generalizing that “[m]ost of the clients [who are] diverted have minor charges, including misdemeanors and lower-level felonies”).

¹⁷² *Id.* at 3.

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ *Id.* (explaining that there is no “‘punishment’ for the failure to follow through”).

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

defense attorneys, have experience with mental health issues.¹⁷⁸ Mental health courts work to identify and order appropriate treatments for individuals suffering from mental illness.¹⁷⁹ These courts work with local mental health service providers and other social service agencies to prepare treatment plans.¹⁸⁰ Such courts focus on “therapeutic jurisprudence” and are less likely to automatically order punishment because they understand that noncompliance with treatment is sometimes caused by the mental illnesses.¹⁸¹

Connecticut’s diversion team program is different from these mental health courts in three major ways. First, the stigma is lessened by the structure of Connecticut’s diversion team program because individuals are kept on the regular docket rather than being referred to a specialized mental health court docket.¹⁸² Second, the diversion teams are there for the individuals who want their assistance and connect those individuals with treatment for as long as they need it.¹⁸³ Finally, Connecticut’s diversion plan is more cost effective than mental health courts because the staff are mental health clinicians.¹⁸⁴

The mentally ill fare better in community-based mental health programs than in prisons.¹⁸⁵ Because of their behavioral problems, the mentally ill often have more discipline reports than other inmates.¹⁸⁶ They

¹⁷⁸ FORENSIC TASKFORCE OF THE NAMI BD. OF DIRS., *supra* note 6, at 8; *Mental Health Courts*, PENN. COMMISSION ON CRIME & DELINQ., <http://www.portal.state.pa.us/portal/server.pt?open=512&objID=5281&&PageID=494082&level=3&css=L3&mode=2> (last visited May 11, 2012); *Mental Health Court: A Systems Collaboration*, AKRON MUN. CT., http://courts.ci.akron.oh.us/programs/mental_health.htm (last visited May 11, 2012).

¹⁷⁹ *Id.*

¹⁸⁰ *See id.* (describing how these treatment plans include “medications, therapy, housing, as well as social and vocational rehabilitation” and the goal is “to assure that the person has the tools and motivation necessary to achieve and maintain a timely and durable recovery”).

¹⁸¹ *Id.* at 9 (emphasis omitted).

¹⁸² Frisman et al., *supra* note 112, at 4.

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ FORENSIC TASKFORCE OF THE NAMI BD. OF DIRS., *supra* note 6, at 6–7 (discussing data that shows that “individuals diverted to treatment subsequently spend significantly fewer days in jails and psychiatric hospitals as compared with those who do not receive these services”); *see also* TEXAS CIVIL RIGHTS PROJECT, “A THIN LINE”: THE TEXAS PRISON HEALTHCARE CRISIS AND THE SECRET DEATH PENALTY 33–34 (2011) (suggesting that “[t]he most effective and humane way to improve mental health care in prisons is to divert mentally ill individuals away from prison conditions that may only exacerbate their problems, and instead relocate them to treatment facilities or community supervision where they can access helpful programs”); TORREY, *supra* note 40, at 34 (“Jails and prisons usually exacerbate psychiatric symptoms, both because the mentally ill are frequently placed in solitary confinement and because they often are not given the necessary medication to control their symptoms.”).

¹⁸⁶ *See* Abramsky & Fellner, *supra* note 1, at 59 (“Some [mentally ill prisoners] exhibit their illness through disruptive behavior, belligerence, aggression, and violence. Many will simply—and sometimes without warning—refuse to follow straightforward routine orders to sit down, to come out of a cell, to stand up for the count, to remove clothes from cell bars, or to take showers.”); *see also*

are more likely than other inmates to get into fights and to break the prison rules.¹⁸⁷ The mentally ill are not only more likely to end up in prison,¹⁸⁸ but are also more likely to serve more of their sentence, and to be denied parole.¹⁸⁹ Additionally, some community programs are hesitant to admit criminal offenders into their programs.¹⁹⁰ Diversion away from the criminal justice system makes it more likely that these individuals will receive the help and care they need. A study conducted by the SAMHSA showed that those who used the diversion team program were “25% more likely to receive mental health counseling services.”¹⁹¹ In addition, the study showed that those who were diverted spent “more time in the community and less time in jail than those who [were] not diverted”¹⁹² The Diversion Team Program provides judges and prosecutors with an alternative for those individuals they know will not benefit from imprisonment and furthers public safety by increasing space in prisons for violent offenders.¹⁹³

2. Jail Re-Interview Programs

The Jail Re-Interview Process represents another program

TORREY, *supra* note 40, at 31 (“Because of illogical thinking, delusions, or auditory hallucinations, many of the mentally ill inmates cannot comprehend the rules of jails and prisons and this has predictable, and sometimes tragic, consequences.”); Fellner, *supra* note 60, at 397 (discussing how “[m]entally ill inmates who act out are typically treated with punitive measures without regard to their mental status”) (quoting *Coleman v. Wilson*, 912 F. Supp. 1282, 1320 (E.D. Cal. 1995)).

¹⁸⁷ Abramsky & Fellner, *supra* note 1, at 60 (“36.7 percent of mentally ill state prison prisoners have been in fights since admission, compared to 24.4 percent of other prisoners. Similarly, 62.2 percent of mentally ill state prisoners have been charged with breaking prison rules, compared to 51.9 percent of other prisoners.”); *see also* Fellner, *supra* note 60, at 396–97 (discussing how correction officers “may not even know a distinction exists—between a frustrated or disgruntled inmate who ‘acts out’ and one whose ‘acting out’ reflects mental illness”).

¹⁸⁸ *See* Abramsky & Fellner, *supra* note 1, at 25; *see also* NAT’L ASS’N OF MENTAL HEALTH PLANNING & ADVISORY COUNCILS, *supra* note 5, at 5 (“Police officers repeatedly arrest the same [people] for offenses (often low-level) which can be clearly be [sic] linked to their mental illness. Prosecutors charge individuals with misdemeanor nuisance crimes, knowing that they are likely to see the same individual again soon. Probation and parole staff . . . see these individuals repeatedly rearrested for the same or similar behaviors that actually represent the symptoms of an untreated and disabling mental illness.”).

¹⁸⁹ Abramsky & Fellner, *supra* note 1, at 69 (“Mentally ill offenders average a total of 103 months in prison, fifteen months longer than other offenders. . . . Because of their disciplinary records—as well as concerns about their mental illness itself—mentally ill prisoners are also at greater risk than others of being denied parole”); *see also* Corrigan & Kleinlein, *supra* note 7, at 20 (“Someone experiencing a mental illness tends to spend more time incarcerated than persons without mental illness.”) (citation omitted).

¹⁹⁰ NAT’L ASS’N OF MENTAL HEALTH PLANNING & ADVISORY COUNCILS, *supra* note 5, at 5 (“Having a history of conviction and being labeled as a criminal may make community-based providers reluctant to treat some individuals.”).

¹⁹¹ *Id.* at 13.

¹⁹² *Id.*

¹⁹³ *Id.* at 6.

implemented in Connecticut.¹⁹⁴ This program was created “to reduce the number of people held in pretrial detention prior to disposition of their cases.”¹⁹⁵ Bail commissioners determine whether individuals who are unable to post bail should be placed in an alternative program that would be more effective than incarceration.¹⁹⁶ Judges are permitted to reconsider the bail requirement if a workable plan can be developed in which the individual is properly supervised.¹⁹⁷

3. *Mobile Crisis Teams*

Mobile crisis teams are groups of mental health professionals who work together with the police departments to provide assistance to individuals in psychiatric crisis.¹⁹⁸ The teams work seven days a week, travel, evaluate people in “[their] homes, jails, shelters, residential programs, hospital emergency rooms, nursing homes, and in other mental health facilities,” and assess whether an individual is in need of treatment.¹⁹⁹ These teams consist of an array of mental health professionals—psychologists, psychiatrists, social workers, and nurses—who do not have the power to place people under arrest, but do work with the police departments to ensure situations are handled in the best way possible.²⁰⁰

4. *Crisis Intervention Teams*²⁰¹

Connecticut also has crisis intervention teams of specially trained police officers who respond to crisis calls involving the mentally ill, perform mental health evaluations, and provide recommendations.²⁰² The mobile crisis teams often provide clinical support and backup for these

¹⁹⁴ IMMARIGEON & GREENE, *supra* note 143, at 10.

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*

¹⁹⁸ *Capitol Region Mental Health Center*, STATE OF CONN. DEP’T OF MENTAL HEALTH & ADDICTION SERVS., <http://www.ct.gov/dmhas/cwp/view.asp?a=2909&q=334712> (last modified Aug. 20, 2010).

¹⁹⁹ *Id.*

²⁰⁰ See SLATE & JOHNSON, *supra* note 1, at 92 (describing how generally mobile crisis teams “are housed separately from [sic] law enforcement agencies, do not have arrest powers, and operate in conjunction with law enforcement”).

²⁰¹ The Memphis Police Department developed the crisis intervention team model in 1988 when it partnered with the University of Memphis, University of Tennessee, and the Memphis Chapter of the National Alliance on Mental Illness to address the special needs of the mentally ill. *Crisis Intervention Teams—Facts & Benefits*, CONN. ALLIANCE TO BENEFIT LAW ENFORCEMENT, <http://www.cableweb.org/wp/wp-content/uploads/2012/01/CIT-Fact-Sheet.pdf>. Connecticut implemented a very similar model.

²⁰² *Id.*; see also *Community Forensic Services (CFS)*, STATE OF CONN. DEP’T OF MENTAL HEALTH & ADDICTION SERVS., <http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=334748> (last modified Aug. 18, 2010) (describing how “Crisis Intervention Teams are a partnership program between the local police and the community . . . that provides training to law enforcement personnel and provides for a joint response to crisis”).

crisis intervention teams.²⁰³ In Connecticut, there are trained team clinicians in Bridgeport, Hartford, New Haven, Norwich, Stamford, and Waterbury.²⁰⁴

The Connecticut Alliance to Benefit Law Enforcement (“CABLE”) has run the crisis intervention team training since 2003.²⁰⁵ Crisis intervention teams consist of police officers that volunteer and are then chosen from the volunteer list.²⁰⁶ Officers are selected based on their “police skill, compassion, patience and the ability to think creatively.”²⁰⁷ The training is one, forty-hour week and is taught by certified instructors.²⁰⁸ These instructors include trained, experienced law enforcement professionals, mental health professionals, and families and persons living with mental illness.²⁰⁹ The training covers topics such as “mental illness, substance abuse, the mental health system, safe de-escalation techniques, suicide by cop, suicide assessment and prevention, children’s mental health and trauma, mental health and the law, excited delirium, and real-life family and consumer perspectives on living with mental illness.”²¹⁰ After the one-week training, officers are allowed to handle calls—they receive advanced training periodically.²¹¹ The goal is to reduce the number of arrests and get mentally ill individuals the treatment they need.²¹²

²⁰³ *Capitol Region Mental Health Center*, *supra* note 198.

²⁰⁴ *Community Forensic Services (CFS)*, *supra* note 202.

²⁰⁵ *Crisis Intervention Team Training*, CONNECTICUT ALLIANCE TO BENEFIT LAW ENFORCEMENT, <http://www.cableweb.org/training/crisis-intervention-teams> (last visited Mar. 16, 2012); *see also CIT Growing in Connecticut*, CONNECTICUT ALLIANCE TO BENEFIT LAW ENFORCEMENT, www.cableweb.org/.../CIT_Growing_in_Connecticut_July2011.pdf (last visited Nov. 4, 2011) (“As of June 2011, over 1300 police officers, state, federal and local police agencies, mental health probation officers from Connecticut’s Court Support Services Division of the Judicial Branch, mental health parole officers of the Department of Corrections and their community partners have received CABLE’s Crisis Intervention Team Training.”); *The Connecticut Model (Power Point)*, CONNECTICUT ALLIANCE TO BENEFIT LAW ENFORCEMENT, www.cableweb.org/.../CIT-The-Connecticut-Model_MANAMI.ppt (showing that Connecticut currently holds twenty trainings a year with six annual refresher conferences and has fifty-five enforcement agencies involved).

²⁰⁶ *Crisis Intervention Team Training*, *supra* note 205.

²⁰⁷ *Id.*

²⁰⁸ *Id.*

²⁰⁹ *The Connecticut Model*, *supra* note 205; *see also* SLATE & JOHNSON, *supra* note 1, at 105 (“Crisis intervention team training is a way of breaking down barriers by bringing law enforcement officers and persons with mental illness and their family members together to establish rapport and enhance future interactions.”).

²¹⁰ *Crisis Intervention Team Training*, *supra* note 205.

²¹¹ *Id.*

²¹² *See id.* (“The goal of the Crisis Intervention Team model . . . is safety: for the community, the law enforcement officers and the person in crisis.”); *The Connecticut Model*, *supra* note 205 (explaining how the goals are to have care that extends beyond the initial encounter by having people in place who can follow-up to ensure that these individuals get the treatment they need, and to ultimately reduce the number of repeat calls so that more people can get help); *see also* SLATE & JOHNSON, *supra* note 1, at 100 (describing how the training seeks to “improv[e] the understanding of the signs and

Connecticut has benefited from these crisis intervention teams in several ways. First, with these teams there is less need for the use of force, which has translated into fewer injuries to both responding officers and mentally ill individuals.²¹³ Second, these teams have lowered the number of arrests and increased access to mental health treatment.²¹⁴ Third, relations with the community have improved because the skills learned by these police officers are used in all aspects of their duties.²¹⁵ Finally, studies have shown that crisis intervention team training reduces the negative attitudes police officers often have toward the mentally ill.²¹⁶ The officers who receive this training have a better understanding of why these individuals should be given mental health treatment rather than be sent to prison.²¹⁷

5. *Transitional Services*

Studies show that many mentally ill individuals reenter through the “[r]evolving [j]ail [d]oor”²¹⁸ because of the lack of proper support systems outside of prison.²¹⁹ During her administration, Lantz created a new reentry model that was designed simultaneously to address this issue and enhance public safety.²²⁰ According to the new model, certain inmates, toward the end of their sentence, are eligible for release to the community under the supervision of the department’s Parole and Community Services Unit.²²¹ The inmate must meet specific criteria to be eligible for this

symptoms of mental illness[]; identif[y] community resources and alternative dispositions; and enhanc[e] crisis communication skills so de-escalation can take place without physical confrontations”).

²¹³ *Crisis Intervention Teams—Facts & Benefits*, *supra* note 205 (reporting an eighty-five percent drop in officer injuries and forty percent drop in injuries to mentally ill individuals); *see also* SLATE & JOHNSON, *supra* note 1, at 99 (explaining that one of the reasons the Crisis Intervention Team program has been “singled out as the premiere model for responding to persons with mental illnesses in crises” is “its effectiveness in diminishing injuries to both persons with mental illnesses and police officers”).

²¹⁴ SLATE & JOHNSON, *supra* note 1, at 99.

²¹⁵ *Crisis Intervention Teams—Facts & Benefits*, *supra* note 205.

²¹⁶ *See* SLATE & JOHNSON, *supra* note 1, at 99 (“[Crisis Intervention Team] training has also been found to potentially reduce law enforcement officers’ stigmatizing attitudes toward persons with mental illness.”) (internal citation omitted).

²¹⁷ *See id.* (“[Crisis Intervention Teams] result[] in improved relationships between law enforcement and advocates.”).

²¹⁸ TORREY ET AL., *supra* note 2, at 81.

²¹⁹ *See supra* Section III.D (explaining why the mentally ill need social support systems—family, friends, and other social networks—to help them recover and reintegrate once released from prison).

²²⁰ *History of the Connecticut Department of Correction*, *supra* note 9; *see also* M. JODI RELL & BRIAN K. MURPHY, STATE OF CONNECTICUT DEP’T OF CORRECTION, PROMOTING PROGRESSIVE EXCELLENCE: STRATEGIC PLAN 2009–2012 15 (2009) (listing the continued goals of the Community Reentry Model as “enhancing public safety, reducing recidivism, reinforcing law-abiding behavior, and reducing the cost of holding offenders accountable”).

²²¹ *Transitional Services Overview*, STATE OF CONN. DEP’T OF CORRECTION, <http://www.ct.gov/doc/cwp/view.asp?a=1492&q=277104> (last modified Jan. 28, 2009); *see also* *Parole and Community Services*, STATE OF CONNECTICUT DEP’T OF CORRECTIONS,

program.²²² The Board of Paroles considers the nature of the inmate's offense, behavior while in prison, and length of time before his or her sentence is completed before making the final decision on release.²²³ This program was designed to lower recidivism rates by creating a bridge for reentry into society.²²⁴ Supervision of these vulnerable individuals during this critical reintegration period also provides additional protection to the public.²²⁵

Lantz wanted to create a program that would provide "a continuum of care, custody and control from the first day of incarceration to the last."²²⁶ She even had the Department of Correction's Mission Statement changed to reflect its new commitment to assisting in the reintegration of inmates.²²⁷ This program is cited as one of the reasons the incarcerated population has decreased in Connecticut.²²⁸ It expanded collaboration between the state agencies that provide assistance to these individuals and focused the entire system toward the same end goal.²²⁹

VI. A BRIEF LOOK AT OTHER STATE PRISON SYSTEMS

The increase in mentally ill prisoners is not limited to Connecticut. It is a national problem and each state has faced the task of finding a way to address the unique needs of the mentally ill. The most recent report, compiled by the Bureau of Justice Statistics in 2005, estimated that 705,600 state prisoners and 70,200 federal prisoners were mentally ill, which represented approximately fifty-six percent of state prisoners and forty-five percent of federal prisoners.²³⁰ These data indicate a significant increase in the number of mentally ill prisoners in both institutions from

<http://www.ct.gov/doc/cwp/view.asp?a=1503&q=265536> (last modified Oct. 31, 2011) (describing how the Parole and Community Services Unit assists with reintegration by "setting expectations, assisting with the attainment of those goals, providing oversight to determine if expectations are being met, and when necessary, removing the offender from the community when further confinement is warranted").

²²² *Parole and Community Services*, *supra* note 221.

²²³ *Id.*

²²⁴ *Transitional Services Overview*, *supra* note 221; *see also* RELL & MURPHY, *supra* note 220, at 15 (discussing how the program creates a continuum of "custody, care and control [that] allows [the Department of Correction] to address the risk and needs of offenders, to reduce recidivism and . . . to enhance public safety").

²²⁵ *Transitional Services Overview*, *supra* note 221.

²²⁶ *History of the Connecticut Department of Correction*, *supra* note 9.

²²⁷ *Id.* The new Mission Statement reads, "The Connecticut Department of Correction shall protect the public, protect staff and provide safe, secure and humane supervision of offenders with opportunities that support successful community reintegration." *Id.*

²²⁸ *Id.*

²²⁹ *Id.*; *see also* *Transitional Services Overview*, *supra* note 221 (explaining that "[t]he purpose of the program is to reduce recidivism by helping inmates prepare themselves to enter society prior to discharge").

²³⁰ JAMES & GLAZE, *supra* note 4, at 1.

the last time the population was surveyed in 1998, when approximately sixteen percent of state prisoners and seven percent of federal prisoners were mentally ill.²³¹ The 2005 report also estimated that approximately forty-three percent of state prisoners met the criteria for mania, twenty-three percent for major depression, and fifteen percent for psychotic disorder.²³² The most recent report on mental health treatment in state prisons, published in 2001, estimated that one in every eight state prisoners was receiving some form of mental health therapy or counseling, approximately ten percent was receiving psychotropic medications, and fewer than two percent was housed in twenty-four hour mental health units.²³³

These numbers speak to the concern that prisons have become the new mental health system and that mentally ill prisoners are not receiving adequate care. The number of people incarcerated in state and federal prisons continues to increase, and with it comes a rise in the number of mentally ill prisoners.

Each state has addressed the increased presence of mentally ill individuals in their prison populations differently. Connecticut's numbers reflect its relative success in this area because more individuals are receiving treatment—whether in or outside of prison.²³⁴ Other states have been equally active in addressing the problem, albeit with varying degrees of success. This section provides a look at how two states comparable in size to Connecticut, one located in the mid-west and the other on the west coast, have approached this issue.

A. Wisconsin Prisons

As of June 2008, 22,451 people were incarcerated in Wisconsin prisons.²³⁵ Of that population, approximately thirty-one percent, or 6957 people, suffered from mental illness.²³⁶ In contrast to Connecticut—which shifted its focus to diversion in order to deal with the increase in mentally ill prisoners—Wisconsin focused on increasing treatment in prison and smoothing the transition from prison back into the community.²³⁷

Upon entry into the Wisconsin prison system, every inmate undergoes

²³¹ PAULA M. DITTON, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT: MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 1 (1999).

²³² JAMES & GLAZE, *supra* note 4, at 1.

²³³ ALLEN J. BECK & LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS: MENTAL HEALTH TREATMENT IN STATE PRISONS, 2000 1 (2001).

²³⁴ See *supra* Part V (discussing the programs Connecticut implemented to address the increase in mentally ill inmates).

²³⁵ KATE WADE ET AL., AN EVALUATION: INMATE MENTAL HEALTH CARE 25 (2009).

²³⁶ *Id.*

²³⁷ See *id.*, at 19–20, 83 (2009) (discussing the mental health classification system used in Wisconsin prisons and the importance of connecting inmates to community services).

a one-month intake assessment process at one of two facilities—Taycheedah Correctional Institution, a female prison, or Dodge Correctional Institution, a male prison.²³⁸ During this process, the Wisconsin Department of Correction (“WDOC”) staff conducts a variety of screenings and assessments “to determine each inmate’s security classification and programming needs.”²³⁹ Following this, inmates are assigned to an institution. According to the WDOC’s policy, no seriously mentally ill inmates may be placed at the Wisconsin Secure Program Facility, previously known as the “Supermax” prison.²⁴⁰ Although an inmate’s mental health classification does not affect which facility he or she is assigned to in most cases, mentally ill inmates may only be placed in one of the nine prisons that have special management units or other special housing units, or in the Wisconsin Resource Center (“WRC”).²⁴¹

The Wisconsin legislature created the WRC in 1981.²⁴² It provides “psychological evaluations, specialized learning programs, [and] training and supervision for inmates whose behavior presents a serious problem to themselves or others in state prisons”²⁴³ The WRC currently houses approximately 314 inmates in fourteen living units that are “each staffed by psychological services personnel, as well as a teacher, a social worker and a therapeutic services staff person”²⁴⁴ Individuals are normally transferred to the WRC for temporary treatment stays.²⁴⁵ In fact, most inmate treatment stays last three months to one year.²⁴⁶ When the inmates first arrive, they undergo a two to three week intake assessment during which their needs are assessed and a treatment plan is developed.²⁴⁷ During their stay, inmates have access to a number of clinical treatment programs, including mental health education, coping skills, personal development, anger management, and cognitive intervention; they also

²³⁸ *Id.* at 21.

²³⁹ *Id.*

²⁴⁰ *Id.* at 33.

²⁴¹ *Id.* at 33–34.

²⁴² WIS. STAT. § 46.056 (1981). As of 2005, the WRC was the only prison in the United States “run by a state agency other than a corrections department.” Pfeiffer, *supra* note 11, at 52. Two advantages the WRC has over an institution like Garner Correctional Institution in Connecticut are that “[i]t can recruit mental health workers more easily, because it does not carry the stigma of a prison” and “[i]t does not compete for funds with other prisons, because it is not part of a corrections department budget.” *Id.*

²⁴³ *Id.*

²⁴⁴ WADE ET AL., *supra* note 235, at 51.

²⁴⁵ *Id.* at 57. Admission to the WRC is normally considered on a case-by-case basis. *Id.* Once the institution requests a transfer, a screening committee composed of two psychologists, a social worker, a therapist, and a unit manager will examine a number of factors—the inmate’s treatment needs, the potential security risks, and the overall benefits and risks of transfer—to determine whether to accept the transfer. *Id.*

²⁴⁶ *Id.* at 53.

²⁴⁷ *Id.* at 59. This plan is consistently adjusted to meet the inmates’ needs. *Id.*

have access to “seventeen different structured mental health and therapy groups that provide support for inmates with specific mental health issues”²⁴⁸

Over the past decade, Wisconsin has improved the care it provides mentally ill inmates significantly. The WRC is one of three secure treatment facilities, managed by the Wisconsin Division of Mental Health and Substance Abuse Services (“WDMHSAS”), at which inmates can receive treatment.²⁴⁹ Additionally, the WDMHSAS operates two psychiatric hospitals for “[those] civilly committed and forensic patients who are committed as a result of a criminal proceeding.”²⁵⁰

Wisconsin has also implemented two programs to assist mentally ill individuals with reintegration. First, the WDOC provides a two-week supply of and thirty-day prescription for psychotropic medications.²⁵¹ This policy is in place “to ensure that inmates have a supply of medication sufficient to last until they can obtain treatment in the community.”²⁵² Second, the WDOC implemented a policy requiring prisons to help inmates apply for Social Security and Medicaid benefits.²⁵³ The WDOC negotiated with Wisconsin’s Medical Assistance program and individuals can now submit applications for benefits twenty-three days before release.²⁵⁴

Although Wisconsin has made significant improvements to its system, a report, compiled by the Legislative Audit Bureau, expressed some concerns indicative of the work that remains. First, the report raised the question of whether seriously mentally ill individuals have the ability to fill their own prescription.²⁵⁵ Second, the report suggested that the WDOC does not normally meet the deadlines set by the benefits assistance policy, meaning that inmates still do not have access to care when released.²⁵⁶ Third, as of January 2008, “none of the special management units were located at medium security institutions, despite the fact that . . . the largest number of mentally ill inmates [were] housed there.”²⁵⁷ Fourth, the ratio of inmates on psychotropic medication to psychiatrists was 345 inmates per psychiatrist, “more than two times the American Psychiatric Association’s

²⁴⁸ *Id.* at 60. The WRC tries to minimize the amount of time inmates spend alone in their cells. *Id.* at 61.

²⁴⁹ *Psychiatric Hospitals and Secure Treatment Facilities*, WISCONSIN DEP’T OF HEALTH SERVICES, http://www.dhs.wisconsin.gov/MentalHealth/DCTF/mh_facilities.htm (last modified Jan. 6, 2011).

²⁵⁰ *Id.*

²⁵¹ *Id.* at 86.

²⁵² *Id.*

²⁵³ *Id.* at 87.

²⁵⁴ *Id.*

²⁵⁵ *Id.* at 86.

²⁵⁶ *Id.* at 87.

²⁵⁷ WADE ET AL., *supra* note 235, at 34.

recommendation.”²⁵⁸ Fifth, psychologists reported having difficulty meeting with inmates on a regular basis because of understaffing.²⁵⁹ Finally, group therapy was limited;²⁶⁰ seven of the nine prisons that provide group therapy reported that “there are not enough groups to meet the inmates’ therapeutic needs.”²⁶¹

B. Washington Prisons

As of December 2011, 16,313 people were incarcerated in Washington’s twelve prison facilities.²⁶² Like Wisconsin, Washington State Department of Corrections (“WSDOC”) focused its efforts on providing treatment in prisons and assisting inmates with reintegration.²⁶³ Approximately 3000 inmates are currently receiving treatment for mental illness in Washington prisons.²⁶⁴ The WSDOC mental health staff includes psychiatrists, psychiatric nurses, psychologists, and psychiatric social workers.²⁶⁵ These individuals provide a number of “inpatient” and “outpatient” services, including “[m]ental health screening at intake[,] [p]sychological evaluation[,] [m]edical evaluation and management[,] [p]sychological assessment[,] [s]uicide prevention and intervention[,] [c]risis intervention[,] [i]ndividual and group treatment[,] [and] [c]ognitive behavioral treatment.”²⁶⁶

Every prisoner undergoes an assessment intake when he or she arrives in prison. Those individuals identified as mentally ill are then “sent to one of four treatment settings—acute inpatient psychiatric treatment, inpatient residential, intensive outpatient, or outpatient treatment.”²⁶⁷ Inmates placed in acute inpatient psychiatric treatment are placed in specialized housing units and receive short-term care including, “observation and assessment, crisis intervention and medication management.”²⁶⁸ Inmates receiving inpatient residential mental health treatment are normally unable

²⁵⁸ *Id.* at 37.

²⁵⁹ *Id.* at 38.

²⁶⁰ *Id.*

²⁶¹ *Id.*

²⁶² *Quarterly Fact Card*, WASH. STATE DEP’T OF CORR., http://www.doc.wa.gov/aboutdoc/docs/msFactCard_003.pdf (last modified Dec. 31, 2011).

²⁶³ MIKE WALLS, STATE OF WASH. DEP’T OF CORR., MENTAL HEALTH TREATMENT SERVICES: THERAPY AND MEDICINE OFFERS NEW LIVES 3–4 (2008) (discussing the treatment options available in Washington prisons and the Department of Correction’s focus on assisting individuals when they return to the community).

²⁶⁴ *Id.* at 3.

²⁶⁵ *Id.*

²⁶⁶ *Id.*

²⁶⁷ Jose Cortez et al., STATE OF WASH. DEP’T OF CORRECTIONS, GOING HOME: ACCOMPLISHMENTS IN PUBLIC SAFETY 21 (Joseph Mitchell ed., 2009).

²⁶⁸ WALLS, *supra* note 263, at 3.

to function in the general prison population.²⁶⁹ The treatment is meant to stabilize the individual, and help him or her transition to a less restrictive environment.²⁷⁰ Individuals receive intensive outpatient treatment when they are transitioning from inpatient residential treatment to less restrictive settings, as well as when they are in need of the treatment to remain in the general prison population.²⁷¹ Finally, outpatient treatment is available for those inmates in the general prison population who have completed intensive outpatient treatment and need additional care.²⁷²

As of December 2011, Washington also had almost 700 people housed in its fifteen work release facilities.²⁷³ These facilities “serve as a bridge between life in prison and life in the community” by helping inmates “find[] and retain[] employment, re-connect[] with family members, and become[] productive members of the community.”²⁷⁴ Inmates are given permission to leave the facility “for work or other specific activities, such as appointments, treatment, shopping, or outings to visit family.”²⁷⁵ To be eligible for this program, inmates must meet certain criteria that vary by facility and have six months of their sentence left to serve.²⁷⁶ In addition, prisoners must follow the program rules, which include getting and maintaining a job, submitting to drug tests, continuing treatment, and refraining from leaving the facility for reasons other than a permitted activity.²⁷⁷ This program has helped numerous inmates maintain employment and stable housing after being released from prison.²⁷⁸ In addition, there is one facility that only houses individuals with mental illness and requires participation in group therapy at least once a week, and at least two other facilities that provide access to mental health treatment and services.²⁷⁹

²⁶⁹ *Id.*

²⁷⁰ *Id.*

²⁷¹ *Id.*

²⁷² *Id.*

²⁷³ *Quarterly Fact Card*, *supra* note 262.

²⁷⁴ *Work Releases*, WASH. STATE DEP'T OF CORRECTIONS, <http://www.doc.wa.gov/facilities/workrelease/default.asp> (last visited Mar. 14, 2011).

²⁷⁵ *Id.*

²⁷⁶ *Id.*; see also ELIZABETH DRAKE, WASH. STATE INST. FOR PUB. POL'Y, DOES PARTICIPATION IN WASHINGTON'S WORK RELEASE FACILITIES REDUCE RECIDIVISM? 2 (2007), available at <http://www.wispp.wa.gov/rptfiles/07-11-1201.pdf>.

²⁷⁷ *Work Releases*, *supra* note 274.

²⁷⁸ *Id.*

²⁷⁹ *Rap House/Lincoln Park Work Release*, WASH. STATE DEP'T OF CORR., <http://www.doc.wa.gov/facilities/workrelease/raplincolnparkwr/default.asp> (last visited Mar. 14, 2012); see also *Longview Work Release*, WASH. STATE DEP'T OF CORR., <http://www.doc.wa.gov/facilities/workrelease/longviewwr/default.asp> (last visited Mar. 14, 2012) (listing mental health treatment as an additional service available in the community); *Peninsula Work Release*, WASH. STATE DEP'T OF CORR., <http://www.doc.wa.gov/facilities/workrelease/peninsulawr/default.asp> (last visited Mar. 14, 2012) (stating that individuals may attend “other treatment in the community”); *Tri-Cities*

As in Connecticut and Wisconsin, there are still areas for improvement. First, more than three of the fifteen work release facilities should be equipped to assist mentally ill inmates. Second, one report suggested that inmates have “only minimal access to therapy and regular group programs, but that they are medicated at the drop of a hat.”²⁸⁰ Inmates are often treated with medication because the “primary responder” is usually a psychiatrist, or a “doctor who medicates[.]” rather than a psychologist, or a “clinician who offers therapy and counseling.”²⁸¹ Ensuring that there are more psychologists to respond to mentally ill inmates could help remedy this problem. Finally, Washington must address its understaffing problem.²⁸²

VII. THE FUTURE: WHAT MORE CAN BE DONE

A. Increase Funding

At the heart of the issue of the incarceration of mentally ill individuals is a lack of funding. The U.S. Supreme Court held that inmates have a constitutional right under the Eighth Amendment to both general medical care and mental healthcare.²⁸³ To rise to the level of an Eighth Amendment violation, however, the injury must constitute an “unnecessary and wanton infliction of pain” and must “offend evolving standards of decency.”²⁸⁴ Thus, while inmates have a right to treatment in prison, they are not entitled to the treatment of their choice. The Court had to recognize the expense of providing this care in prisons. For example, Connecticut’s budget for prison healthcare—for both physical and mental conditions—is about \$3.5 billion in deficit for the next fiscal year.²⁸⁵ While prisons should have a sufficient number of treatment services and mental health professionals, a system to keep track of clinical records, procedures for screening and identifying the mentally ill, and protocols to ensure timely access to care, research suggests that “no prison system provides all of these components” in large part because of the cost.²⁸⁶

The current system would significantly improve if there were a way to

Work Release, WASH. STATE DEP’T OF CORR., <http://www.doc.wa.gov/facilities/workrelease/tricitieswrt/default.asp> (last visited Mar. 14, 2012) (providing intensive outpatient treatment and outpatient treatment as two of the programming opportunities).

²⁸⁰ Abramsky & Fellner, *supra* note 1, at 113.

²⁸¹ *Id.* at 114.

²⁸² *Id.* at 125 (discussing how understaffing leads to problems when inmates refuse to take their medications, and later become a danger to themselves or others and must be involuntarily medicated).

²⁸³ *Estelle v. Gamble*, 429 U.S. 97, 105 (1976) (holding that deliberate indifference to an inmate’s medical condition constitutes cruel and unusual punishment in violation of the Eighth Amendment).

²⁸⁴ *Id.* at 105–06 (internal quotations omitted).

²⁸⁵ *CT Prisons Facing Increase in Mentally Ill Inmates*, *supra* note 8.

²⁸⁶ Abramsky & Fellner, *supra* note 1, at 94.

increase funding so that the standard level of care provided in these institutions could be raised. Funding, however, has been and will likely continue to be an issue. The question then is what other steps can be taken to decrease the number of mentally ill individuals in prison and to ensure that these individuals receive the care and treatment they need.

B. *Address the Criminalization of and Characteristics Common to the Mentally Ill*

As an initial matter, one must consider certain factors that have led to the criminalization of mental illness. All police officers should receive mental health training, not just those officers on crisis intervention teams or mobile crisis teams. Police officers must understand the symptoms of mental illnesses to be able to identify when an individual is suffering from a mental illness and to evaluate how best to deal with that individual in crisis. This mental health training may also increase the number of individuals taken to psychiatric emergency rooms because police officers are likely to feel more confident that a doctor would agree with their assessment and admit the individual. Another way to increase psychiatric emergency room visits is to speed up the process. Many police officers do not take individuals to the psychiatric emergency room because it takes a long time and doctors may disagree and release the individual. Creating a faster system, where police officers feel more confident about their decision to take someone to the emergency room would decrease the number of individuals charged and sent to prison.

Inadequate support systems are also problematic. Mental illness is a burden not only for the individual, but also for his or her friends and family who must see the effects of the disorder on a person they care for. Many families and friends disconnect themselves from these mentally ill individuals because they do not know how to care for the individual and mistakenly believe that he or she will receive care and treatment in prison. States should create more support and educational programs to help alleviate this burden. Families and friends should understand that they are needed and that they play an important role in the mentally ill individual's life.²⁸⁷ It is likely that more families and friends would provide support if taught how to care for the mentally ill person.

²⁸⁷ ALEXANDRA H. SMITH & JENNIFER J. PARISH, WHEN A PERSON WITH MENTAL ILLNESS GOES TO PRISON: HOW TO HELP 22 (2010) ("Family involvement is no less as important when the person with mental illness is in prison."). Families can and should reach out to the mental health staff treating their loved one in prison. *Id.* at 21–22. To make an accurate assessment of an individual's condition, the mental health staff needs as much information as possible. *Id.* at 22. The unique knowledge family members have about their loved one's background and treatment history can help the mental health staff make a proper assessment and develop an effective treatment plan for the mentally ill individual. *Id.*

Additionally, homelessness is a major issue for the mentally ill.²⁸⁸ Because such a large portion of the mentally ill population is homeless, it is plausible that far fewer of these individuals would turn to crime if there were more shelters available. More supportive housing programs and group homes could provide the support these individuals need.

Additionally, a system that ensured that mentally ill individuals applied for and were reinstated for Medicaid benefits before release from prison could eliminate one of the burdens on these individuals.²⁸⁹ People lose access to their Medicaid benefits when they are incarcerated and, therefore, do not have access to treatment when released.²⁹⁰ For those individuals with no family or friends, whose first concern is finding a place to stay, applying for Medicaid benefits is not a simple task or even a task worth prioritizing. Even states like Wisconsin, which have already implemented this policy, must continue to work to ensure that applications are submitted as early as possible. These two steps alone—increasing housing and ensuring that Medicaid benefits are available upon release—could result in far fewer individuals entering or reentering the criminal justice system.

A third step that could be taken is a serious effort toward fully integrated treatment programs. To successfully treat mental illness, states should also implement programs to address co-occurring drug or alcohol abuse problems.²⁹¹ Fully integrated treatment programs would ensure that every individual receives the treatment he or she needs for all of his or her illnesses. Even states such as Connecticut, that have most of their mental health clinicians trained in the treatment of substance abuse disorders, must work toward having their programs fully integrated so that individuals with co-occurring disorders receive the most effective treatment possible.

Finally, the negative stigma attached to mental illness must be eliminated. Society, as a whole, does not understand mental illness. The horrific actions of a small subsection of the population have branded the mentally ill as “violent,” “dangerous,” and “criminals.”²⁹² The truth,

²⁸⁸ See *supra* Part IV (discussing four characteristics—homelessness, lost access to Medicaid benefits, co-occurring disorders, and stigma—common to the mentally ill population).

²⁸⁹ Connecticut considered such a program in 2003, but as of today there is nothing in place. Abramsky & Fellner, *supra* note 1, at 197–98. Massachusetts and Tennessee set up similar programs, but neither has ensured that every mentally ill individual has access to care when released. *Id.* at 198. Furthermore, Wisconsin implemented a benefits assistance program, but the WDOC does not normally meet the deadlines, meaning many inmates do not have access to treatment when released. WADE ET AL., *supra* note 235, at 87. Many states “simply do not view this type of transitional care as part of their job.” Abramsky & Fellner, *supra* note 1, at 199. That attitude must change.

²⁹⁰ NAT’L ASS’N OF MENTAL HEALTH PLANNING & ADVISORY COUNCILS, *supra* note 5, at 5.

²⁹¹ See *supra* Section IV.C (discussing the need for integrated mental health and substance abuse treatment programs).

²⁹² See *supra* Section III.E (explaining that most of the mentally ill population is not violent, and discussing the factors used to help predict the risk of violence amongst this population).

however, is that very few of these individuals are violent or dangerous, and that while many may technically be “criminals,” an overwhelming number of these individuals are arrested for nonviolent misdemeanor crimes, such as trespassing.²⁹³ The stigma society has attached to the mentally ill affects their employment prospects, chances of getting housing, and access to treatment.²⁹⁴ Regardless of the difficulty, attempting to change the stigma is worthwhile because societal attitudes toward the punishments mentally ill individuals deserve would almost certainly change if this negative stigma was eliminated.

C. Focus on Diversion

The number of individuals receiving institutional care can also be decreased significantly by shifting the focus to diversion. When an inmate attacks a correction officer, there is no time for him or her to determine whether a mental illness caused that aggression. That officer and the officers that come to his or her aid must act quickly to protect one another and to secure the prison.²⁹⁵ It is clear that many mentally ill individuals are much better served outside of prison in community-based mental health programs—which is why diversion is one of the best solutions. Although, diversion will not work for everyone, these programs may still benefit everyone by decreasing the overall number of individuals seeking institutional care, and thus providing more opportunity for those who cannot be diverted to receive appropriate treatment while in prison.

VIII. CONCLUSION

Today, the United States faces a crisis in that prisons are among the largest mental healthcare providers. Some mentally ill individuals turned to crime after deinstitutionalization left them on the streets with no support system. Others wound up in prison because police officers lacked the proper training to identify persons as mentally ill and in crisis, or mistakenly believed that individuals receive adequate treatment in prison. The change in civil commitment laws also made it harder to commit the mentally ill, and society as a whole wants these individuals punished, mentally ill or not.

If policy-makers addressed four characteristics common among the mentally ill population—homelessness, lack of access to Medicaid

²⁹³ See *supra* Section III.C (describing how most of the mentally ill who end up in prison are charged with minor crimes).

²⁹⁴ See *supra* Section IV.D (discussing the negative affects of stigmatization).

²⁹⁵ See Abramsky & Fellner, *supra* note 1, at 61 (explaining why correction officers have a legitimate interest in maintaining order and how they “fear that accommodating mental illness will encourage excuses for misconduct, condone malingering, encourage others to engage in similar misconduct, and promote a general breakdown in order”).

benefits, co-occurring disorders, and stigma—the number of these individuals in prison would decrease. If more shelters were available, fewer individuals would be arrested for misdemeanor crimes, such as trespassing. Creating a system where mentally ill prisoners re-applied for Medicaid benefits before being released would ensure that they have access to the care they need. Finally, integrating mental health and substance abuse programs would ensure that these individuals receive the most effective treatment available, and eliminating the stigma attached to mental illness would increase the number of individuals that seek that treatment.

Connecticut has taken several steps in the right direction to deal with this steady and substantial increase of mentally ill individuals in its prisons. Commissioner Lantz shifted the focus to diversion and assistance with reintegration, and Connecticut now has several programs designed to provide the mentally ill the treatment they need in community-based mental health programs rather than in prison. Despite these efforts, however, tragic stories such as that of Timothy Perry continue to occur.²⁹⁶ Timothy was only twenty-one years old when he was found dead in his cell. He was severely mentally ill and should never have been transferred from the mental hospital to the correctional center. He never received the treatment that he needed in prison, and the symptoms of his illness—impulsive, aggressive behavior—are what called attention to him on the day of his death.

Wisconsin and Washington have also been successful in the area of prison mental healthcare, but have each addressed the issue differently than Connecticut. Both states focused on improving the treatment programs available in their facilities and implementing new programs to assist with reintegration. There are still several ways, however, that each system can and should be improved. Treatment stays at the WRC are often temporary, meaning inmates are returned to the prison facilities from which they were originally transferred once treatment is deemed “complete.” Many of these individuals, however, are in constant need of care. Similarly, more of the work release facilities in Washington should be dedicated to assisting mentally ill inmates prepare for reintegration.

Timothy died in 1999, but he is certainly not the only mentally ill individual to suffer because of the criminal justice system’s inability to treat his illness. Although states such as Connecticut, Wisconsin and

²⁹⁶ See Pfeiffer, *supra* note 11, at 52 (describing how inmate Dennis Kinsman, a schizophrenic, was placed in Garner Correctional Institution in 2004, acted out during his sixth week at the facility, and died one hour after being restrained by the correction officers); see also *The State’s Costly Mistakes*, HARTFORD COURANT, <http://www.courant.com/news/connecticut/hc-lawsuit-payouts-list-0701-html,0,1810089.html>page (last visited May 28, 2012) (stating that the family of Dennis Kinsman received \$900,000 from the state of Connecticut in 2008).

Washington, have taken several steps in the right direction, the fight to end such tragedies wages on.

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