INSANE INJUSTICE:
THE MENTALLY ILL AND THE CRIMINAL JUSTICE SYSTEM

A Thesis
submitted to the Faculty of
The School of Continuing Studies
and of
The Graduate School of Arts and Sciences
in partial fulfillment of the requirements
for the degree of
Master of Arts in Liberal Studies

By

Sharise Harrison, B.A.

Georgetown University
Washington, DC
March 12, 2012
INSANE INJUSTICE: THE MENTALLY ILL AND THE CRIMINAL JUSTICE SYSTEM

Sharise Harrison, B.A.

MALS Mentor: Dr. Joseph Palacios, PhD

ABSTRACT

The de-institutionalization movement in the United States has led to an explosion in the prison population throughout the country. While the previous conditions led to abuse and isolation, releasing the mentally ill into society without safeguards not only endangers their well being but that of the general public. The current mental health system fails both patients and society.

The thesis begins with an analysis of societal views of mental illness and the reasons for incarceration. Next, the understanding of current mental health issues will begin with an introductory overview of mental health history and legislation. An analysis of the closing of asylums and subsequent creation of state mental hospitals will follow with a focus on the ethical challenges of institutionalizing the mentally ill against their will. The resulting impact of releasing the mentally ill into society will be examined through the path a mentally ill individual takes through the criminal justice system beginning with interaction with police and ending with parole. The state of Ohio will be studied due to its role in leading the nation in providing services to the mentally ill within the criminal justice system. Information concerning the subject matter was
gathered through criminal justice and mental health literature, media articles, government laws and policies, and experts in the fields of mental health, corrections and law.

The thesis results include a new way to view the mentally ill. Instead of locking the mentally ill away in prison or in mental hospitals it was determined that the best course of action was to treat the mentally ill in the criminal justice system as individuals deserving of dignity. To end the practice of defining them solely by their illness and to grant them the protections which are already outlined in US law. The major issue with the incarceration of the mentally ill is that most who find themselves in the system have been denied basic human and constitutional rights based on their race and socio-economic status. The thesis concludes that US society does not take the time to understand anyone who exhibits behaviors deemed unacceptable. These individuals are labeled as outcasts, reduced to caricatures and deemed violent deviants. Due to these stereotypes it has been easy inspire fear which results in the incarceration and denial of rights to those who are different.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>CHAPTER 1: RACIAL INSANITY</td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER 2: HISTORY OF TREATMENT</td>
<td>7</td>
</tr>
<tr>
<td>CHAPTER 3: MENTAL HEALTH LEGISLATION</td>
<td>20</td>
</tr>
<tr>
<td>CHAPTER 4: DISTURBING THE PEACE</td>
<td>33</td>
</tr>
<tr>
<td>CHAPTER 5: A JURY OF YOUR PEERS</td>
<td>44</td>
</tr>
<tr>
<td>CHAPTER 6: BEHIND BARS</td>
<td>51</td>
</tr>
<tr>
<td>CHAPTER 7: OHIO: RIOTS, LAWSUITS, CHANGE</td>
<td>60</td>
</tr>
<tr>
<td>CHAPTER 8: CULTURAL CHANGE</td>
<td>79</td>
</tr>
<tr>
<td>REFERENCE LIST</td>
<td>88</td>
</tr>
</tbody>
</table>
CHAPTER 1: RACIAL INSANITY

Mental illness and criminal behavior have been linked for centuries. Lack of understanding and acceptance of mental illness has led to torture and imprisonment of individuals suffering from psychiatric disorders. While there has been a consensus among mental health, criminal justice professionals and the general public that the current system is a failure, there have been few attempts to correct the situation. These attempts are often short lived due to the lack of government funding for mental health services.

Currently, the majority of the prison population in the United States suffers from a diagnosable mental illness. This thesis will analyze the reasons the mentally ill enter the criminal justice system by following the path from arrest to imprisonment. The idea of this thesis was sparked by the Frontline special *The New Asylums*, a documentary set in Ohio concerning prisons becoming psychiatric wards. The documentary showcased the conditions in prison for those suffering from severe mental illness and the programs available after release. The thesis will delve further into the history of the Ohio prison system and their attempts to deal with mentally ill inmates. Ohio will be further analyzed to determine what events led to current practices and determine why the state is considered a leader in prison mental health services.

While Ohio may be a leader in prison mental health services the question remains as to why so many mentally ill individuals find themselves in the
criminal justice system. The United States criminal justice system is plagued with numerous issues including: racism, classism and sexism. Throughout the research process of this thesis I became determined to not make this a racial issue. As an African-American I attempt to conduct research and produce analysis without a racial lens. Try as I might the issue of race continued to arise throughout the thesis process. The election of a Black president ushered in a new era in America in which society was supposed to have improved race relations and ideas of racism were antiquated excuses.

Beginning with a history of mental illness in the United States, the thesis will examine how our cultural origins have led to the current state of mental health services. The cyclical manner of which reform occurs will be analyzed as well as the American attitude concerning mental illness which includes influences from our African, European and Native American ancestors. The history of the mentally ill in America is tortuous and well documented. The horrors of life inside asylums have been featured in novels, news reports and movies. After many efforts at reform, the age of the asylum with indefinite institutionalization for the mentally ill ended in the 1960s. While touted as a victory for the mentally ill and human rights, the deinstitutionalization movement serves as the marker for the current state of mental health services.

The conditions for the mentally ill in the United States have not been ignored. The thesis will analyze legislation aimed at improving services and
preventing discrimination against mentally ill individuals. There are several safety nets set up through legislation to assure that the mentally ill are treated with dignity and respect. The laws on the books conflict with the reality for the mentally ill in America. There are many reasons for this disconnect including the perception of mental illness by the public.

The majority of mentally ill individuals that find themselves in the criminal justice system suffer from psychotic disorders, including Schizophrenia and Bipolar Disorder. The National Institutes of Health defines schizophrenia as follows:

A chronic, severe, and disabling brain disorder. . . .People with the disorder may hear voices other people don't hear. They may believe other people are reading their minds, controlling their thoughts, or plotting to harm them. This can terrify people with the illness and make them withdrawn or extremely agitated. (U.S. Department of Health and Human Services, Schizophrenia: National Institute of Mental Health 2009, 1)

Scientific experts believe that schizophrenia is caused by genetics and environment. While schizophrenia only occurs in one percent of the population, it occurs in ten percent of individuals with direct relatives, parents or siblings who suffer from the disorder; and in 40 to 65 percent of identical twins when one is diagnosed. The exact gene that causes schizophrenia has not yet been determined by scientists; it has been found that individuals with higher gene mutations are susceptible to developing the disorder. Scientific research into nutrition and birth conditions is currently ongoing to determine if these factors can contribute to the
development of the disorder (U.S. Department of Health and Human Services, 
*Schizophrenia: National Institute of Mental Health* 2009, 9). While the exact 
cause has yet to be determined, the disorder does have physiological traits that 
allow it to be identified. The brain of a schizophrenic differs from one who does 
not have the disorder. These differences are assumed to have occurred fetus 
development. These differences of brain activity become pronounced during 
puberty and young adulthood when schizophrenic symptoms of hearing voices 
and paranoia begin to appear.

The National Institutes of Health defines bipolar disorder (also known as 
manic-depressive disorder) as, “a brain disorder that causes unusual shifts in 
mood, energy, activity levels, and the ability to carry out day-to-day tasks” (US 
Department of Health and Human Services, *Bipolar Disorder* 2009, 1). Similar to 
that of the schizophrenic, the bipolar individual exhibits behaviors that do not 
conform to societal rules. The name bipolar comes from the description of the 
extreme states of mood in which the mentally ill person exists. These states are 
referred to as mood episodes.

An overly joyful or overexcited state is called a manic episode, and an extremely sad or hopeless state is called a depressive episode. Sometimes, a mood episode includes symptoms of both mania and 
depression. . . . Extreme changes in energy, activity, sleep, and 
behavior go along with these changes in mood. Someone with bipolar disorder can experience a long-lasting period of unstable 
moods rather than discrete episodes of depression or mania. Sometimes symptoms are so severe that the person cannot function
normally at work, school, or home. (US Department of Health and Human Services, *Bipolar Disorder 2009*, 1)

Symptoms of a bipolar individual in a manic episode include: a feeling of euphoria, extreme irritability, jumpiness, speaking quickly while moving from one idea to the next, easily distracted, restlessness, insomnia, impulsivity, and an unrealistic belief in one’s own ability. Depression episodes include: long periods of worry, disinterest in activities, fatigue, trouble concentrating, forgetfulness, change of eating or sleeping habits, thoughts of or attempts at committing suicide (US Department of Health and Human Services, *Bipolar Disorder 2009*, 2). Like the schizophrenic the brain of the bipolar individual looks different from that of someone not suffering from the mental illness. There is no cure, the current course of treatment is psychotherapy and to prescribe mood stabilizing, anti-depressant or anti-psychotic medications.

Both disorders cause the individual to act in ways that are not easily understandable by the public. This lack of understanding results in fear, when one is fearful they contact the authorities to handle the situation. Thus begins the path of the mentally ill through the criminal justice system. This path is not only affected by race but also socio-economic status. Mental health treatment is expensive and permanent institutionalization is no longer an option in most cases. The attitude toward the mentally ill is complicated at best. The thesis will
examine ways in which the public views individuals with psychiatric disorders and the result of misinformation that pervades culture concerning their actions.

The treatment of the mentally ill has an effect on everyone. While conducting research and discussing my thesis topic with family members, friends and co-workers I learned that everyone has a story of mental illness. Whether it was a friend, relative or even themselves the needs to talk about the issue was overwhelming. In most cases individuals shared the conflicting feelings of shame, sympathy and confusion when sharing their stories. While several mental health support groups and organizations exist to help loved ones, there remains a void in the discussion of mental health. Research will distinguish the types of mentally ill individuals currently in the criminal justice system by disorder, race, age, and socio-economic status. Percentages and numbers will be discussed in order to give the reader a concept of the magnitude of the issue. The process of researching the varied disorders and their treatments, the laws and programs established, and the history and opinions led to one stark realization. Everyone has a story, yet, as a group we are woefully ignorant of mental illness and how to deal with it. We do not view the mentally ill individual outside of their disorder. Once the humanity is taken from an individual their treatment ceases to become a priority.
CHAPTER 2: A HISTORY OF TREATMENT

Throughout history cultures have struggled to understand the mentally ill. This lack of understanding has led to imprisonment, torture and isolation. Whether they were labeled possessed, mad, or insane the mentally ill have consistently been stigmatized by society. The history of mental illness treatment in the United States has been one of minimal triumph and great tragedy, culminating in the policies that shape the lives of the mentally ill.

According to the United States Surgeon General, the term mental illness is used to collectively describe mental disorders. Mental disorders are consistently characterized by abnormalities in cognition, emotion or mood. These abnormalities are usually developmentally and culturally specific. While a diagnosis can differ between cultures there are symptoms which are typically ascribed to mental illness. These symptoms include: anxiety, psychosis, lack of impulse control, disturbances of mood and cognition (U.S. Department of Health and Human Services Report 1999, 39). There have been many medical advances that aid in present day diagnosis; however, the ability to understand mental illness by the lay person has not significantly progressed throughout history.

Mental illness has been a societal concern since the beginnings of recorded history. Allusions to madness can be found from antiquity onward. Many cultures have attempted to cure mental illness, without success. From the Middle Ages through early colonial times in America mental illness was assumed
to be caused by an imbalance in the humors: blood, phlegm, yellow and black bile. The accepted explanation was based on the theory that a person’s character and health were determined by these four liquids. The European colonists believed that common physical problems including fever or an upset stomach could cause a form of madness. Treatment for these disorders usually included the practice of bleeding or purging the patient (Gramwell and Tomes 1995, 15).

In addition to physiological causes of mental illness, Native Americans, African Slaves and Puritan ministers looked to the supernatural. Some Native American societies believed that mental illness was brought on by supernatural entities as a punishment for individuals who broke moral laws. In some cases the illness was referred to as “soul loss” or “being lost to oneself.” Similar to those with physical illness, the mentally ill underwent healing ceremonies for specific disorders (Gramwell and Tomes 1995, 11). As with Native Americans, African slaves brought their belief of the supernatural causing affliction to humans to America. The African culture viewed extended illness as a possible sign of sorcery (Gramwell and Tomes 1995, 17). According to slave accounts, many slaves wore charms or amulets to ward off supernatural attacks, and the mention of a curse was thought to send one into madness (Gramwell and Tomes 1995, 18).

New philosophical ideas concerning the mind began to emerge during this time in Europe and its colonies. The Enlightenment led many in colonial America to view reason as the essence of human nature. Any perceived loss of reason was
equal to the loss of humanity (Gramwell and Tomes 1995, 18). This view of the mentally ill would shape the reaction and treatment in the United States for centuries.

In addition to attempting to medically or spiritually treating the mentally ill, colonial society viewed the mad as a family problem. The mentally ill were treated no differently than the physically sick or disabled. If the mentally ill individual was non-violent he was able to participate in daily life. In cases where the family was poor or the individual became violent the community would intervene and send them to private households or almshouses (Gramwell and Tomes 1995, 20). During this time there were no laws enacted that referred specifically to the treatment - social and economic issues were emphasized over therapy (Grob 2009, 10).

Only once the population of the colonies began to grow did the legislatures begin to acknowledge there was an issue with the mentally ill. The first hospital in the colonies, Philadelphia Hospital, founded in 1751, included an area for the insane. In addition to housing the mentally ill, it was hoped that the hospital could restore reason to its patients through treatment (Gramwell and Tomes 1995, 20).

Shortly thereafter the first hospital completely dedicated to the care of the insane, Eastern State Hospital, was opened in 1773 in Williamsburg, VA. The
hospital was opened primarily due to the insistence of Royal Lord Fauquier. In 1766 he addressed the House of Burgesses concerning the mentally ill:

It is expedient I should also recommend to your Consideration and Humanity a poor unhappy set of People who are deprived of their senses and wander about the Country, terrifying the Rest of their fellow creatures. A legal Confinement, and proper Provision, ought to be appointed for these miserable Objects, who cannot help themselves. Every civilized Country has a Hospital for these People, where they are confined, maintained and attended by able Physicians, to endeavor to restore to them their lost reason. (Gramwell and Tomes 1995, 20)

Eastern State hospital was the only hospital of its kind in America for nearly fifty years until the opening of Eastern Lunatic Asylum in Lexington, KY in 1824 (Deutsch 1948, 71).

During the first half of the nineteenth century, America expanded and grew exponentially. This growth made it necessary for the country to expand the mental hospital system. Americans resorted to both public and private institutions to care for the insane (Grob 1983, 3). The mid-1800s saw the rise of the first movements for better treatment of the mentally ill. One noted reformer was Dorthea Dix. Dix was a teacher from New England who by chance agreed to teach women at a local prison. She was shocked and dismayed by the conditions in which the mentally ill were kept. She spent two years travelling throughout Massachusetts, researching conditions at jails and almshouses. She presented her findings to the state legislature:
I come to present the strong claims of suffering humanity...I come as the advocate of helpless, forgotten, insane and idiotic men and women. . . . of beings wretched in our prisons, and more wretched in our Alms-Houses. I proceed, Gentlemen, briefly to call your attention to the state of insane persons confined within this Commonwealth, in cages, closets, cellars, stalls, pens: chained, naked, beaten with rods, and lashed into obedience! (Deutsch 1948, 165)

Dix determined that state hospitals were the answer to the suffering of the mentally ill. She declared that “state hospitals are the only places where insane persons can be at once humanly and properly controlled” (Deutsch 1948, 168). Dix began to take her message to the nation. She proved to be a major force in enlarging and improving mental hospitals (Deutsch 1948, 171).

While the reforms made by Dix spanned many states the treatment of the mentally ill was most commonly transferred from the prisons and alms-houses to the mental hospitals. During this time the most common treatment for the mentally ill was the use of restraints. Restraints were categorized as “any apparatus that interferes with the free movement of the patient, and which he is unable to remove easily” (Deutsch 1948, 218).

The extensive use of restraints led to reform movements in Europe in the early 1800s. The most noted advocate of change was Frenchman Phillipe Pinel. Pinel sought to improve the care of the insane in Parisian hospitals. He highlighted the importance of acknowledging the emotional causes of mental illness and advocated more careful diagnosis and observation (Gramwell and
Tomes 1995, 37). Additionally, mental institutions in England began to renounce the use of restraints in response to calls for moral treatment. American institutions largely continued the use of straight-jackets and other restraints justifying the practice by claiming that their patients were simply more difficult to control than their British counterparts. American doctors advocated the use of restraints over manual restraint which could injure the patient or hospital staff (Gramwell and Tomes 1995, 46).

In response to reform movements in Europe some American institutions adopted moral treatment. Advocates of moral treatment believed that the mentally ill could be cured if exposed to a structured asylum regimen. This regimen included a daily course of exercise, work and amusement (Gramwell and Tomes 1995, 39). Moral treatment was typically found in private institutions. Due to the cost of private institutionalization the expansion of state mental health hospitals increased (Gramwell and Tomes 1995, 55). The typical state hospital in the 1800s included a center building, kitchen, store rooms, reception areas, business and medical offices, chapel, library, living quarters for the medical officers, and patient wings on both sides to separate the male and female patients (Grob 1983, 11).

Due to the increasing American population and numbers of mental institutions the process for admission became more complex. The census of 1880 revealed that there were 91,997 individuals deemed insane out of a total American
population of fifty million. Thirty years earlier the numbers were 15,610 out of a population of twenty-one million. In 1880, about 9,300 were kept in almshouses, half in mental institutions, and the remainder with their families. At this time the breakdown of illnesses included: 38% mania, 28% dementia, 19% melancholia (depression), and 9% epilepsy (Grob 1983, 8).

In the 1800s individuals that found themselves in an institution usually exhibited an extreme form of behavior. These behaviors included: violent suicidal or homicidal acts, hallucinations, agitation, delusions or deep depression (Grob 1983, 9). While many commitments were instituted by the family by the late 1800s states began to employ justices of the peace, asylum boards, juries and court appointed commissions to decide the fate of the mentally ill (Grob 1983, 10). Upon determining the individual mentally ill they were admitted to the nearest public mental health hospital. By 1883 there were 18 local or state hospitals and one federal institution. The average number of patients was 544, however nine of the largest hospitals had an average of 1,254 and the smallest an average of 139 (Grob 1983, 11).

For the mentally ill admission to an institution was a frightening experience. The individual was launched into a place with its own behavioral norms. Large portions of the population were involuntarily admitted and the primary means of confining patients was by force to maintain internal discipline (Grob 1983, 15). The 1800s saw the first public accounts by former patients
concerning inhumane practices. Many of these patients did not believe they were insane and resented the treatment they suffered at the hands of attendants and doctors. In some cases individuals brought lawsuits against their institutions or families (Gramwell and Tomes 1995, 62).

One of the most popular accounts was that of Clifford W. Beers. Beers was a white male born in 1876, after graduating from Yale University and holding several jobs in New York he made an unsuccessful suicide attempt due to increased anxiety. After treatment in a general hospital he was returned home where his mental condition continued to deteriorate. He was sent to Stamford Hall, a small private institution, by his family in 1900. After eight months he was sent to the public Connecticut Hospital for the Insane when his family was unable to afford the high costs of Stamford Hall (Grob 1983, 147). During his stay Beers was beaten, choked, spat upon, imprisoned in dark, padded cells and forced to wear a strait jacket for twenty-one consecutive nights (Deutsch 1948, 303).

Beers was discharged in 1903 and decided to write his autobiography, A Mind that Found Itself, hoping to help others struggling with mental illness. His goal was to create a movement to help the institutionalized by improving conditions in mental hospitals (Grob 1983, 147). Beers went on to establish the Mental Hygiene Movement in 1908. The objectives of this movement were as follows:
Work for the protection of the mental health of the public; to help raise the standard of care for those in danger of developing mental disorder…to promote the study of mental disorders…and to disseminate knowledge concerning their causes, treatment and prevention; to obtain. . . . reliable data regarding conditions and methods of dealing with mental disorders; to enlist the aid of the Federal Government. . . . to coordinate existing agencies and help organize in each state an allied, but independent, Society for Mental Hygiene. (Deutsch 1949, 315)

The Mental Hygiene Movement witnessed an increase in interest following the First World War. The public became interested in preventable mental illness and improving existing methods to treat these disorders. This trend resulted in more individualized treatment of the mentally ill by psychiatrists (Deutsch 1949, 318).

The Mental Hygiene Movement also prompted states to take action against inhumane conditions at mental institutions. One example is that of the Cleveland State Hospital. In 1944 a grand jury in Cuyahoga County, Ohio indicted not an individual but the entire community and social system. The grand jury investigation declared that:

Cleveland State Hospital is a shabby-looking mélange of gloomy prison-like stone building. . . . occupying 100 crowded acres on a bluff about ten miles from the heart of the city. In its words, with a normal capacity of 2,200 were 2,750 men and women patients—an overcrowding of 25%. . . . meaning less chance for proper classification… and less individual treatment. . . . Three of the nine buildings used as patients’ living quarters were condemned years ago by the state architect as unfit for human habitation. (Deutsch 1948, 59)

The presentment of the Grand Jury included the following charges:
Cleveland State Hospital presents a case history of brutality and social criminal neglect. Patients have died shortly after receiving violent attacks from the hands of attendants or other patients, made possible only by the lack of proper supervision. In other cases patients have died under circumstances which are highly suspicious. . . . Frequent active assaults have resulted in broken bones, lacerations, bruises, and a consequent deterioration of the mind. Favorite weapons have been the buckles of extremely heavy straps, the loaded end of the heavy key rings, metal-plated shoes, and wet towels which leave no mark after choking. . . . Violent patients have been used for “strong-arm” purposes by attendants who persist in running the hospital as a penal institution. The atmosphere reeks with the false notion that the mentally ill are criminals and subhuman who should be denied all human rights and scientific medical care. (Deutsch 1948, 58)

The investigation also uncovered that the Cleveland State Hospital was infested with vermin, with rats crawling over the patient wards and kitchens. A large number of patients were emaciated due to the lack of fresh food at the hospital. At the time, the state of Ohio had a $125 million surplus in its treasury and spent $.10 a meal for its mental patients. Inmates in the prison system were better fed (Deutsch 1948, 61).

The ongoing attention to mental healthcare resulted in the National Mental Health Act of 1947. The act attempted to tackle a problem traditionally handled by local or state governments. The act aided in supplying funding to the research of the cause, prevention, and treatment of mental illness which was predicted to reduce the stress on state hospital populations. Training of psychiatrists and other mental hospital personnel was standardized. The most far reaching effect was to create a nationwide network of mental health clinics that would offer faster
diagnosis and outpatient treatment to the mentally ill. The act also authorized the United States Public Health Service to establish a National Mental Health Institute which would serve as the center for psychiatric research, training and a clearing house for psychiatric information (Deutsch 1948, 179-180).

The passing of this measure signified a shift in opinion concerning mental hospitals. Once created to fight stigma and provide humane care, state hospitals became stigmatized themselves. During the 1940s through the 1950s there was a marked increase in the fight for patients’ rights and a shift in medical professional values (Dowdall 1996, 47). Accompanying the ideals of patients’ rights included the first arguments for deinstitutionalization or the releasing of the mentally ill from hospitals. As a movement, deinstitutionalization placed its emphasis on freedom, independence, individuality, mobility, personalized life experiences and a high degree of interaction in a free society (Scheerenberger 1976, 125). The main principle behind deinstitutionalization is the right of an individual to receive treatment and programming in the least restrictive environment. The 1973 Mental Health Law Project states as follows:

A least restrictive environment means a person should not be hospitalized with drastic curtailment of liberty involved, if he can be treated in a community, at outpatient clinics or community mental health centers. . . . the right to be treated in a setting less restrictive than an institution required by the constitutional principle of the least drastic means. (Scheerenberger 1976, 126)
The 1949 Council of State Governments met to discuss the custody and care of the chronically mentally ill. The group made the recommendation that community-based psychiatric programs would lessen the flow of the mentally ill into asylums but would also siphon patients from the institutions back into the community (De Young 2010, 117). New York experienced a major policy shift in 1954 with the passage of the Community Mental Health Services Act which encouraged the development of local mental health services outside of the state hospital system (Dowdall 1996, 140).

The ability to provide care for the continually mentally ill outside of state institutions was aided by the development of the new psychiatric drugs, chlorpromazine and reserpine in 1950. These drugs were initially used in trial quantities at Creedmoor State Hospital, New York in 1954. The results were viewed as positive. In the 1955 annual report, the state hospital reported as follows:

It may be said, at this time, however, that the use of the new drug is encouraging. It has not been found that they can entirely replace conventional shock therapies, but the use of shock therapy has diminished with the expansion of the drug program and a number of people who failed to improve with electric shock and insulin therapy showed gratifying improvement with the new drugs. (Dowdall 1996, 142)

The success of the psychiatric drugs allowed more patients to be discharged into the community.
From the 1950s through the 1980s the number of state institutions decreased markedly. Many factors lead to this mass effort of deinstitutionalization, including: growing professional and public hostility towards state hospitals, new treatment programs, more rigorous involuntary commitment criteria, increasing state government costs, increase of welfare spending in the 1960s, advent of Medicare and Medicaid, and the introduction of private for-profit nursing home industry (Dowdall 1996, 44). During this time the number of patients in state asylums decreased from 559,000 to 120,000 (De Young 2010, 116).

The history of the mentally ill in the United States is plagued by terror, hardship and despair. While the mentally ill have had their champions in Dix and Beers, the movements they created were not enough to overwhelmingly improve conditions in which the mentally ill live. While government from the local to federal level has attempted to create humane conditions for the mentally ill it has not translated into common practice. While not regulated to Alms-houses or mental institutions the mentally ill of today remain victims of societal ignorance towards mental illness. The history behind the treatment of the mentally ill show a need to consistently monitor institutions and government programs aimed at helping this population.
The treatment of the mentally ill is closely tied to legislation on all levels of government. The deinstitutionalization movement led to more mentally ill individuals becoming integrated into the general public. Since the 1960s the levels of homelessness and incarceration of the mentally ill have increased substantially. Attempts to quell both of these trends by the government have failed.

The beginning of deinstitutionalization can be attributed to the Lanterman-Petrus-Short Act of 1969. This new law restricted involuntary psychiatric institutionalization to a maximum of seventeen days for any individual that was not proven to be imminently dangerous. The criteria for declaring someone imminently dangerous required physical evidence of danger to be displayed in a court of law. If the individual was found to be a danger to themselves or others the hospitalization was extended 90 more days (Torrey 2008, 28). This law completely contrasts the previous status quo of institutionalizing the mentally indefinitely for continuous treatment. The representatives that drafted this law were influenced by the volatile culture of the day which celebrated individual rights and a mistrust of government institutions.

An architect of the act, Frank Lanterman, felt that nearly all mentally ill individuals were competent enough to make informed decisions regarding their need for treatment. In response to criticism by mental health organizations and
psychiatrists, Lanterman stated that the idea that a mentally ill individual will not admit to being sick and will not accept recommended treatment was indefensible (Torrey 2008, 31). Under this new act, the goal was to allow anyone to freely decide whether they wished to be admitted or discharged from a mental hospital. Lanterman described this law as freeing thousands of individuals from the “tyranny of help” which he claimed was disguised as the denial of liberty and basic human dignity for the mentally ill (Torrey 2008, 31).

The rigid institutionalization requirements of the Lanterman-Pretis-Short Act resulted in the systematic emptying of state mental health hospitals throughout the 1970s. A direct result was the increase in the homeless population. A 2005 federal study reported that about 500,000 individuals and 250,000 families are homeless in America at any given time. Of that number, it has been reported that at least one-third of men and two-thirds of women suffer from a serious mental illness that is often exacerbated by alcohol or drug abuse (Torrey 2008, 124). The state of Ohio reported that 36% of patients discharged from a public psychiatric hospital became homeless within six months. Prior to release, the individuals were treated with medications and were psychologically stable. Once they left the confines of the hospital, they often failed to seek follow-up care, because they no longer believed they were sick (Torrey 2008, 126).
When dealing with increased numbers of mentally ill individuals in communities without constant treatment the public required an education on the disorders that never came. Understanding how to deal with the mentally ill was not mastered by the institutions in which most were housed much less the general public and those tasked with maintaining law and order. In major cities, psychiatric ghettos began to appear in form of nursing homes, boarding homes, and general homelessness. Without an understanding of mental illness the populations of these areas often felt that these individuals were intrusive and dangerous. Communities began to oppose placement of the mentally ill in their neighborhoods, even when mental health planners screened out patients with violent or sexual offense pasts (Brown 1985, 141).

Left to traverse society largely alone the mentally ill often became victims of crime. Individuals with schizophrenia and bipolar disorder are often disoriented and confused which can leave them vulnerable to robbery or rape. With an impaired judgment they could be led into dangerous situations where they became victims. Violent behavior, including psychotic outbursts or paranoid accusations, also led to situations where they were targets of violent retaliation by individuals unaware of their mental illness (Torrey 2008, 135). In addition to being victimized, those suffering from mental illness often ran afoul of the law due to their volatile behavior.
Throughout the 1970s and 1980s the United States experienced a movement towards stricter more conservative laws. The war on drugs, which harshly criminalized substance abuse, caused more mentally ill individuals to enter the justice system (Hinshaw 2007, 184). This proved to be troublesome for prison officials. Issues of mediating prisoners and providing therapy became commonplace. In 1989 the case of *Washington v. Harper* went to before the Supreme Court. At this time Walter Harper had been incarcerated in the Washington state prison system since 1976. Initially convicted of robbery, he assaulted two nurses while on parole. While in prison he was diagnosed with manic depressive disorder and later schizophrenia.

Throughout his prison sentence he received treatment which included antipsychotic drugs (Hilliard 2004, 290). Occasionally his condition deteriorated and he became violent. Twice he was transferred to the Special Offender Center, a state facility for mentally ill convicted felons, where anti-psychotic drugs were administered against his will. Harper argued that involuntary medication without a judicial proceeding was a violation of procedural and substantive due process. The trial court found in favor of the state, however, the Washington Supreme Court reversed the decision arguing that the due process clause required a judicial hearing before administering these medications against the will of the patient (Hilliard 2004, 291).
The case made it to the US Supreme Court where the court found that the existing Washington state policy adequately addressed substantive and procedural due process concerns on the part of Harper. The policy stated:

Inmates may be subjected to involuntary medications only if the inmate suffers from a mental disorder and is gravely disabled or possesses a likelihood of serious harm to himself, others, or their property. The policy also requires that inmates be given 24 hour notice and that a committee in the institution where the inmate is housed periodically review medication decisions. (Hilliard 2004, 291)

This court set a precedent of prisons becoming default mental institutions.

Shortly after this decision, the United States Congress passed the American’s with Disabilities Act (ADA) in 1990. The ADA was the first ever far reaching set of laws addressing the civil rights of the disabled. The law was enacted after the following findings by Congress:

Some 43,000,000 Americans have one or more physical or mental disabilities. . . . historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem...census data, national polls, and other studies have documented that people with disabilities, as a group, occupy an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally. . . . the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity. (Americans with Disabilities Act Law 2008, Sec. 12101 – A)
Congress defines a disability as, “a physical or mental impairment that substantially limits one or more of the major life activities of such an individual; a record of such an impairment; or being regarded as having such an impairment” (Americans with Disabilities Act Law 2008, Sec. 12101 – A).

The ADA attempted to address the far reaching discrimination against the mentally ill in public and private settings. Section 12112 specifically dealt with discrimination in the workplace. Employers were no longer allowed to deny positions to mentally ill individuals who otherwise met all other qualifications. These employers were also now required to make accommodations for the mentally ill.

The act also addresses the responsibility of law enforcement in distinguishing criminal behavior from conduct that is derived from mental illness without criminal intent (Rubin and McCampbell 1995, 2). The intent was for law enforcement to work with mental health authorities to ensure the appropriate response to the offense by determining whether the offense is a manifestation of a disability. Failure to do so would violate the ADA, in addition to burdening correctional institutions with individuals who have mental health needs that the institution is not equipped to meet (Rubin and McCampbell 1995, 2). The National Alliance on Mental Illness (NAMI), published two studies, one in 1992 the other in 2004 reporting that 40% and 44% of seriously mentally ill individuals had been arrested (Torrey 2008, 129).
Title II of the ADA addresses how correctional facilities are to make their programs and services accessible to inmates with mental disabilities. The law requires the facility to evaluate each program so that, when viewed in its entirety, it is readily accessible to and usable by eligible inmates with disabilities. In order to determine which inmates are eligible they must be qualified. A qualified inmate is an individual with a disability who meets the eligibility requirements for the receipt of services or the participation in programs provided by a public entity. Program access is not required when an included individual poses a direct threat to others. The determination that an inmate poses a direct threat to others must be based on an individualized assessment and not be based on generalizations or stereotypes about the effects of a particular disorder (Rubin and McCampbell 1995, 2). Under the ADA, the courts would now consider a correctional facility’s deliberate indifference to an inmate’s mental disability the same as an indifference to an inmate’s physical medical condition (Rubin and McCampbell 1995, 4).

Keeping with the trend to address mental illness, in 2000, President Bill Clinton signed the America's Law Enforcement and Mental Health Project into law. This law created 100 mental health pilot courts across the nation to deal with the influx of the mentally ill on the criminal justice system (Library of Congress 2001, Sec. 2201). The aim of this project was to relieve the justice system of the non-violent offenses caused by the mentally ill. The project was a direct reaction
to a Justice Department survey that reported 16% of all inmates suffered from a mental illness. Under the project, eligible offenders would be given mental health treatment as opposed to jail time. This treatment could be inpatient or outpatient and was meant to be administered in the least restrictive manner available.

Eligible individuals were generally charged with misdemeanors or non-violent crimes (Library of Congress 2001, Sec. 2201). Judges of these courts determined the eligibility of an offender after conferring with psychiatrists or legal advisers.

The project was not uniform at all 100 locations. Specific arrangements were under the discretion of the local or state community. Each location was to abide by the same definition of mental illness: “a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria within the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*” (Library of Congress 2001, Sec 2202 – A). Generally the mental health courts consisted of a judge, prosecutor, public defender, and a mental health services coordinator.

The new laws created a greater demand for treating and identifying disabilities and mental illness. President Clinton attempted to overhaul the United States healthcare system during the 1990s. While the Clinton Health Care Reform Act failed, it led to changes in mental health financing with the Federal Mental Health Parity Act of 1996 (Grob and Goldman 2006, 183). This law required that insurance companies provide equal coverage to both physical and
mental illnesses. A major drawback to this law was that the parity was not necessary if the insurance plan did not cover mental illness at all. This mandate addressed two main issues:

(i) Mental health is crucial for overall well being

(ii) Mental disorders must be investigated and treated with the same urgency as physical illness. (Hinshaw 2007, 178)

The integration of mental health into the world of health care was very significant.

Following in the path of President Clinton, President Bush announced that he would create a New Freedom Commission on Mental Health in 2002 (Grob and Goldman 2006, 184). This commission focused on improving community participation and the integration of disabled individuals (Grob and Goldman 2006, 183). Five principles guided the work of the commission:

First, the commission was to focus on the desired outcomes of mental health care, which are to attain each individual’s maximum level of employment, self care, interpersonal relationships and community participation. Second, the need was for community level models of care that efficiently coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services. Third, the commission, should emphasize those policies that maximize the utility of existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers. Fourth, there was a need to determine ways in which mental health research findings could be used most effectively in influencing the delivery of services. Finally, the commission should follow the principles of federalism and ensure that its recommendations promote innovation, flexibility and accountability at all levels of government and respect the constitutional role of the states and Indian tribes. (Grob and Goldman 2006, 174-175)
While working under these guiding principles the Commission returned with numerous criticisms of the mental health care system. The Commission found that the mental health services in the United States were fragmented and disorganized.

Using information gathered, six goals were suggested to transform the system:

First, that mental health was essential to overall health; second, that mental health had to be consumer and family driven; third, that disparities in mental healthcare had to be eliminated; fourth, that early mental health screenings, assessment and referral to services had to become common practice; fifth, to ensure that excellent mental health care was delivered and research accelerated; and finally, that technology be employed to access mental health care information. (Grob and Goldman 2006, 177)

The Commission recommended that communities establish a system of coordinated care, increase responsiveness to family and community needs, further integration of the mentally ill and increase the amount of information available about the causes and treatments of mental disorders (Hinshaw 2007, 178). While the Commission aimed at revamping the system, the Bush Administration was embroiled in two wars, attempts to privatize social security benefits and immigration issues, all of which took priority over mental health. At the end of his presidential term, the United States was facing rising debt, a collapsing housing and financial market. The goals of the Commission would never come to fruition.
During the election of 2008, Barack Obama ran on a pledge to reform the healthcare system in America. After his election, he succeeded in drafting and passing comprehensive health care reform through the Health Care and Education Reconciliation Act (HCERA) of 2010. While there were many edits and amendments, the act directly addressed mental health services in the United States. The new law requires that state Medicaid benefits include mental health and substance abuse services. Prior to the HCERA states had a choice whether to add these services to Medicaid. Starting in 2014, these benefits will be available for individuals joining Medicaid, Federal health officials will determine whether these benefits will retroactively apply to anyone already receiving benefits (The Staff of the *Washington Post* 2010, 184-185). Additionally, for the first time mentally ill individuals unable to function well enough to secure employment would be able to qualify for Medicaid without having a minor child. Previously, an individual had to qualify as disabled under Social Security requirements; by 2014 any adult can qualify as long as they meet Medicaid income restrictions in their home state (The Staff of the *Washington Post* 2010, 185).

Expanding on parity legislation enacted under President Clinton, the HCERA will attempt to combine mental health and primary care services. The goal is to consolidate information on all treatment and medication used by individuals with at least two chronic conditions. A serious long-term mental illness would not be considered a chronic condition. The new system should
operate by creating interdisciplinary treatment teams or assigning patients to a health care facility that would oversee their care (The Staff of the Washington Post 2010, 185).

Since the late 1960s the United States mental health care system has been influx. The expansive and rapid deinstitutionalization of the mentally ill has led to evolving legislation to address the integration of the mentally ill into our communities. While the George W. Bush and Obama administrations have attempted to streamline and improve the mental health services the instability of the economy as well as two wars in the Middle East have hampered the execution of legislation aimed at improving the lives of the mentally ill. The legislation has operated in a circular motion. Crimes are reported by the media then the pressure is put on the government to intervene. Legislation to inject dignity into the criminal justice process is attempted however at its core the system is to broadly punish individuals for acting out of the norm. The attempts of the government to legislate away the issue of the mentally ill will continue to fail without a dedicated system of financial resources and a cultural change.

In the 2011 report, State Budget Crisis, NAMI reported that non-Medicaid state mental health funding was cut by $1.6 billion between 2009 and 2011. State Medicaid funding of mental health services are expected to be cut further after June 30, 2011 after a temporary increase in state funding is terminated (Honberg, Diehl, Kimball, Gruttro, and Fitzpatrick 2011, 1). While the ideas and legislation
exist to aid in improving the services of the mentally ill, the money rarely exists to make these lofty goals a reality.
CHAPTER 4: DISTURBING THE PEACE

The life of a mentally ill individual can be frightening and lonely. When one’s mind works differently than others the structure of society with its embrace of conformity and adherence to rules can pose a problem. Due to limited education on mental illness and stereotypes that the mentally ill are dangerous the general public is not equipped to handle most situations. Once someone witnesses an individual acting outside of the norm the first step is to call the police. This interaction with the police can determine the future path of the mentally ill individual. The outcome of law enforcement interacting with a mentally ill individual can result in one of four scenarios: the individual is committed to an institution, they are released back into the community, they are arrested or they are killed.

The motto of the law enforcement is to serve and protect. While police are trained to handle a variety of scenarios in the public they are not trained psychiatrists. When entering a situation the police officer does not know if the individual is mentally ill or will become violent towards themselves or others. The deinstitutionalization movement of the 1960s which released thousands of mentally ill individuals into communities led to a new problem for law enforcement. Since mentally ill individuals could no longer be housed indefinitely in institutions there had to be alternatives once they caused a
disruption. This new population of mentally ill individuals created a sub-set in society that required special police treatment. Sociologist Egon Bittner states:

The police have certain special duties with respect to persons who are viewed as less than fully accountable for their actions. Examples of those eligible for consideration are those who are under age or mentally ill. Although it is virtually never acknowledged explicitly, those receiving special treatment include people who do not lead “normal” lives and who occupy a pariah status in society. (Bittner 1967, 703)

There is an understanding within law enforcement that dealing with a mentally ill individual requires a different perspective than dealing with other individuals.

In several police districts across the United States trainings have been instituted in order to aid officers with handling situations with a mentally ill individual. Groups of first responders including police officers are now routinely trained to deal with the mentally ill in violent situations. These groups are called Crisis Intervention Teams (CIT). The need for these teams was realized after the shooting death of a mentally ill man in Memphis, Tennessee. In 1987, the city of Memphis remained heavily segregated with half of the city’s population of African-Americans living at or below the poverty level. An emergency call was made concerning 27 year-old DeWayne Robinson who had a history of mental illness. Robinson was cutting himself with a knife and threatening to commit suicide. Two white officers arrived on the scene, confronted Robinson, and demanded that he drop the knife. Robinson became more agitated and began to run towards the officers. Similar to policies across the nation, Memphis police
are trained to use deadly force when they feel their lives are threatened. The two officers fired upon and killed Robinson.

Due to the racial overtones of the killing, the mayor established a task force to prevent this type of incident in the future. This task force included: the police, psychology department faculty at the medical center at the University of Tennessee, the board of education, representatives from the University of Memphis, National Alliance for the Mentally Ill (NAMI), mental health facility workers, and local citizens (Vickers 2000, 4). The inclusion of the many different individuals who work with and are affected by the behavior of the mentally ill on a daily basis aided the task force in improving communication between law enforcement and the community.

The University of Tennessee Medical Center Psychiatric Unit (The Med) agreed to receive any individuals the CIT brought in. The new system allowed for any individual brought in by an officer to be admitted within 15 minutes. A state statute determined that police are allowed to determine whether an individual is a danger to themselves or others and should be taken to The Med. The individual is placed in protective custody with no charges while doctors decide whether to transfer to a state hospital, give a community referral, medical detoxification, rehabilitation services or refer to social services (Vickers 2000, 5). This process allows the mentally ill individual to obtain services that they may have been unable to locate without the police intervention. The CIT method in
Memphis attempts to treat the mentally ill individual as a patient and less like a criminal. The system attempts to treat the individual with a dignity that was previously absent.

The Memphis model of CIT was the first and has been used to create CITs across the nation and internationally. NAMI publishes a CIT curriculum to be used when training new officers for the program. In order for the teachers to fully understand the officer’s role when interacting with the public, it is suggested that they participate in a ride along. The training for an officer consists of a 40-hour comprehensive course which emphasizes mental health-related topics, crisis resolution skills and de-escalation training, and access to community-based services. The format includes: lectures, on-site visitation and exposure to mental health facilities, intensive interaction with individuals with a mental illness, and scenario based de-escalation skill training. The desired result of this intensive training is the retention of behavioral changes learned throughout the course (Dupont, Cochran and Pillsbury 2007, 14).

While the CIT model is being implemented at law enforcement agencies across the country; the disconnect between the mentally ill and the police still remains. The CIT model shows a preference of hospitalization over arrest however; this decision is solely that of the responding officer. One such case of an individual being taken to a mental hospital occurred on a crowded subway car in the Maryland suburbs of Washington, DC.
In June 2011, a 51 year-old woman of Indian descent boarded a red line car at 7:45am. According to Metro Transit Deputy Police Chief Ron Pavlik, the woman dropped to her knees and yelled, “You killed my family. And now I’m going to kill you all”. . . . Passengers on the train alerted the operator over the intercom, and the operator stopped the train. About 35 passengers exited the stopped train and began walking in the track bed to Twinbrook. . . . The suspect got off the train with other passengers and did not resist when she was apprehended in the Kiss & Ride area by a Federal Protective Security officer. The woman was pointed out to police by passengers. (Hedgepeth and Orndorff June 13, 2011)

According to Metro Spokesperson Dan Stessel the woman was taken to undergo a mental health evaluation at a local hospital. By that afternoon, the woman had been “involuntarily committed” at a facility with more mental health resources (Hedgepeth and Orndorff June 13, 2011).

While the officers involved were not reported to be CIT members the situation was handled according to the model. Initially it was reported that the woman claimed she had a bomb, however, subsequent reports proved that the bomb statement was false. Due to the extreme stance on security in the nation’s capital all bomb threats are taken seriously. This woman was granted the dignity of being referred for an evaluation and not treated like a suspected terrorist. After the evaluation the hospital commitment was deemed the best course of action for the woman.

In some cases hospitalization is not the outcome of a mentally ill individual’s interaction with the police, sometimes the individual is simply sent on their way as was the case with a 24 year-old pilot from Cornwall, NY.
In April 2011, Jason Maloney was recorded making a series of bizarre requests and jokes to an air traffic controller at JFK airport shortly before splashing his plane into the surf on Rockaways Beach, Queens. Maloney, a medical student at Georgetown University, was contacted by the radio tower after they spotted him on their radar, to which he said: 'Whoa... what if I want to hide from you?' He later declared a few he wanted to 'drop a pastor off' at JFK who is doing some medical mission work'. . . . When that request was rebuffed he declared: 'We'll just chill here'. . . . The audio recording of the conversation, posted on the New York Post website, revealed that shortly after his declaration to 'chill', Maloney asked: 'Hey tower, I got a question for you. This might be crazy but are we allowed to land on the beach?'

He was advised that such a stunt on a public beach would only be possible in an emergency and that in such an event the fire department would need to be informed and the beach closed off. He responded by claiming to be a paramedic and then asked: 'Any private beaches around?' Again he was told no, at which point he changed tack for a third time and, in a cheerful manner, said that his single-propeller Piper PA-28 is suffering mechanical difficulties. ‘You know what tower? My engine might be running a little teensy bit rough,’ he said. When asked if he needed help with his sick passenger or engine difficulties by the air traffic controller, Maloney refused and instead declared he was going to make a 'precautionary' landing. 'I've a sick passenger on board so I'm not going to declare an emergency but I am going to land on the beach,' he said.

The landing on Rockaways Beach at around 7pm on Monday saw an emergency response team scrambled with police boats attending. None of the three people on board were injured. According to reports, Maloney looked dazed and was not wearing shoes. Maloney was taken to a police station after the incident but it is understood that he was not tested for alcohol or drugs as he didn't appear to be under any undue influence. No criminal charges are anticipated. (Daily Mail Reporter April 7, 2011)
The situation with Maloney the FAA and the police ended with no charges being filed. Maloney would be described as a “troublemaker”. Professor of Psychiatry, Linda Teplin, describes troublemakers as, emotionally disturbed citizens not arrested or hospitalized because the case is considered not worth the trouble (Teplin 2000, 11). Later Maloney was diagnosed with bipolar disorder; however, he has not faced any charges in response to his emergency landing. Again as in the case of the woman on the subway, Maloney interacted with several government agencies and it was decided that his actions did not warrant arrest.

It would be ideal if every interaction between a mentally ill individual and the police resulted in mental evaluation or release in many cases the individual is arrested. Individuals with schizophrenia or bipolar disorder may be easier to identify due to the actions exhibited once an officer arrives at the scene of the disturbance. In other cases it is difficult to determine if an individual is mentally ill when the police approach. These individuals are identified as “Quiet, Unobtrusive Mentals” by Teplin. These individuals possess symptoms that are not considered serious enough to warrant commitment. Usually quiet mentals are considered more disordered than disorderly and are usually unlikely to provoke arrest (Teplin 2000, 11). In the case of Reginald Latson the inability of the officer to determine his mental capabilities resulted in his arrest.
This much is not debated: 18-year-old Reginald Cornelius Latson was sitting outside a library in Stafford County, waiting for it to open. To someone, he looked suspicious.

The sheriff’s office says it received a call at 8:37 a.m. reporting a "suspicious male, possibly in possession of a gun," sitting on the grass outside Porter Library, across from an elementary school. Officers were dispatched, a search was launched and more than a half-dozen schools were put into lockdown. What happened next remains unclear.

Authorities gave this account: About 20 minutes into the search, Deputy Thomas Calverley, the resource officer at a nearby high school, saw Latson and noticed that he matched the description of the suspicious man. Asked for identification, the teenager began "to attack and assault the deputy for no apparent reason." Latson struck the deputy several times. The officer unloaded pepper spray on the teen, who, wrestled the container away and sprayed the officer. Latson then ran. Other officers found Latson in the nearby woods and the deputy on the ground with a head laceration, cuts and a broken ankle that would require surgery.

Latson, through his mother, offers a different version: He got bored waiting for the library to open, so he left. When the deputy confronted him, Latson submitted to a search. He had no weapon. The deputy addressed him with racial slurs, and the teenager accused the deputy of harassing him. When Latson turned to walk away, the deputy grabbed him from behind and started choking him. Latson was kicked, tasered and pepper-sprayed before running away. Latson is charged with malicious wounding of a law enforcement officer, assault and battery, and disarming an officer. (Vargas June 1, 2011, 1-2).

The specifics of the encounter between Latson and the officer differ; however, the fact is that Latson, and at the time of his arrest was an African-American 18 year-old male diagnosed with Asperger’s Syndrome. The National Institute of Health identifies Asperger’s as a developmental disorder in the
Autism spectrum. Characteristics of Asperger’s include: repetitive routines or rituals; peculiarities in speech and language; socially and emotionally inappropriate behavior and the inability to interact successfully with peers; problems with non-verbal communication; and clumsy and uncoordinated motor movements (NINDS). Latson may have appeared a normal young man when confronted by the officer; however, his disorder prevented him from understanding the situation in which he found himself. Eleven days after his arrest Latson was transferred to a mental institution to determine if he was mentally fit to stand trial. After his evaluation he was returned to jail. Latson remained in jail until his trial in March 2011. Latson’s attorneys argued he should be sentenced to time in a Virginia hospital followed by a residential treatment program. He was found guilty of all four charges and sentenced to two years in prison with time served. Latson’s mother declared the verdict unjust and stated that Latson’s mental state had deteriorated in prison and he was contemplating suicide (Vargas June 1, 2011, 1-2).

The case of Reginald Latson is a reflection of what can happen when the arresting officer is not aware of an individual’s mental state and proceeds as if they do not have a disorder. A CIT team could have been effective; however, the initial police call did not identify Latson as possibly mentally ill or in crisis. In instances of the quiet mentals all officers should attend CIT training courses in
order to be better equipped to handle situations where the mental illness is not as apparent.

The CIT trainings are only as effective as the officers in the field. Interaction with any police officer and a mentally ill individual can end in injury or death. Even when the police and mental health workers work together to deal with an unstable individual, the results can be tragic.

A man who reportedly had a history of mental-health issues was fatally shot by D.C. police after he stabbed one officer, barricaded himself in his residence and later lunged at other officers, authorities said.

D.C. police Commander Hilton Burton, said police were called about 1:30 p.m. to assist city mental-health workers so they could take the man to a facility. The man, whose name has not been released, was described as about 55.

Armed with ‘sharpened objects’ that police believed to be filed-down screwdrivers, the man attacked officers as they went to the door of the apartment and an officer was stabbed in the arm, Burton said. The officers and mental-health professionals then left the apartment, and officials declared a barricade situation and called in the Emergency Response Team.

Team members started to negotiate with the man about 3:30 p.m., but he would not come out, Burton said. About two hours later, members of the team entered the apartment and tried to take him into custody, believing that the man was passed out or asleep. The man then woke up and lunged at officers with the sharpened objects, Burton said. ‘Officers fearing their safety . . . . had to use deadly force,’ Burton said. The man’s mental condition was taken into account before the entry, he added. ‘We tried to talk him out. We tried to wait him out,’ Burton said. The man, who was struck in the upper body, was transported to Howard University Hospital, where he was later pronounced dead. The officer who was stabbed was treated at a hospital and released. (C. Williams June 14, 2011)
In this case the police and mental health workers failed to successfully remove the man from a dangerous situation for everyone. The CIT training cannot account for every situation. Many police districts enact the CIT training in response to the killing of a mentally ill individual.

Police interactions with mentally ill individuals can be tense and dangerous. Most officers are not equipped with making a snap judgment on the mental health of an individual causing a disturbance. Due to the rapid deinstitutionalization of mental health facilities over the past forty years law enforcement agencies are routinely presented with mentally ill individuals in communities. Mental health training programs have been created to aid police when responding to mentally ill individuals; however, these programs are not infallible. While the best case scenario is for a mentally ill individual to receive treatment, many police interactions result in prison time. This action has led to a large percentage of inmates suffering from mental illness.
CHAPTER 5: A JURY OF YOUR PEERS

The United States legal system is based on a premise of fairness and equality. In reality it is anything but. The right to a jury trial is viewed as an equalizer when determining guilt or innocence. A defense attorney working with a mentally ill client faces a battle against, stigma, ignorance and prejudice. The extensive portrayals of the mentally ill as violent in the media, general prejudice and lack of extensive mental health education for juries and judges create an unequal environment for the mentally ill defendant.

The images of the mentally ill are all around us, on television, in the movies and general advertising. There has been much research and discovery in understanding mental illness and how it affects an individual. Outside of people who work in mental health the public is largely ignorant. The mentally ill are systematically labeled as crazy. When one hears the word crazy images of difference and violence come to mind. In the media, individuals labeled as different are often the subject of disrespectful humor, extreme stereotypes, lack of character development. They are shown as different in appearance, background and character (Wahl 1995, 36). Racial minorities and homosexuals are often victims of this type of stereotyping, however, with advocacy the instances have lessened. The mentally ill remain plagued by these images.

Movies like American Psycho, The Crazies, and The Shining all portray the mentally ill as violent. Most violent portrayals are individuals suffering from
manic or psychotic disorders. While scientific research has shown that the mentally ill are not particularly prone to violence, media shows mentally ill individuals as blood thirsty and driven by the desire to harm and view human suffering. When the mentally ill individual does become violent it is typically in response to someone they are familiar with, those who have frustrated or challenged them (Wahl 1995, 82). These extreme images have numerous effects on the general population. The public has little sympathy for individuals who harm others; these images make it difficult to empathize with a mentally ill person on trial. People who accept the stereotypes and view the mentally ill as violent are less likely to support policies that create community care facilities (Harper 2009, 33).

In addition to portrayals of violence, even non-violent characters in the media are often portrayed as different from other characters who have established identities. They are not included as normal members of society. Their lives do not include the daily trials of home and work to which most viewers can relate. They are characterized solely by the illness they suffer from (Wahl 1995, 42-43). In the late 1950s, psychologist Jum Nunnally conducted a study of mental illness representations in mass media. Nunnally determined that in most presentations the mentally ill were typically recognized by their appearance and behavior as deviant and bizarre. He described the media portrayals as:
In general, the cases, symptoms, methods of treatment and social effects portrayed by the media are far removed from what the experts advocate. In particular, the media in their overall presentation emphasize the bizarre symptoms of the mentally ill...In television drama for example, the afflicted person often enters the scene staring glassy-eyed, with his mouth widely open, mumblings incoherent phrases or laughing uncontrollably. (Wahl 1995, 36-37)

In news media coverage the portrayals are similar. News coverage of the mentally ill as violent is overwhelmingly the most common. Headlines linking mental illness and violence are often headlines while sympathetic articles are restricted to the back page (Harper 2009, 42).

The constant images of violent and deviant mentally ill individuals become intertwined with racial and socio-economic stereotypes in a court setting. Once a mentally ill individual is arrested and charges are brought in a court of law a trial soon follows. The due process clause in the US Constitution states that no defendant can be tried or sentenced if; because of mental disease or defect he cannot understand the nature of the proceedings against him or cannot assist his lawyer in preparing his defense. Judges proceeding over a criminal trial have the constitutional obligation to question the defendant’s competency if they act bizarrely in the courtroom. If found incompetent to stand trial the mentally ill individual is to be committed to a mental institution until they have regained consciousness or released and charges dropped (National Alliance on Mental Illness April 17, 2008, 25-26). This requirement appears to aid the mentally ill
when presented with a trial; however, prisons are filled with mentally ill inmates who have all received trials.

As noted in the Mental Health Legislation chapter, Mental Health Courts have been established across the country to decrease the instances of the mentally ill facing incarceration. In reality, these courts have very strict requirements and do not deter a large number of mentally ill defendants from a typical jury trial. Judge Elizabeth Mattingly of Hamilton County, Ohio Mental Health Court states her impressions of these courts:

The first thing I found was that, like most other such programs, the flood of defendants we all anticipated did not occur. Some did not have the required mental health diagnosis of schizophrenia, schizoaffective disorder, bipolar or major depression. Others were excluded due to violent histories; violent charges were considered on a case-by-case basis. While our program offered mentally ill defendants the best, most comprehensive mental health services in Hamilton County, one of two eligible defendants elected to forego the program in favor of taking his chances with standard probation or just serving some days in jail. As a result only 18 of 37 eligible defendants interviewed in arraignment this year agreed to participate. Virtually all had substance abuse in addition to severe mental illness. (Mattingly 2004, 1-2)

An individual suffering from mental illness in a court setting requires knowledge on everyone’s part of how the illness impairs judgment, can be closely associates with substance abuse and the reasons for the crime. Often, mentally ill individuals do not acknowledge their disorder or it can be viewed as an excuse to avoid charges.
One reason for this is the racism that permeates the criminal justice system. As seen in previous chapters, mental illness diagnosis can be limited in poor and minority communities. The existence of a mental illness may not be acknowledged or recognized until the individual is incarcerated. Racial minorities are more likely to interact with the police, to be arrested, defended by a public defender, convicted and given a harsher sentence (Kupers 1999, 94). Since the “War on Drugs” began in the 1980s, racial disproportion in sentencing has increased substantially. Incarceration rates for drug charges for Blacks rose 707% between 1985 and 1995 compared to 306% for whites. Blacks comprise 13% of those arrested for drug possession, account for 55% of drug possession convictions and 74% of inmates serving time (Kupers 1999, 95).

An internally flawed criminal justice system that is skewed against minorities and the poor only serves to limit the ability of the mentally ill to access a fair trial. As seen in the Latson case in the previous chapter, a mentally ill individual can be given a mental evaluation and deemed competent to stand trial although they still exhibit symptoms of their disorder. A jury trial usually consists of a jury of 6 to 12 individuals to determine if the defendant is guilty of their crime. In many cases the jury must come to a unanimous decision (National Alliance on Mental Illness April 17, 2008, 29). While the US Constitution allows for a jury trial by one’s peers, this is impossible for the mentally ill. Juries are made up of the general public with noted exceptions. The US Federal Courts
eliminate anyone with a mental illness or previously felony convictions from serving on a jury (US Courts Juror Qualifications 2011). The jury is populated with individuals who have been subject to a barrage of stereotypes by the media without alternative education on mental illness. Individuals in the law profession are not trained psychiatrists and may not be aware of the symptoms associated with mental illness. Even if expert testimony by mental health professionals is included in the trial, the association with violence cannot be unlearned in a few hours. The attorney working on behalf of a mentally ill defendant has an uphill battle against stigma and prejudice.

Another option is the insanity defense. Legal definitions of insanity differ from state to state where available. Traditionally the insanity defense argues that at the time of the crime the defendant lacked the ability to know the wrongfulness of their actions, or the nature and quality of their actions and this lack of ability was caused by a defect of reason (National Alliance on Mental Illness April 17, 2008, 30). If this defense is used evidence of a diagnosable mental illness that impairs judgment is required. It must be proven that this person is unable to adjust their behavior to conform to the requirements of laws (Wahl 1995, 83).

In many cases a person may suffer from a mental illness, commit a crime and not be considered legally insane. It is argued that not all mentally ill individuals, even ones suffering from severe or psychotic disorders, are unable to understand the results or nature of their actions. If an individual has problems
controlling their actions they do not necessarily have a mental illness, therefore, criminal acts that result from lack of impulse or emotional control are not eligible for the insanity defense. Mental illnesses that possess symptoms of antisocial or criminal behavior are excluded from the insanity defense in many states (Wahl 1995, 83). Due to the many restrictions on the ability to utilize the insanity defense it has not resulted in the release of large numbers of mentally ill individuals into the community (Wahl 1995, 84).

Once the defense and prosecution have made their cases, the jury is left to determine guilt. If the mentally ill individual has been found competent and the verdict is guilty, it is then the responsibility of the judge to impose sentencing. Judges may have to impose mandatory sentences or sentence based on personal prejudice or ignorance of mental illness. Overall, a mentally ill individual is less likely to receive a fair trial than that without an illness due to preconceived notions of mental disorders, institutional racism, and lack of understanding. Constitutional protections and mental health courts do not adequately prevent incarceration of the mentally ill. The criminal justice system in the US does not adequately reflect the laws that are in place. Mentally ill individuals are now being incarcerated at unprecedented rates.
CHAPTER 6: BEHIND BARS

The life of a mentally ill individual can be filled with loneliness, fear and confusion. These feelings are compounded when in prison. Being incarcerated is stressful for non-afflicted individuals, being mentally ill in a prison environment can be unbearable. Prison offers no freedom and a rigid set of rules that may not fully be understood by a mentally ill individual. Rewards and punishments are based on these rules and inmate behavior. More rigid than general society, the prison environment does not allow for the unpredictability of the mentally ill. A majority of inmates in the United States prison system suffer from mental illness. These individuals typically serve longer sentences, lack adequate psychiatric treatment, and face racial and socio-economic prejudice.

According to the 2005 Bureau of Justice Statistics (BJS) Special Report more than half of all inmates in Federal, State prisons or local jails had a mental health problem. These problems must have occurred in the last calendar year or the inmate must have a clinical diagnosis or treatment by a mental health professional (James and Glaze, September 2006). The report analyzed the most prevalent types of mental problems in prison: major depression, mania and psychotic disorders. Major depressive and mania symptoms include:

(a) Persistent sad, numb or empty mood

(b) Loss of interest or pleasure in activities
(c) Increased or decreased appetite
(d) Insomnia or hypersomnia
(e) Psychomotor agitation or retardation
(f) Feelings of worthlessness or guilt
(g) Diminished ability to concentrate or think
(h) Attempted Suicide
(i) Persistent anger or irritability
(j) Increased/decreased interest in sexual activities.

Psychotic disorder symptoms included the presence of delusions or hallucinations (James and Glaze, September 2006). The identification of symptoms as opposed to diagnosis serves to include inmates without a mental illness diagnosis.

Within the corrections system, State prisoners were most likely to report a history of mental illness. In State prison 24% of inmates reported having at least one symptom of a psychotic disorder and 49% having at least one symptom of a depressive or mania disorder (James and Glaze, September 2006, 2). Of the characteristics of mentally ill inmates studied: 61% had a current or past violent offense, 74% had substance abuse problems, 58% were charged with violating facility rules and 20% had been injured in a fight since admission (James and Glaze, September 2006, 1). These numbers illustrate the high percentage of individuals confined to prison that cannot conform to the system. The BJS study
also finds that individuals with mental illness served more prior sentences than those without. It was reported that the mean maximum sentence of a mentally ill inmate was five months longer than an inmate without a mental illness (James and Glaze, September 2006, 8).

This large population of the mentally ill in prison is mainly found in inmates 24 and younger. In local jails 70% of inmates 24 and younger had a mental health problem compared to 52% for those over the age of 55 (James and Glaze, September 2006, 4). Schizophrenia and other mental illnesses usually manifest in early adulthood reflecting the large numbers in the study.

Individuals with mental illness have difficulty coping in their own community; if they are poor or minorities and there is a significant amount of prejudice in the institution they are prone to develop symptoms at a higher rate. These individuals are more likely to have feelings of despair and hopelessness that can lead to depression or suppressed rage that can trigger psychotic symptoms (Kupers 1999, 105). Inmates with mental illness are twice as likely to be homeless than those without an illness. Mentally ill inmates were also more than 10% more likely to have received public assistance while growing up (James and Glaze 2006, 4).

As shown previously, race and social status can affect an individual’s ability to receive a mental health diagnosis prior to entering prison. In the United States, racial discrimination is often involved in deciding whether to punish an
individual or refer them to a mental health professional (Kupers 1999, 108). The poor and people of color have little access to therapy and when their mental illness disturbs the community around them they tend to be medicated in psychiatric hospital wards and admitted for brief stays (Kupers 1999, 109). This automatically puts the poor and racial minorities at a disadvantage since early detection and treatment programs are beneficial in preventing more symptoms from arising (Kupers 1999, 74).

The percentage of people of color in the prison population has risen astronomically for decades. In 1930, 75% of all prison admissions were white and 22% were black. More than 60 years later in 1992, 29% were white, 51% black and 20% Hispanic (Kupers 1999, 95). While whites make up the smallest percentage of individuals incarcerated those with identified mental illness make up 71.2% of inmates in local jails, 62.2% in State prison and 49.6% in Federal prison. Mentally ill blacks account for 63.4% in local jails, 54.7% in State prison and 45.9% in Federal prison. Hispanics with mental illness account for 50.7% of inmates in local jails, 46.3% in State prison and 36.8% in Federal prison (James and Graze 2006, 4).

The large and diverse population of mentally ill inmates leads to the necessity for treatment while incarcerated. The BJS report states that, 33.8% of State prison, 24% of Federal prison, and 17.5% of local jail inmates ever received mental health treatment while incarcerated. These treatments include: overnight
hospital stays, medication, and professional therapy. Of the inmates identified as mentally ill: 49.5% of State prison, 35.3% of Federal prison, and 42.7% of local jail reported ever having mental health treatment (James and Graze 2006, 9). Once an inmate is identified as mentally ill they lose freedoms afforded to inmates in the general population. They are locked in prison units without much human interaction, there are no stimuli, no activities. Intense isolation causes the inmates to act out in various ways. Mental illness coupled with isolation can lead to an increased deterioration for the mental health of the inmate (Kupers 1999, 32).

Access to mental health treatment in the prison system is based on the staff determining whether inmate behaviors are simply manipulative or due to mental illness (Kupers 1999, 109). Inmates with mental health problems were twice as likely to be charged with violating correctional facility rules (James and Glaze 2006, 10). Within the prison system security takes priority over health concerns. Since order and conformity are necessary to control the prison population the guards retain authority over every aspect of care. Inmates with mental illness are at a disadvantage in nearly every instance. Psychologist Terry Kupers states:

In many high security prisons, when violence erupts on the yard the armed guards in the towers or on top of the buildings yell “Down!” all prisoners are required to fall to the ground, face down. Many prisoners taking psychotic medications are unable to react to
the command in time because their reactions are slowed, either by illness or medication. (Kupers 1999, 25)

In this instance the mentally ill are held to a higher standard than the typical inmate. Although they are inhibited by medications and illness they are expected to react in the same way as the other inmates. In an individual situation where the prison guards are aware that the inmate is suffering from a mental illness, the illness does not prevent harsh consequences when disobeying the rules. If a mentally ill inmate is involved in a fight the consequence is punishment, not adjusting their mental health treatment program. When inmates housed in a psychiatric unit become violent or disrespect an officer they are transferred to a detention section and lose mental health treatment access (Kupers 1999, 25).

Prisoners of color were more likely to be disciplined when they exhibited severe signs of mental health problems than to be referred to a psychiatric professional (Kupers 1999, 109). Compounding the issue of adequate mental health access is that of an interracial setting. This situation leads to misunderstandings and miscommunication (Kupers 1999, 108). Five problems with racial bias infiltrating psychiatric assessments have been identified:

(a) The failure by most professionals in the mental health field, whatever their ethnicity, to allow for racial bias in practice and institutional racism in the delivery of services;

(b) Institutional practices that are inherently institutionally racist being put through in a color blind fashion that does not allow for bias;
(c) Social pressures that apply differently to people from minority communities not being picked up so that justified anger arising from racism in society is not taken into the equation when mental health assessments are made;

(d) The sense of alienation felt by many people from minority communities being interpreted as a sign of illness – often seen as their problem, rather than a problem for society as a whole (Fernando 2010, 73).

Ignoring the differences in racial perception and not confronting the institutional racism that exists within society does a disservice to the mentally ill. Due to the nature of mental illness many factors can contribute to the increase in symptoms.

Mentally ill inmates in local jails were four times as likely to be charged with a physical or verbal assault on a staff member or another inmate. These mentally ill inmates were also twice as likely to be injured in a fight with another inmate (James and Glaze 2006, 10). In correctional facilities there exists a strict racial segregation in the yards. If a conflict arises most lone individuals join the larger group of their own race. Mentally ill inmates are mostly unable to sense the racial conflict and join the correct group (Kupers 1999, 96). This leads to more conflict and isolation within the prison system.

When analyzing the BJS report and occurrences in prison it is clear that the mentally ill population is at a significant disadvantage in care. Once incarcerated a mentally ill inmate is less likely to be treated as a sick individual and more like a traditional inmate. The staff members of the correctional facility
are the sole judges of whether an individual is punished or referred to a mental health professional. The statistics reflect that all mentally ill individuals do not receive the same treatment. The treatment of the mentally ill in correctional facilities is inadequate and poses a danger to the inmates and staff.

When examining the world of the mentally ill convict it is important to view their journey as a whole. As previously written, the majority of inmates with mental illness find themselves in prison due to lack of medication and services. The lack of services can be attributed to society’s view of the mentally ill and racial minorities who are least likely to be referred for treatment. Once the mentally ill individual enters prison their ability to help themselves or personally seek out treatment is destroyed. They are at the mercy of prison officials. This situation amounts to torture to a mentally ill individual due to their increased impairment.

Psychologist Kupers states that there are ten essentials for a mental health program in prison. The first is a comprehensive level of care. This includes direct admitting privileges for prison psychiatrists. Psychiatrists should be able to admit an inmate to a mental hospital without numerous other evaluations or blockages to care. Procedures must be in place which guarantees an inmate cannot be refused a bed due to insufficient bed space (Kupers 1999, 220). This essential removes inmates with the greatest need for treatment from the prison
setting. A direct course of treatment only serves to benefit the inmate and the institution by providing them with appropriate treatment in an appropriate setting.

The next essential is suicide prevention. Prison staff must be trained to identify the signs of an inmate at risk. Once an inmate is identified as a suicide risk they are to be seen by a mental health professional and precautions taken so that they will not take their own life. In the current system, individuals on suicide watch are placed in solitary confinement. Instead of creating an environment of more desperation, constant surveillance is necessary (Kupers 1999, 222-223).
CHAPTER 7: OHIO: RIOTS, LAWSUITS AND CHANGE

The issue of the mentally ill in the criminal justice system has impacted agencies across the country. The lack of training and treatment for mentally ill inmates is endemic of all jurisdictions. The state of correctional facilities is not only inadequate for the mentally ill but also the general population. When state governments face budget cuts the first services to be cut are usually those to the “undeserving”. The undeserving includes: convicted criminals, the non-working poor and the mentally ill. Unlike individuals who suffer from physical illnesses as previously state the stigma that comes with mental illness allows the population to be easily forgotten or cast aside. The dismal conditions in Ohio state prisons lead to one of the longest and deadliest prison riots in United States history. This riot triggered lawsuits that demanded better conditions for the incarcerated particularly the mentally ill. As a result, the state of Ohio has become a leader in mental health services for its inmates.

In 1972, Act 494 established the Department of Rehabilitation and Correction in the state of Ohio. Previously the department was housed under the Department of Mental Hygiene. In this same year the lawsuit, Davis v. Watkins was filed against the Lima State Mental Hospital due to its conditions which resulted in Ohio prisons establishing formal mental health programs (Wilkinson 1). Bennett Cooper created the agency and established the groundwork for the growth of corrections in the state. One of the first duties was to build a maximum
security prison in Lucasville, Ohio, 110 miles east of Cincinnati. The Southern Ohio Correctional Facility (commonly known as Lucasville) was a $32.5 million technologically advanced building designed by George S. Voinovich, brother to future governor, George V. Voinovich. The prison contained 1,640 cells, a main corridor that ran throughout the facility, and three residential cell blocks. The cell blocks, labeled: J, K and L contained eighty cells each. The penitentiary’s mission was: “To efficiently provide a safe and secure environment for inmates, employees and the community, and to provide the incarcerated offenders positive adjustment, behavior and ability to return to a lower security facility” (G. Williams 2006, 4-6).

Contrary to its stated mission, Lucasville was constantly marred by violence and upheaval. In 1973, corrections officer Gary Underwood was shot by another officer after he was misidentified as an inmate that held him hostage. In 1976, prisoners staged a three day hunger strike in protest of prison conditions. Lucasville began housing two prisoners per cell instead of the standard one, which lead to two lawsuits arguing, cruel and unusual punishment in 1977. In 1978, in response, the United States Supreme Court declared that two prisoners per cell did not constitute cruel and unusual punishment. The overcrowding of the facility continued throughout the 1980s and eventually led to the establishment of the Governor’s Committee on Prison and Jail Crowding once in 1984 and again in 1989. By 1990, the state of Ohio ranked ninth in overall
assaults on prison staff and second in assaults requiring medical attention. In the early 1990s overcrowding at Lucasville rose from 142.2 percent to 186.9 percent (G. Williams 2006, 6-8).

On Easter Sunday, April 11, 1993 Lucasville inmates took control of the prison. The siege lasted eleven days and resulted in the deaths of ten, one guard and nine inmates (Lynd 2011, 1). That morning inmate took over L Section; by the evening the inmates controlled all of L Section, and had taken eight corrections officers hostage. The reason outlined for the riot was the new requirement that all inmates were to be tested for tuberculosis. The Muslim inmates protested against this requirement on religious grounds. It was learned that there would be a lockdown April 12th where all inmates would be confined to their cells for the mandatory testing. On the evening of April 10, the leaders of the largest groups in the prison, Muslim, Black Gangster Disciples and the Aryan Brotherhood met to plan the riot. The white supremacist Aryans, Muslims and Disciples hated each other but felt a prison riot would be mutually beneficial. Each group took control of a specific section of the cell block. In a 2005 column, Ohio state Justice Paul Pfeifer gives his account of the riot:

In the early stages of the riot, [officer] Robert Vallandingham locked himself in the corrections officers' restroom in L1. But inmates battered open the door and took him hostage. They held him in L6, which was controlled by the Muslims. Another guard – Jeff Ratcliff – had taken refuge in the back stairwell of L2. The stairwell was supposed to be a safe-haven in such situations, with cement-block walls and a steel door. But using a metal bar from
the weight-lifting set in the gym the inmates punched a hole in the wall. When Ratcliff came out they beat him. An inmate named Earl Elder was in the stairwell with Ratcliff. Elder was considered a ‘snitch,’ and when he emerged from the stairwell they began beating him with baseball bats and stabbing him with shanks. Jason Robb said to Elder, ‘You want to be police, we will show you what it is to be police.’

Later that night, after meeting in the gym with a Muslim inmate, George Skatzes took Roger Snodgrass, another Aryan Brotherhood member, to L6, where Elder, battered but not dead, was being held in a cell. Outside Elder's cell Skatzes told Snodgrass, ‘I want you to take this guy out. Go ahead and take care of your business, son.’ Snodgrass went into the cell and stabbed Elder numerous times. When Snodgrass came out, Skatzes put his arm around him and said, ‘you did a good job, brother, I am proud of you.’ Elder was dead. The next morning his body was placed in the recreation yard. Within two or three days of the takeover, FBI technicians had placed microphones in the tunnels underneath L block. The inmates didn't know it, but their conversations were being recorded.

During the first half of the riot, Skatzes was one of the lead inmate negotiators. After three days, when the inmates were unable to break the stalemate over their demands, the leaders of the three gangs met to discuss their next move. Skatzes and the others voted to kill a guard if their demands were not met. Prison authorities had cut the power and water in L block. On the morning of April 15, Skatzes got on the phone and demanded that it be restored or ‘there would be a guaranteed murder.’ When the deadline – set by Skatzes – passed without restoration of power or water, Muslim inmates in L6 killed Robert Vallandingham.

When a settlement was finally negotiated on April 21, the inmates began the process of surrendering. At that time, the gang leaders decided that inmate David Sommers, who controlled the phones and recorded the calls throughout the negotiations, ‘had to die, he knew too much.’ Apparently believing the confusion of the surrender would hide their actions, several inmates, including Skatzes, went after Sommers. When they found him in L7, one inmate tackled Sommers and began stabbing him; Skatzes ran up
and kicked him in the head while another inmate choked Sommers with an extension cord. Then Skatzes hit Sommers in the head with a baseball bat at least three times while the others repeatedly stabbed him. Skatzes and the others cleaned themselves, burned the clothes they'd had on, and surrendered to authorities. But the confusion wasn't enough to mask their foul deeds.

With diligent investigation, the FBI recordings, and eyewitness accounts, law enforcement officials were able to painstakingly piece together the events inside the prison and bring those responsible to justice. For his part, Skatzes was found guilty as one of the inmates responsible for the murders of Vallandingham, Elder and Sommers. A jury recommended death for the murders of Elder and Sommers and a life sentence for the murder of Vallandingham. After reviewing his appeal, we affirmed Skatzes' convictions and death sentence by a seven-to-zero vote. (Pfeifer May 18, 2005)

Once order was restored in the prison, changes began to happen immediately. Retired Lucasville guard on duty during the riot stated: "It was like everyone finally realized what could happen if they didn't do something." As a result, the prison system's budget rose from $680 million in 1993 to more than $1.5 billion in 2001. New prisons and 900 new guards were added to bring the guard to inmate ration to 5.4 to 1. Ohio reduced the number of inmates per cell to one. Community drug treatment centers were built in some cities to keep low-level drug offenders out of prison; and more money was diverted to medical care, mental health programs and security (Horn April 6, 2003).

The Lucasville Riot brought many problems within Ohio correctional facilities to light. This resulted in the class action lawsuit of Dunn v. Voinovich brought on behalf of all mentally ill inmates in Ohio state prisons. Plaintiffs,
Juan Dunn, Jeffrey Hartwell, Mario Henderson, Donald Hall, Eugene Lemmons, Donald Glenn, Lewis Williams, Jr., Jose Machin, John Mayher, II and Thomas Ruffin were selected to represent themselves and other mentally ill inmates against Governor George V. Vonich, Director of the Ohio Department of Rehabilitation and Correction, Reginald Wilkinson, and Director of the Department of Mental Health, Michael Hogan. The lawsuit stated that the plaintiffs wished to obtain relief from the “diminished or non-existent psychiatric coverage” in Ohio’s prisons. As a result of this coverage or lack thereof it was argued:

Psychiatrically impaired inmates are subjected to conditions that fall below the standards of human decency, to needless suffering, and to an environment that threatens not only the mental and physical well-being of the psychiatrically impaired inmate, but all other inmates within Ohio’s prison system as well. (Court Case Dunn v. Voinovich 1993, 2)

Attorneys for the plaintiffs argued that each inmate was mentally ill and were systematically denied adequate psychiatric care. The legal complaint stated that Plaintiff Juan Dunn was previously diagnosed as schizophrenic, suffering from paranoid chronic atypical psychosis, intermittent explosive disorder and other forms of mental illness. While serving his sentences at Lucasville and Lebanon prisons he was involved in encounters with prison staff resulting in serious injuries to both parties. Additionally, Dunn drove a pencil into his ear canal in an attempt to silence auditory hallucinations. Dunn was repeatedly sent
to Oakwood Forensic Center for mental health treatment. He responded well to the course of treatment and was returned to prison. After his return he failed to receive follow-up psychiatric care and his condition began to deteriorate (Court Case Dunn v. Voinovich 1993, 4-5).

Plaintiff Jeffrey Hartwell was institutionalized at the age of eight at Longview State Hospital for psychiatric problems. Initially incarcerated in 1988, Hartwell was transferred to Lucasville in 1991. Due to lack of mental health treatment, his symptoms became worse and he began to beat his head against the cell wall. Other inmates have beaten Hartwell and poured bleach into his open wounds. While at Lucasville Hartwell was one of 300 inmates in the Office of Psychiatric Services to Corrections (OPSC) caseload. As a member of this caseload, Hartwell was eligible for psychiatric treatment and care sixteen hours per week. In March 1993, due to lack of staffing, Hartwell and 74 other mentally ill inmates were in lockdown status due to their inability to function in the general population. Two of the 75 inmates committed suicide prior to the Lucasville Riot (Court Case Dunn v. Voinovich 1993, 5-6).

Plaintiff Mario Henderson was transferred from Lucasville to Lima prison after the riot. Prior to his imprisonment at Lucasville he was in three mental institutions. Due to his mental illness and lack of treatment Henderson has been shackled to his bed, and placed in lockdown in poorly ventilated cells with temperatures constantly around 90 degrees. A mentally ill inmate died August 30,
1993 of heatstroke while held in these conditions. Similar to Henderson, Plaintiff Donald Glenn was also transferred to Lima after the riots. Glenn was diagnosed by five different evaluators as a paranoid schizophrenic. He repeatedly asked for treatment and was eventually transferred to Oakwood where he received treatment. After his treatment at Oakwood he was transferred back to prison where, without treatment, he had several severe psychiatric episodes.

Plaintiff Donald Hall was diagnosed as severely mentally retarded and seriously mentally ill. Due to his impaired condition Hall was frequently abused by other inmates and the victim of force by prison staff. Initially incarcerated in Lucasville he was transferred to Lima after the riots (Court Case Dunn v. Voinovich 1993, 6-7). Similar to Hall, Plaintiff Eugene Lemmons grew up in the care of Longview State Hospital. While incarcerated at Lima Lemmons was unable to manage simple personal needs and in a state of near total incoherence. Lemmons was never provided access to psychiatric care while incarcerated.

Plaintiff, Lewis Williams, Jr. is also mentally ill and on death row. He was assaulted by individuals hearing voices while being held in a psychiatric ward. Plaintiff, Jose Machin also suffers from mental illness and has lost teeth due to prison staff use of force. Plaintiffs, John Mayer, II and Thomas Ruffing were both transferred to Lima and kept in lockdown due to the lack of adequate psychiatric care (Court Case Dunn v. Voinovich 1993, 7-8).
All of the Plaintiffs listed suffer from a mental illness that goes untreated by corrections staff. In only one case was the inmate available to access a mental health professional while in the facility. In numerous instances the inmates were transferred to a psychiatric facility where their symptoms improved, only to be transferred back to the prisons and denied treatment. The attorneys for the plaintiffs identified Governor George V. Voinovich as a defendant because he appoints and has the authority to remove the Director of the Ohio Department of Rehabilitation and Correction. The department is also a defendant because it holds the responsibility as follows:

Maintaining, controlling, training, and rehabilitating persons convicted of crime and sentenced to an Ohio penal institution. . . . the Department of Rehabilitation and Correction is given all the power and authority necessary for the full and efficient exercise of the executive, administrative, and fiscal supervision over the state institutions under its jurisdiction. (Court Case Dunn v. Voinovich 1993, 9)

Defendant, Reginald Wilkinson supervises the work of each division of the department and is held responsible for establishing minimum standards for jails in Ohio. The Department of Mental Health is named as a defended due to their role as in providing and designating facilities for the custody, care and special treatment of inmates in Ohio’s prison system. Similar to Wilkinson, Michael Hogan was named a defendant due to his authority to establish procedures and appoint employees.
In section V items 33 through 37 the case document outlines the following allegations accepted as factual:

33. Psychiatrically impaired inmates in the care and custody of the Ohio prison system are unable to seek psychiatric care. The state is under a duty to provide these inmates with adequate psychiatric care. Defendants are responsible for providing psychiatric care to the psychiatrically impaired inmates in their care and custody.

34. In the general population, psychiatrically impaired individuals number approximately 15 percent. In the prison population psychiatrically impaired inmates account for approximately twice the community rate of the general population during any six month period.

35. Psychiatrically impaired inmates who do not receive adequate psychiatric care pose serious problems for prison staff, other inmates, and themselves.

36. A key component in the treatment of psychiatrically impaired inmates is adequate access to ongoing psychiatric care and treatment. Ohio’s prison system suffers from systematic problems in staffing, facilities, and medical procedures that make adequate access to ongoing psychiatric care and treatment impossible.

37. The psychiatric care and treatment received by psychiatrically impaired inmates in the state of Ohio’s prison system facilities is grossly inadequate and constitutes deliberate indifference to these prisoners’ serious medical needs. (Court Case Dunn v. Voinovich 1993,, 12-13)

These statements describe the defendants as wantonly negligent and wholly responsible for creating an environment of suffering and neglect for mentally ill inmates. The argument is made that mentally ill inmates are victims of cruel and unusual punishment while incarcerated in Ohio, a violation of the 8th and 14th Amendments. The demand from the Plaintiffs was simple, they wished
that the actions and policies outlined in the complaint be viewed as a direct violation of their constitutional rights, the defendants be prevented in continuing with said practices, place the agencies under the supervision of the court and award Plaintiffs costs and attorney fees (Court Case Dunn v. Voinovich 1993, 15). The state agencies and their representatives decided not to fight the lawsuit. Instead, the Department of Rehabilitation and Corrections decided to cooperate with other agencies to avoid court-imposed monitoring and change. Attorney Fred Cohen led an investigative and fact finding team that evaluated mental health care in Ohio prisons (Wilkinson 1997, 1). The judge found in favor of the Plaintiffs and a new era of corrections began.

The Dunn v. Voinovich lawsuit instituted a huge cultural change. Internally, the culture changed from psychology to mental health. The range of treatment and disciplines covered expanded. The lawsuit forced the state of Ohio to reconsider the treatment of their inmates. The testimony by the inmates led the courts to this decision to change the prison culture to protect the inmates and prison workers. The Department of Mental Health, Department of Rehabilitation and Corrections and the Ohio Department of Drug and Addiction Services all began to coordinate their efforts to treat mentally ill patients (Wilkinson 1997, 1). The groups developed the following mission statement:

To develop an organized approach for the continuity of holistic, quality treatment for juveniles and adults who come into contact
with the criminal justice, mental health, and substance abuse systems. (Wilkinson 1997, 2)

With a new mentality, Ohio government agencies were able to enact change within the justice system for the mentally ill. In 1994, the Future Search Conference assembled 25 agency individuals in order to teach them organizational concepts in order to reduce conflict between agencies and establish organizational change in mental health service delivery. The participants created a vision statement to guide their work in the future:

A singly managed delivery system for offenders with external oversight responsible for development and monitoring of standards to ensure a continuum of quality, comprehensive, integrated mental health services. Resources will be provided to meet the needs of a customer-driven system. (Wilkinson 1997, 2)

The group then determined the pros and cons of the new vision using the terms “dreams and nightmares.” Dreams consisted of: change, improvement, more resources, better quality, and an integrated system. Nightmares included: shrinking resources, failure, losing the importance of treatment, pretending to change, and lack of treatment for the entire mentally ill population (Wilkinson 1997, 2). By 1997, the results of the new partnerships were evident, they included: the elimination of staff conflict inherent in the old system, more mentally ill patients being identified and treated, consistent care from entrance through release, improved quality of service, a new sense of ownership and
accomplishment by staff and a more successful mental health system (Wilkinson 1997, 4).

According to Debbie Nixon-Hughes¹, the current Deputy Director of the Ohio Department of Mental Health, Dunn v. Voinovich, was the catalyst to bring change to mental health treatment in Ohio. What was once a system of failures and tragedy has drastically improved to become a model for other states to emulate. This change could not have occurred without the cooperation of several state agencies, medical professionals and the public. Mrs. Nixon-Hughes describes the current state of mental health services available to inmates in Ohio. As of 2011, the Ohio prison system housed 51,000 offenders. Of this number

¹ Deborah Nixon-Hughes leads a team of staff who collaborate with consumers, families and community stakeholders to plan initiatives in adult recovery, children’s mental health, advocacy, prevention, housing, emergency preparedness and forensic services. She has more than 29 years of experience in mental health service delivery, planning and policy development within local, county and state settings.

Before being appointed to ODMH, Nixon-Hughes served as chief of the Bureau of Mental Health Services for the Ohio Department of Rehabilitation and Correction, where she was responsible for a $68 million budget and more than 600 staff. They connected approximately 50,000 offenders in 32 prisons with community mental health services that facilitated the offenders’ reentry into society and linked them to appropriate systems of support.

Earlier in her career, Nixon-Hughes served as interim director and deputy director of the Hamilton County Mental Health Board and as executive director of the Columbus Area Community Mental Health Center. (Ohio Department of Mental Health 2011)
between 16 and 20% were identified as having a diagnosable mental illness. Between eight and ten percent are identified as severely mentally ill.

The current standard is to identify inmates at admission and then re-evaluate them after fourteen days. This triggers an array of services. Mentally ill inmates are assigned to Residential Treatment Units (RTU) within the prison system. The units are created to provide a level of care that the inmate would have received in a community setting outside of the institution. As previously stated, mentally ill inmates can pose a danger to themselves, others and staff, therefore, the response was to create these units. Prison staff comprising the RTU includes:

- Clinical Director: A mental health professional appointed by the Central Office Bureau of Mental Health Services responsible for overseeing the mental health program.

- RTU Coordinator: A mental health professional with administrative responsibilities and monitoring of RTU programs.

- Nurses: Certified RN to administer medications, respond to sick calls, and makes one round per shift.

- Treatment Team: Team of mental health professionals responsible for providing direct care to the inmates. The team is tasked with administering the treatment plan for the inmate including: diagnosis, goals, interventions, objectives, targets and outcomes. (State of Ohio Department of Rehabilitation and Correction 2010, 1-4)

The inmates are then divided into tiers in order to treat their illnesses appropriately. The severely mentally ill are Level I, identified as those with
schizophrenia, on suicide watch or have personality disorders which include
violent outbursts and hallucinations. These inmates usually have a history of
mental hospitalization and have been on anti-psychotic medications. They are
confined to their cells all but one hour a day unless otherwise requested by a
mental health professional. When out of the cell they remain handcuffed. In
addition to the Department of Rehabilitation and Corrections the Ohio Re-entry
Coalition\(^2\) is also charged with assuring treatment for the mentally ill. As of

\(^2\) Created in 2008, the Ex-Offender Reentry Coalition serves as a guiding hub for
expanding and improving reentry efforts across state and local agencies. The Coalition’s
overriding goals are to: reintegrate offenders into society, reduce recidivism, and
maintain public safety.

The Coalition will achieve these goals through collaborative partnerships with
government entities, faith and community-based organizations, and other stakeholders. It
will utilize a holistic evidence-based approach that starts at the point of contact with the
criminal justice system and includes an emphasis on education, families, health services,
alcohol and other drug treatment, employment, mentorship and housing.

Its major responsibilities include:

1. Coordinate and guide member departments and agencies by creating,
   modifying, and aligning policies, programs, and operational practices supportive
   of system improvements targeting the successful transition of offenders returning
   to regions across the state

2. Lend technical assistance and encourage agency partnerships with local
   jurisdictions seeking to form reentry task forces

3. Develop and implement comprehensive reentry planning initiatives

4. Serve as a clearinghouse for resources and information, and research findings
   on reentry efforts within the state and elsewhere

5. Develop recommendations and advocate for legislative and administrative
   remedies to eliminate or reduce barriers confronting offenders once they leave
   prison, jail, community-based correctional facilities, or a detention facility
2010, the Re-entry Coalition reports that 75% of all inmates with a severe mental illness received the Wellness Management and Recovery Program\(^3\) while incarcerated (Ohio Ex-Offender Reentry Coalition Annual Report 2010, 9).

Level II inmates are not treated as such severe cases; they mostly suffer from anxiety disorders and depression. These inmates are allowed out of their cells between two and six hours per day, receive contact from a psychiatrist once every two weeks and administered medications. Level III inmates are treated for situational problems that result from being incarcerated. The issues arise as a direct result of the prison atmosphere. The inmates at this level are allowed six to eight hours outside of their cell per day, contact with a psychiatrist monthly and access to medications. Level IV inmates are in transition from RTU to the

\(^{6}\)Consult and collaborate with individuals and/or representatives from service providers, housing associations, community advocacy groups, faith-based organizations, victims’ groups, offenders, and other relevant stakeholders engaged in offender transitional issues; and

\(^{7}\)Identify and support the preparation of grant applications aimed at securing federal, state, foundation, and other sources of funding to create, and sustain evidence-based reentry initiatives. (Ohio Ex-Offender Reentry Coalition 2010)

\(^3\)The Wellness Management and Recovery Program (WMR) curriculum is presented through a 10 week psycho-educational group that is co-facilitated by a person providing services in the mental health system and a person receiving mental health services. The WMR program is delivered in a small group-level intervention with adults who have a psychiatric disorder and may have co-occurring substance use and other health disorders. It is based on Social Cognitive Theory and, as such, focuses on the development of skills, positive expectations, and promoting self-efficacy. New behaviors are learned through modeling and practicing new skills. The inclusion of a mental health peer as a facilitator not only enriches the group learning process but provides a model for recovery as an empowered, collaborative process between the peer and the professional treatment team. (Wellness Management and Recovery Program 2011)
general population. It has been determined that these individuals are stable enough to participate in daily activities and conform to the rules of the prison (State of Ohio Department of Rehabilitation and Correction 2010, 4).

While incarcerated mentally ill inmates are also under the care of the Department of Mental Health. In order to prevent a disconnect when released from prison, inmates in the RTU are routinely visited by social workers who work with their RTU team to determine what services will be needed after release. Specialized re-entry programs have been established to create an easier transition for the mentally ill back into society. In 2010, 15% of mentally ill inmates refused all services offered to them upon release. A goal of the Re-entry Coalition is that over the next five years the amount of inmates who attend their first mental health appointment after release will increase by forty percent (Ohio Ex-Offender Reentry Coalition Annual Report 2010, 9).

The Department of Mental Health begins processing Social Security claims while the inmate is still incarcerated. In most cases the mentally ill individual was not employed prior to arrest and conviction. The inmates were typically receiving Medicaid or homeless. Previously Medicaid was suspended if incarcerated for less than a year. After release it would take three to nine months to receive benefits again. Without Medicaid and social services the mentally ill ex-offenders became homeless and their condition deteriorated, putting them at risk for arrest and incarceration again. This cycle was proven to be more
expensive than funding a plan to aid mentally ill ex-offenders upon release. With many states facing budget shortfalls the funding to Medicaid has been cut in Ohio. According to Mrs. Nixon-Hughes this funding will run out in June 2011. In cases where the individual has been deemed a danger to themselves or others involuntary admission to state hospitals are arranged upon release.

Once released from prison on parole, the duty to locate appropriate housing is daunting. There is no one appropriate program for all mentally ill ex-offenders. If the individual is not referred for hospitalization there are many other options. Similar to traditional inmates on parole, the mentally ill have the option of group homes or family care homes. Group homes consist of the mentally ill with minimal skills and no families to provide them support. A group home is usually licensed by a city. A family care home consists of non-professional staff and houses two to five ex-offenders at a time. Due to limited space some mentally ill ex-offenders are placed in half-way houses which do not focus on mental health services. Another option is Permanent Supportive Housing. In this program the mentally ill ex-offenders have their own space. It is set up similar to group homes but with more privacy. Their activities are monitored by a community care manager or social worker on site. The last option consists of scattered sites. In this scenario the individual lives independently with the support of a Forensic Assertive Community Treatment (FACT) Team. FACT teams are made up of several individuals meant to aid in re-entry, social workers,
medical professionals and parole officers are routinely involved in these teams. The FACT team provides employment referrals, and 24/7 availability of a nurse and psychiatric doctor. This system provides individualized attention to mentally ill ex-offenders while allowing them the freedom to live independently. While this is the most attentive to the individual’s needs it is also expensive, as of 2011 the state of Ohio is operating under an $8 billion budget deficit.

The state of Ohio has experienced many changes within its criminal justice system. The Lucasville Riot and subsequent Dunn v. Voinovich lawsuit allowed the individuals running the government agencies to recognize there was a problem in denying treatment to mentally ill inmates. No system is perfect; however, Ohio continues to provide mental health treatment and individualized care to inmates that has not been seen nationwide. Recognizing that the mentally ill cannot be subject to the same conditions, rules and regulations as the general prison and parole population is a step toward restoring dignity to this population. Unfortunately, the lack of funding serves to inhibit the progress being made by the multi-agency cooperative model of Ohio when serving the mentally ill in the criminal justice system.
CHAPTER 8: CULTURAL CHANGE

The mentally ill have been subject to isolation, torture and imprisonment throughout history. Behavior outside of the acceptable norms is a crime in every society. The mentally ill are routinely defined solely by their illness and labeled as violent, deviant and crazy. These individuals are viewed as disordered and in need of treatment and a cure. Mental illness treatment includes convincing the mentally ill they need to conform by changing thoughts and behaviors they naturally possess. Drug treatment removes symptoms that society deems inappropriate. This course of treatment removes the natural personality of the disordered individual. In lieu of attempting to adapt to these disorders and aid in individual care, the mentally ill have been removed from society.

The United States is no exception. Since the beginnings of American society individuals with mental illness have been separated and locked away in alms houses, asylums and prisons. Prior to the 1960s the vast majority of the mentally ill were permanently confined to mental hospitals better known as insane asylums. Little was known concerning the conditions inside these asylums. Patients were subject to electric shock therapy, lobotomies, beatings and unsanitary conditions. In most cases there was a complete loss of dignity and self-worth. Mental health patients and advocates exposed the conditions of these asylums and the public demanded better treatment. The last major protest occurred in the 1960s, labeled the deinstitutionalization movement. Using the
independence and equality based ideology of the time the leaders of this movement argued that the mentally ill deserved to have a say in their own treatment. They deserved the ability to consent to permanent institutionalization. The invention of anti-psychotic medications in the 1950s allowed for a new course of treatment that did not require long-term hospital care.

Over the past fifty years, psychiatric hospital patient numbers in the United States have reduced significantly. While the deinstitutionalization movement served to release those with mental illness from involuntary confinement they were released with no direction. The general public was left to absorb hundreds of thousands of mentally ill individuals into their communities without any understanding of mental disorders. Once these individuals were released the question of what to do with them was never answered. Individuals with severe psychotic and antisocial disorders were the most likely to cause problems.

Laws have been created in order to aid the mentally ill in transitioning back into society. Community mental health programs and facilities were created; however, the funding was sparse. Many of the public mental health facilities were based in poorer communities and based on a patient’s willingness to submit to treatment. Due to the massive numbers of the mentally ill in the community, the government was not able to staff the facilities to meet the need. Criminally, laws were created to prevent the mentally ill from landing in prison. Safeguards
were created in order to assure humane treatment and to recognize the unique issues the mentally ill accused of criminal behavior possess. Police departments across the country have created task forces of special trained officers to deal with the mentally ill. Mental health panels and courts were created with judges and professionals with knowledge of mental illness in order to divert mentally ill criminals from prisons.

Many individuals with severe mental illness including schizophrenia and bipolar disorder can become homeless or run afoul of the law. Law enforcement officers and the general public are generally ignorant of the symptoms of mental disorders. This ignorance is due to the lack of mental health education available to the public and the overwhelming stereotypes that plague the mentally ill. The public is bombarded by images of the mentally ill as violent and deviant. Only in rare cases are individuals with severe mental illness portrayed in a positive light. Movies, news stories and television create an image of the mentally ill that inspires fear and disconnect. The mentally ill are regulated to the fringes of society due to lack of understanding and stereotypes. Without empathy the mentally ill who break the law are convicted by juries without knowledge of their disease. Lack of empathy is the major reason the mentally ill find themselves in the criminal justice system. There is no voice, just the disease. Once society refuses to recognize the humanity of an individual they are doomed to seclusion and mistreatment.
These stereotypes are often compounded if the mentally ill individual is African-American. African-Americans are less likely to receive a mental health diagnosis earlier in life due to their own set of stereotypes. When displaying the same symptoms of a mental illness as a white counterpart the African-American is more likely to be disciplined, not recommended for treatment. The numbers of African-American inmates have exploded since the 1960s partially due to the mass incarceration of the mentally ill. As revealed in this thesis, race is one of the main determining factors of whether an individual will be recommended for treatment or arrested. Without a professional mental health evaluation African-American prisoners are not as likely to be eligible for treatment. Lack of treatment can lead to more infractions and punishments by the prison guards. This not only torture the inmate but can lead to serving more time than an inmate without mental illness.

Currently, the majority of inmates in the US prison system are suffering from a mental illness. Without extensive knowledge of mental illness, the public routinely convicts individuals suffering from a disorder. Due to an inability to process and respond to societal rules the mentally ill cause disturbances that the public is not equipped to handle.

The history of the mentally ill in prisons consistently follows the same pattern as that of asylums. Abuse suffered by the mentally ill exists in all prisons. Eventually, the abuse is exposed to larger society in the form of sensational
headlines. The public reacts to the inhumane treatment of the inmates and there is a reform movement. Prison mental health care access changes with public attitudes about rehabilitation. The public then focuses on another injustice and loses sympathy for criminals. During economic downturns the new programs meant to help the mentally ill are cut, and deemed ineffective or seen as coddling criminals (Kupers 1999, 217-218).

The increased population of the mentally ill in the criminal justice system has created the need for new programs to help the mentally ill receive treatment in the prison system and after release. The state of Ohio is currently leading the nation in criminal justice, mental health cooperation to aid its mentally ill inmates. While steps are being taken to reintegrate the mentally ill into society these programs are often expensive and routinely cut when there are budget problems.

The United States criminal justice system has accepted that prisons have become the new asylums. Throughout the country programs are being created to adapt to the increased numbers of the mentally ill. While economic problems usually lead to the scaling back of mental health programs it is cheaper in the long run to treat the mentally ill outside of the criminal justice system. Mentally ill inmates with minimal access to treatment require more jail and prison services than traditional inmates due to crisis intervention, therapy and medications.

Once released from prison the current programs for ex-offenders vary from community to community. In the case of Ohio, there are numerous
programs available to ex-offenders which take their mental state and ability to care for themselves into account. While these programs are impressive they are not widespread and risk losing funding during a budget crisis. The programs that involve cooperation between social welfare and mental health agencies should be implemented before the mentally ill individual enters the criminal justice system.

There is no one solution to decreasing the mentally ill population in the criminal justice system. The first step is to view the mentally ill as individuals not as an illness; they have personalities, emotions and desires like the rest of us. Increased education on mental health will aid in ending the stigma surrounding mental disorders. Once the fear aspect is removed it will be easier to include the mentally ill in society. This step will be the most difficult for our culture. Preventing the mentally ill from being classified as other, deranged or deviant will be a long and arduous journey. Embracing the humanity within everyone and embracing the different is contrary to our history. While the financial and cultural costs may appear substantial, the alternative costs of lives and dignity are priceless.

Once this step is taken the change in culture will lead to step two, treatment that reflects the whole person not simply the disease. Once society understands the complexities of mental illness treatments will follow. Currently, individuals with mental illness are constantly told they are broken. They do not have the opportunity to understand their illness and work with their mental health
professional to correct behaviors the patient deems undesirable. Removing the psychotic drug prescription as the most prevalent way to treat these illnesses will be a start. Every mentally ill individual will not respond to treatment or be able to adapt to society. For those who cannot, humane institutionalization is the best course of action. This institutionalization should be outside of a prison setting. The environment should include mental health practitioners, social workers and general physicians. These new mental institutions should be engaging and social. While an individual may suffer from a mental illness, they are no less a human being that needs companionship and attention. Strict monitoring should be instituted in order to prevent abuse and neglect. These institutions should be available to all Americans regardless of economic status.

The last step is to recognize that laws are in place to protect the mentally ill from landing in prison however they are routinely ignored due to the race of the individual. If the severely mentally ill were treated equally regardless of race or socioeconomic status the prison population would not only significantly decrease but would be more reflective of the general population. Discrimination based on services only serves to worsen an already broken system. Once there is equality in diagnosis and sentencing the scope of the problem will significantly diminish. Individuals suffering from severe Schizophrenia or similar disorders where they are unable to control their actions or understand the results of their actions do not belong in the prison system. Without an understanding of the
crime that has been committed there is no hope of rehabilitation or true punishment, only torture. Understanding of one’s crime is significant in creating equality within the prison system. As outlined in this thesis and viewed in many news stories and documentaries, the punishments for the mentally ill far outweigh their crimes. Subjecting a severely mentally ill individual with no concept of self to the isolation and abuse that pervades the prison system is cruel and unusual.

The mentally ill make up only a small portion of the general population, however, they represent the majority of the prison population. They are scapegoated, vilified and misunderstood. Everyone knows of mental illness; however very few understand it. The mind has intrigued humanity for centuries. As a society we are often fearful of actions we do not understand.

Changing the collective mindset of Americans is a huge task. Once the stigma of mental illness is erased it will be easier for the public to feel empathy towards the mentally ill. Erasing racial, gender and mental illness stereotypes from the media are a first step. Stereotypes and prejudices are so engrained in our culture they affect how we view everything including criminality. In the chapter entitled DISTURBING THE PEACE, I show the different treatment of three mentally ill individuals based on race and gender. The racial dimension of mental health treatment in American cannot be ignored. Race constitutes the largest disparity in services for the mentally ill. Once this is addressed equality in services can become a reality. The mentally ill population makes up one of the
most vulnerable in the country. It is the duty of everyone to help those who
cannot help themselves. In order to end the suffering we must confront our
prejudices and fears.
REFERENCE LIST


Dupont, Rudolph, Sam Cochran and Sarah Pillsbury. 2007. Crisis Intervention Team Core Elements. *University of Memphis, School of Urban Affairs and*
Public Policy, Department of Criminology and Criminal Justice (September).


http://www.mh.state.oh.us/who-we-are/leadership-biographies/ (accessed September 6, 2011).


Wellness, Management and Recovery Program. Overview.


