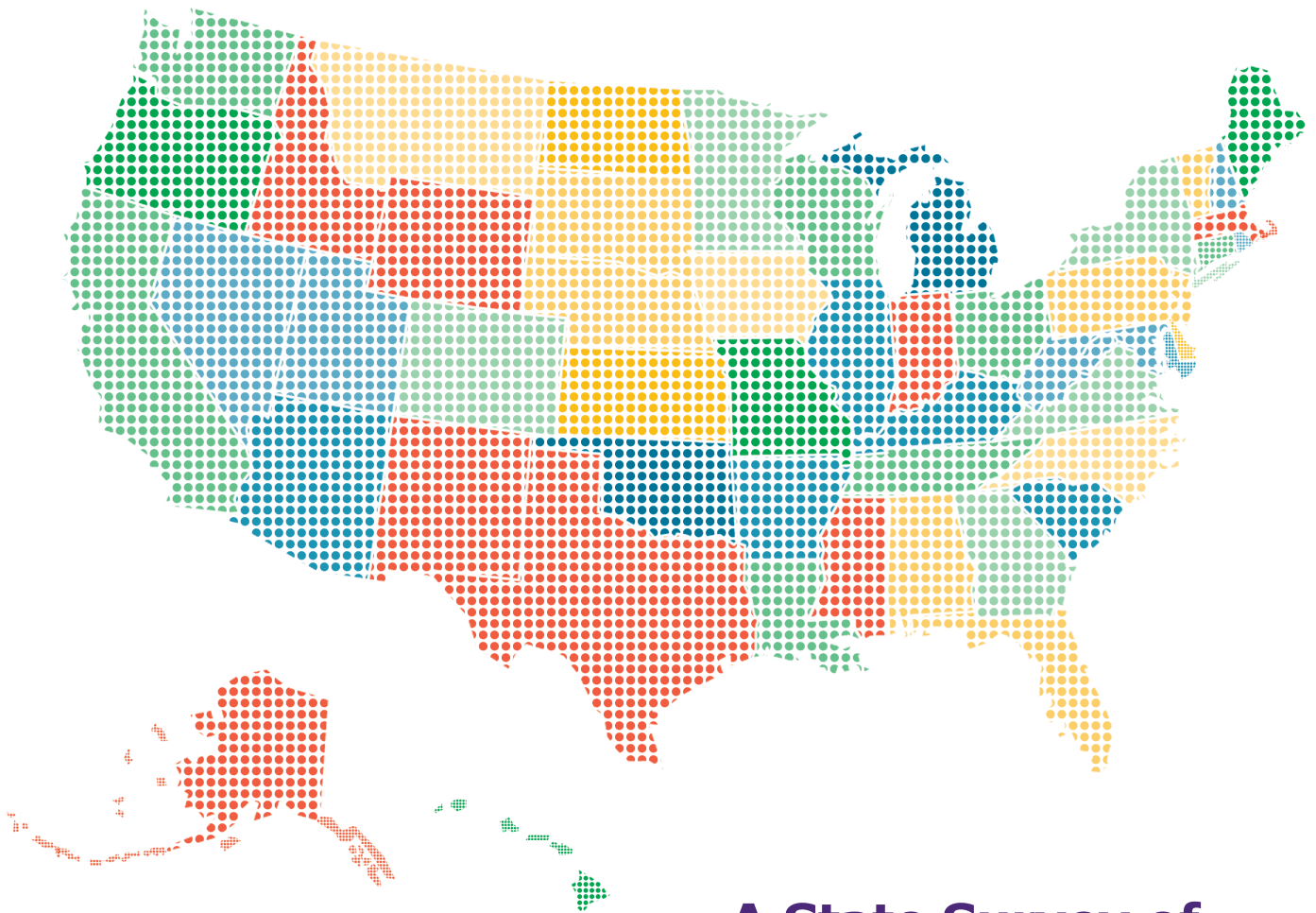


Treat or Repeat



A State Survey of Serious Mental Illness, Major Crimes and Community Treatment

September 2017



A REPORT FROM THE
**OFFICE OF RESEARCH
& PUBLIC AFFAIRS**

TreatmentAdvocacyCenter.org/treat-or-repeat

The gatekeepers of the chronically mentally ill must recognize that a failure to assess not just the rights of the mentally ill persons, but also their ability to achieve a minimum standard of acceptable behavior in the community will further erode public confidence in the professionals who govern patient care. ... When the personal freedom of the mentally ill is given priority over all other considerations, the tyranny of some will jeopardize the autonomy of all.

— Gary Maier, M.D., 1989
“The Tyranny of Irresponsible Freedom”
Hospital and Community Psychiatry, 40, 453

Treat or Repeat

A STATE SURVEY OF SERIOUS MENTAL ILLNESS, MAJOR CRIMES AND COMMUNITY TREATMENT

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EXECUTIVE SUMMARY

In Maine, Chuck Petrucelly, diagnosed with schizophrenia, killed his brother during an episode of acute psychosis. He was found not criminally responsible and was hospitalized for more than four years. He was then moved into the community with ongoing treatment and intensive supervision and also slowly given increasing levels of autonomy. Nine years after the homicide, Petrucelly lives in a supervised apartment, takes medication and holds a job.

In West Virginia, Jeanette Harper, diagnosed with schizophrenia, killed a stranger. She was found not guilty by reason of insanity (NGRI) and hospitalized for less than three years. Upon discharge, she was monitored by a community mental health center for one more year, after which she was released from the program with no follow-up. Three years later, while living in Virginia, she killed a woman who had sheltered and tried to help her. Today, Harper lives in a woman's prison, where she is likely to spend the rest of her life.

Treat or Repeat: A State Survey of Serious Mental Illness, Major Crimes and Community Treatment details potential reasons for the different outcomes experienced by Chuck Petrucelly and Jeanette Harper and how much of the difference between their paths can be attributed to the state where each lived at the time symptoms developed. This survey found Maine, where Petrucelly lived, to be one of the few states making a significant effort to prevent reoffending of individuals with serious mental illness who have committed major crimes. Harper, by contrast, lived in West Virginia, a state with a weaker treatment system in place for those reentering the community after committing a major crime. The question remains, would her outcome have been different in a different state?

The present study was undertaken to ascertain each state's structure and programming to assist individuals with serious mental illness who have committed major crimes succeed after community reentry. Although these individuals make up only 2% of all individuals with serious mental illness, high-profile incidents such as these generate much of the stigma that accrues to all individuals with mental illness. To this end, the Treatment Advocacy Center first conducted a literature review of past research on individuals with serious mental illness who have committed major crimes living in the community. The results are as follows:

- ◆ **The reoffending rate for individuals with serious mental illness is high.** Although the reoffending rate is high among all individuals with criminal histories, the rate for those with serious mental illness is higher than for those without serious mental illness.¹
- ◆ **The reoffending rates in the United States are high compared with other countries.** For individuals who have committed major crimes and have a psychotic disorder, the rate of reoffending is twice as high in the United States compared with the rate in nine other countries with comparable data.²
- ◆ **The reoffending rate for individuals with serious mental illness who are involved in the criminal justice system is high, regardless of whether they are discharged from psychiatric hospitals or released from jails or prisons.** In studies carried out in the United States between 1956 and 1998 on individuals with serious mental illness who had committed major crimes, the average five-year re-arrest rate for individuals released from psychiatric hospitals was approximately 40%; for those released from jails and prisons, it was approximately 60%. For both groups, approximately 20% of the crimes leading to re-arrest were violent crimes. (See Chapter 1, Table 1.1 and Table 1.2.)

- ◆ **Past studies have shown that many individuals with serious mental illness who have committed major crimes had been arrested and/or psychiatrically hospitalized multiple times prior to their crime.** This group of repeat offenders makes up only 2% of all individuals with serious mental illness; however, this group causes a grossly disproportionate share of the problems and consumes a large amount of public resources.³
- ◆ **Evidence-based programs for individuals with serious mental illness reduce reoffending rates.** For individuals with serious mental illness who have committed major crimes, the use of programs such as extended conditional release, psychiatric security review boards (PSRBs), and forensic assertive community treatment (FACT) teams reduce re-arrest rates from 40%–60% to 10% or less.⁴

Because the successful treatment of individuals with the most severe mental illnesses is the focus of its mission, the Treatment Advocacy Center conducted a survey of states to determine what systems and structures are in place for individuals with serious mental illness who have committed major crimes and who are living in the community. The result is the first published effort to systematically collect and analyze each state's policies and practices for community supervision and support for individuals with serious mental illness who have committed major crimes. This benchmark study examines state practices for treating at-risk individuals whose histories suggest a need for intensive services and who are at high risk for re-arrest, regardless of whether they are released from a psychiatric care hospital or from a corrections setting. The states were graded from A to F based on these practices.

Major Findings

We identify three major findings from the survey of the states:

- 1. The majority of states do not provide adequate support in the community for individuals with serious mental illness who have committed major crimes, resulting in higher re-arrest rates and all the attendant human and economic costs of re-incarceration.** No state received a grade of A. Only 16 states received a grade of B, indicating that they either use or have the ability to enact most of the evidence-based practices associated with lower re-arrest rates for criminal justice-involved individuals with serious mental illness. An additional 13 states were graded C and use some of the practices. The remaining 21 states were graded D or F, indicating little or no evidence-based practices for reintroducing this population to the community with the follow-up and supports that have been demonstrated to reduce the risk of re-arrest. (See the table that follows and Chapter 6, Table 6.1, for a list of the states by grade.)
- 2. States vary greatly in how they address reentry from hospitals, jails and prisons into the community for individuals with serious mental illness who have committed major crimes.** Although some states have similar programs, no two states implement these programs in the same way, nor do states allocate resources to these programs uniformly. There are also major differences in the way states organize their forensic services. In most states, such services are the responsibility of the state department of mental health, but the process can vary. In Vermont, for example, the Office of the Attorney General plays a major role. These variations can lead to broad differences in the treatment process. Whereas in one state, all incompetent to stand trial (IST) examinations are carried out in a state forensic inpatient facility, another state may authorize such examinations in a community mental health center as an outpatient. A third state may do the majority of IST examinations in county jails. One consequence of this diversity is that it is difficult to obtain comparable numbers from state to state.

3. Data indicate the magnitude of the problem is getting worse. Many state respondents noted significant increases in the number of individuals with serious mental illness involved in the criminal justice system in recent years. For example, Colorado reported that the number of court orders to restore competency for mentally ill individuals who have been found IST has been increasing overall annually. Los Angeles County reported a 350% increase in the number of IST cases referred for evaluation between 2010 and 2015; although this increase primarily involved misdemeanor offenses, the stress on the system for all forensic and civil patients has been extreme.⁵

Grading of states on efforts to create a system to decrease re-arrest by individuals with serious mental illness who have committed major crimes

A	State is making an excellent effort and has most components of a model program.	A No state received an A grade.
B	State is making a commendable effort and has many components of a model program.	B+ Hawaii, Maine, Missouri, Oregon
		B California, Connecticut, Louisiana, Ohio, Tennessee, Washington, Wisconsin
		B- Colorado, Georgia, Minnesota, New York, Virginia
C	State is making a modest effort and has some components of a model program.	C+ Michigan, Oklahoma
		C Arizona, Arkansas, Illinois, Kentucky, Maryland, South Carolina
		C- Nevada, New Hampshire, Rhode Island, Utah, West Virginia
D	State is making a small effort and has few components of a model program.	D+ Delaware, Kansas, North Dakota
		D Alabama, Florida, Nebraska, New Jersey, Pennsylvania, South Dakota, Vermont
		D- Iowa, Montana, North Carolina
F	State is making almost no effort.	F Alaska, Idaho, Indiana, Massachusetts, Mississippi, New Mexico, Texas, Wyoming

Note: The grade refers specifically to the state’s forensic services and corrections programs for individuals with serious mental illness. Other aspects of the state’s mental health services program may be rated higher or lower than this grade.

The four states that received the best grades under this study—Hawaii, Maine, Missouri and Oregon—are all models other states should look to for various aspects of their successful programming. Apart from these states, we found a number of laws, programs and practices in individual states that we recommend as models for other states to consider to improve outcomes for individuals with severe mental illness who have committed major crimes. These exemplar state programs and practices can be found in Chapter 6, Table 6.2. Specific information on named programs is available in the state narratives of Chapter 5.

Recommendations

Based on these findings, the Treatment Advocacy Center recommends the following steps:

- ◆ **Federal, state and local governments must create policies to stop the criminalization of individuals with serious mental illness.**

Failing to treat mental illness in a timely fashion can give rise to conduct that entangles individuals with serious mental illness in the criminal justice system. *Treat or Repeat* found that all states with good grades on their forensic treatment systems displayed weaknesses or gaps in their civil systems. As admirable and necessary as a strong forensic system may be, to reverse trends of criminalization, policymakers need to eliminate treatment barriers for individuals with serious mental illness before they enter the criminal justice system. A system that requires violence or criminal conduct before the initiation of treatment fails both the individual and the public, at high cost to both. The 21st Century Cures Act, passed by Congress and signed into law by President Barack Obama in December 2016, is a first step in this process.

- ◆ **Federal, state and local governments must prioritize treatment for individuals with serious mental illness who are involved in the criminal justice system.**

Government agencies, including the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the US Department of Justice (DOJ), should work together to create programs that function across budgets and across the public mental health and criminal justice systems to help prioritize the provision of treatment for individuals with serious mental illness who have committed major crimes. Prioritization and treatment for these individuals, who make up only 2% of individuals with serious mental illness, is necessary to reduce reoffending, a concern for the safety of the public and of the individuals and their families.

- ◆ **State and local governments must implement evidence-based treatment programs for individuals with serious mental illness who have committed major crimes.**

Programs such as FACT teams, PSRBs and evidence-based corrections programs, as well as civil programs such as assisted outpatient treatment, have been shown to reduce the risk of reoffending among individuals with serious mental illness. State and local governments should implement programs such as these to treat individuals living in the community who are at risk for reoffending and to provide every opportunity for success.

- ◆ **Researchers and government agencies must conduct research and evaluate programs to inform best practices for individuals with serious mental illness who have committed major crimes.**

Research and analysis of data are necessary to inform decisions on which programs to expand and which to eliminate. It is also necessary to expand the evidence base on effective programs for individuals with serious mental illness to inform these policy decisions. The federal government, through the DOJ and SAMHSA, should conduct research and fund projects to systematically collect data to analyze and share best practices that are effective in reducing the criminalization of individuals with serious mental illness, including individuals with severe psychiatric disorders who have committed major crimes.

◆ **Data collection, treatment and supervision must be individualized and based on outcomes.**

State-collected data do not currently track the sequence of events and outcomes for individuals as they move through the corrections and forensic mental health systems. Instead, data are disconnected from the individual and are collected at each point of interaction with the system: at entry into the criminal justice system, receipt of forensic or corrections services, and reentry into the community. The resulting data cannot be compared across systems to measure the effectiveness of or outcomes associated with different practices along the entire continuum. For example, the data do not show how many individuals initially found IST continue through the system and are ultimately found NGRI or how many are instead convicted of crimes and incarcerated. Evaluation of efforts to prevent reoffending requires the ability to assess an individual's journey through the system and the resulting outcomes. A best practice is to follow the individual through the criminal justice and mental health care systems into the community following release. Such data could be used to determine longitudinal outcomes and patterns including competency restoration, criminal behaviors, treatment and recidivism in order to assess the effectiveness of different interventions and to identify individuals cycling in and out of systems. Understanding how individuals interact with the systems would enable services to be individualized, care to be better coordinated across civil and criminal systems, and success in the community to be promoted.

◆ **State and local governments should incorporate mandatory, detailed population-level data collection and reporting for programs serving individuals with serious mental illness who are involved in the criminal justice system.**

Many questions remain on the efficacy of programs adopted by states; this is largely due to lack of data upon which to evaluate them. Statutes and policies can and should include requirements for data collection and analysis. Such data should include specifics on outcomes, such as reductions in psychiatric symptoms, re-arrest rates, rehospitalization rates and costs throughout the system. This would allow for evaluations of these programs and would help determine state-specific solutions. What works best in Rhode Island may be quite different from what works best in Texas or Wyoming.

INTRODUCTION

James Hadfield was the John Hinckley Jr. of his era. On May 15, 1800, Hadfield fired a pistol at King George III as the king entered a theater in London, narrowly missing the monarch. Hadfield claimed that his attack was in response to God's command as a means for bringing about the Second Coming. At his trial six weeks later, Hadfield was found to be "Not Guilty, being under the influence of Insanity at the time the act was committed."¹

Among the [psychiatric] incurables, there are some who have intervals of perfect soundness of mind, but who are subject to relapses, which would render it improper, and even dangerous, to trust them at large in society."

— J. Haslan, MD,
*Observations on Madness
and Melancholy*, 1809

Until Hadfield's trial in 1800, an insanity defense had rarely been used in England, and there was no legal provision under English law for the continued detainment of such individuals. Since Hadfield was manifestly dangerous and a threat to the king, Parliament hurriedly passed a Criminal Lunatics Act with retrospective provisions allowing Hadfield to be psychiatrically hospitalized indefinitely. He was confined to Bethlem Hospital for the remainder of his life, during which time he again demonstrated his potential for dangerousness by murdering a fellow patient. John Haslan, a prominent English psychiatrist, expressed the prevailing wisdom in his 1809 textbook, *Observations on Madness and Melancholy*: "Among the [psychiatric] incurables, there are some who have intervals of perfect soundness of mind, but who are subject to relapses, which would render it improper, and even dangerous, to trust them at large in society."²

Such thinking dominated English and US psychiatry for the following 150 years. Individuals with mental illness who committed serious crimes were usually confined to psychiatric hospitals, not jails or prisons, for many years, often for life. It was thus assumed that individuals with mental illness, especially those who had committed serious crimes, belonged in hospitals, not in jails or prisons.

As the state psychiatric hospitals became increasingly overcrowded in the early 20th century, it became necessary to discharge more patients, including some who had committed serious crimes. Such discharges were done selectively because of fears among the general public that such persons might be dangerous. A 1945 publication titled "How Dangerous to the Community Are State Hospital Patients?" sought to reassure the public by comparing the criminal history, prior to hospitalization and after their release, of 1,676 patients released from a Connecticut state hospital between 1940 and 1944. Among these, 314 patients had been arrested prior to their hospitalization—32 for felony crimes that included one murder and 10 sexual assaults. In the two-year period following their release from the hospital, these 314 patients committed only seven felony crimes, the most serious of which were two sexual assaults. The authors of the study concluded, "The felony rate of patients leaving the hospital is extremely small and significantly lower than the biannual State average for the general population. ... From our data it appears that the popular fears of violence or other serious anti-social behavior on the part of persons who have been in the state hospital are generally unfounded."³

The discovery of chlorpromazine (Thorazine®) in the 1950s made it possible to control the symptoms of many individuals with serious mental illness—a major impetus to the emptying of state psychiatric hospitals. From a high of 559,000 patients in 1955, deinstitutionalization decreased their numbers to 475,000 in 1965; 193,000 in 1975; 110,000 in 1985; 69,000 in 1995; 51,000 in 2005; and approximately 35,000 today.⁴ This decrease took place during a period when the US population, and thus the need for psychiatric beds, was doubling.

Included in this massive transfer of psychiatric patients from state psychiatric hospitals to the community have been many patients who had committed crimes associated with their mental illness.

Because the successful treatment of individuals with the most severe mental illnesses is the focus of our mission, the Treatment Advocacy Center conducted a survey of states to determine how each state supervises and directs services and supports to individuals with serious mental illness involved in the criminal justice system within the community to minimize the chances of reoffending and to maximize each individual's ability to succeed. The result, *Treat or Repeat: A State Survey of Serious Mental Illness, Major Crimes and Community Treatment*, is the first published effort to systematically collect and analyze the policies and practices surrounding community supervision for individuals with serious mental illness who

We focus, insofar as possible, on individuals whose conduct involves a potential threat to public and individual safety, which will be referred to in this report as *major crimes*. This term encompasses felonies and some misdemeanors involving crimes against persons and excludes nonviolent crimes such as substance abuse offenses and probation violations.

have committed major crimes. This benchmark study illuminates state practices for treating at-risk people whose histories suggest a need for intensive services and a potential for dangerousness without them. These individuals are at high risk for reoffending or for criminalized conduct associated with untreated mental illness, regardless of whether they are discharged from hospitals or released from a corrections setting.

This study is focused exclusively on individuals with serious mental illness. This term is defined differently in different studies but almost always includes those diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder or major depression with psychotic features. We also focus, insofar as possible, on individuals whose conduct involves a potential threat to public and individual safety, which will be referred to in this report

as *major crimes*. This term encompasses felonies and some misdemeanors involving crimes against persons and excludes nonviolent crimes such as substance use offenses and probation violations. The federal government defines felonies as crimes punishable by death or by imprisonment for longer than one year. Many individual states have their own definition of felony crimes, but almost all include such crimes as homicide and attempted homicide, manslaughter, rape, aggravated assault, kidnapping, armed robbery and arson.

Although this study focuses on a small segment of individuals with mental illness who have committed major crimes, research studies have clearly shown that violent crime by individuals with serious mental illness is a persistent source of stigma.^{5,6} Therefore, the most effective approach in decreasing stigma is to decrease the prevalence of such crimes. Reducing reoffending by individuals with serious mental illness would be a significant step in the right direction. The findings from this study highlight that although this population has often been overlooked in programming and funding decisions, prioritizing evidence-based treatment for forensic populations works to prevent negative outcomes for them and the public and aids in their success.

CHAPTER 1

Studies of Reoffending by Individuals With Serious Mental Illness

Recidivism of individuals with severe psychiatric disease released from jails and prisons is widely reported:

- ◆ A 2013 report from the Center for Evidence-Based Corrections at the University of California, Irvine, found that inmates with serious mental illness released from prison were almost twice as likely to be re-arrested within one year of release compared with individuals without mental illness.¹
- ◆ A 2011 summary of 27 studies from 10 countries reported that released prisoners who had been diagnosed with a psychotic disorder had a reoffending rate 60% higher (pooled odds ratio = 1.6) than prisoners with no mental disorder.²
- ◆ A five-year follow-up study of individuals released from prisons in 30 states in 2005 reported that 77% of the released prisoners had been re-arrested within the five-year period.³

There is an even greater link between psychiatric disorders and recidivism for violent crimes. In Sweden, where national databases facilitate such research, 47,326 prisoners who were released between 2000 and 2009 were followed for 10 years. Male released prisoners

Reoffending is defined in this report as an individual committing a crime after release from jail, prison or forensic hospitalization that results in either a re-arrest or rehospitalization for forensic services.

with psychiatric disorders committed 60% more violent crimes than those without psychiatric disorders, and female released prisoners with psychiatric disorders committed twice as many violent crimes as those without psychiatric disorders. The psychiatric disorders with the highest risk for violent reoffending were substance abuse and bipolar disorder. The definition of violent reoffending includes homicide, assault, robbery, arson, sex offenses, and illegal threats and intimidation.⁴

In the United States, the link between psychiatric disorders and arrest for violent acts was reported in a large study in Texas. The criminal records of 79,211 individuals who were admitted to the Texas prison system in 2006 and 2007 were examined. Compared to prisoners with no psychiatric disorder, those who were diagnosed with schizophrenia or other psychosis had significantly higher rates for having committed assault, homicide and robbery. In addition, it was reported that “the risk of having four or more incarcerations in the six-year study period was particularly high for inmates with bipolar disorder.”⁵

The rate of recidivism by individuals with serious mental illness is higher in the United States than it is in other developed countries. In a summary of the 27 studies from 10 countries referred to earlier, the risk of re-arrest reported for individuals with psychotic disorders in the nine studies from the United States was twice as high as the risk of re-arrest in the 18 studies based elsewhere (Canada, the United Kingdom, Sweden, Germany, France, Italy, Belgium, Japan and Brazil).⁶ Thus, it appears that the US process for supervision and treatment of individuals upon release, compared with other countries, is uniquely ineffectual. Suggestions for why this may be the case are highlighted later in this report.

Recidivism Rates in the United States

Individuals with serious mental illness who are charged with crimes in the United States are often found criminally responsible under the legal standard. This has led to a significant number of individuals with serious mental illness being incarcerated in jails and prisons, both before and after trial. Before a trial, defendants with serious mental illness may be deemed incompetent to stand trial (IST), also called not competent to stand trial (NCTST), and be ordered by the court to restoration treatment in a state hospital, in the community or in jail. Subsequent to competency restoration, defendants may be found competent to stand trial but not guilty by reason of insanity (NGRI) and mandated to psychiatric treatment, typically in a state hospital. Alternatively, defendants may be restored to legal competency, acquitted, or found guilty at trial and sentenced to serve time in jail or prison. In 2016, an estimated 383,000 individuals with mental illness were incarcerated in the United States as a result of one of these circumstances.⁷

INCOMPETENT TO STAND TRIAL

Many states have reported sharp increases in IST referrals in recent years. For example, in 2015, Colorado reported a 500% increase in competency evaluations for IST patients over a 10-year period.⁸ A 2000 meta-analysis of relevant literature estimated that approximately 60,000 IST evaluations were being conducted in the United States each year.⁹ An average of 10%–20% of these, or approximately 9,000 individuals, are not able to be restored to competency after the statutory treatment period and are reclassified as incompetent to stand trial and nonrestorable (IST-NR).¹⁰ Among these, half have been charged with a violent crime. Thus, each year, approximately 4,500 individuals who have a diagnosis of severe psychological distress and have committed a major crime are found to be IST-NR.

Although there is an abundance of literature on the details of conducting competency examinations, there is a paucity of information on what happens to those deemed IST or IST-NR thereafter. If the person has been charged with a misdemeanor crime, the charges will often be dropped and the person released from custody. If the person has been charged with a more serious crime, he or she may be held in a psychiatric hospital or jail for longer periods of treatment or be referred for civil commitment as a psychiatric inpatient or outpatient (e.g., under a conservatorship). Those who do not meet criteria for civil commitment, which varies from state to state, present major problems for the mental health and criminal justice systems as “not competent, not restorable, and not committable.”¹¹⁻¹³

Ultimately, however, almost all of these individuals are released into the community at some point, with or without community supervision. Some are released from the forensic units of state psychiatric hospitals, where they had been held for competency restoration treatment, whereas others have been released from civil units of state psychiatric hospitals following their civil commitment. Still others are released from jails where they had been held since their arrest. It should be emphasized that the majority of these individuals are well known to the mental health and criminal justice systems. A summary of 68 studies of IST individuals reported that 53% of these individuals had previous psychiatric hospitalizations, and 60% had prior arrests.¹⁴

NOT GUILTY BY REASON OF INSANITY

Historic research into the disposition of individuals found NGRI is more complete and indicates that most such individuals are sent to the forensic division of state psychiatric hospitals and then later released. In the late 20th century, 10 studies focusing on this population reported on the disposition of individuals released from jails and prisons between 1956 and 1990, prior to the widespread introduction of specialized programs (described in Chapter 2). Because of this timing, this research can offer some insight into the common outcomes of inmates with serious mental illness who are released from corrections facilities without specialized forensic programs.

The studies (summarized in Table 1.1) reported on populations in five states—New York, Maryland, Missouri, Oklahoma and Hawaii.¹⁵⁻²⁴ Approximately 60% of these individuals with mental illness were diagnosed with a psychotic disorder, mostly schizophrenia. Among the offenses resulting in NGRI rulings, about two-thirds were crimes of violence, including homicide, manslaughter, felony assaults, sexual crimes, arson and armed robbery—that is, they were acts defined as major crimes in this report.

Table 1.1 Follow-up studies of individuals found not guilty by reason of insanity and then released from state psychiatric hospitals

STATE, YEARS OF STUDY	NUMBER OF INDIVIDUALS	PSYCHOTIC DIAGNOSES	INDEX CRIMES	LENGTH OF FOLLOW-UP	RE-ARREST RATE	RE-ARREST CRIMES
Missouri, 1956–1962 ²⁵	44 NGRI	45% functional psychosis	11% homicide 18% assault 9% arson 9% sexual crime	Average 5 years	52% felonies only	N/A
New York, 1965–1976 ²⁶	37 NGRI	54% psychosis	61% homicide 20% assault	Average 5 years	24% (30 total arrests)	1 homicide 1 assault 1 rape 1 robbery
Maryland, 1967–1982 ²⁷	86 NGRI	N/A	5 homicides 4 attempted homicides 6 rapes / attempted rapes 7 assaults 4 armed robberies	Average 9.5 years	56% (130 total arrests)	1 homicide 13 assaults 1 rape
Maryland, 1967–1983 ¹⁸	127 NGRI	65% psychosis	30% homicide 32% assault 8% rape 10% robbery	Average 5 years	54% (165 total arrests)	15% homicide, rape 19% assault, arson
Hawaii, 1970–1984 ²⁹	107 NGRI	64% psychosis	22% homicide 2% manslaughter 9% assault 4% sexual crime 14% robbery	Average 11 years	67% (362 total arrests)	3 homicides 1 manslaughter 22 assaults 24 robberies 3 sexual crimes

Table 1.1 Follow-up studies of individuals found not guilty by reason of insanity and then released from state psychiatric hospitals, continued

STATE, YEARS OF STUDY	NUMBER OF INDIVIDUALS	PSYCHOTIC DIAGNOSES	INDEX CRIMES	LENGTH OF FOLLOW-UP	RE-ARREST RATE	RE-ARREST CRIMES
New York, 1971–1976 ³⁰	33 NGRI	66% psychosis	68% homicide	Average 2 years	15% (17 total arrests)	3 assaults 6 burglaries 2 sexual crimes
New York, 1971–1981 ³¹	133 NGRI	60% psychosis	73% homicide, attempted homicide, manslaughter, assault and rape	Average 7.5 years	29% (131 total arrests)	3 homicides 2 attempted homicides 4 sexual crimes 15 assaults 3 arson
New York, 1980–1987 ³²	331 NGRI	77% psychosis	20% homicide 13% attempted homicide or manslaughter 19% assault 16% arson 5% sexual crime	Average 3.8 years	22%	36% felonies
Maryland, 1983–1990 ³³	60 not criminally responsible	85% schizophrenia and bipolar	18% homicide 40% assault	Average 6 years	53%	37% arrested for severe crimes
Oklahoma, 1983–1989 ³⁴	61 NGRI	72% psychosis	82% had committed “a violent offense”	Average 3 years	24%	N/A

The re-arrest rate for new crimes committed by individuals reported in the 10 studies ranged from 15% of individuals re-arrested within a two-year follow-up to 67% individuals re-arrested within an 11-year follow-up. In most studies, the largest number of re-arrests occurred in the first two years following release, though re-arrests continued for the duration of the follow-up period. The average re-arrest rate five years after release was approximately 40%.

The average re-arrest rate five years after release was approximately 40%.

All except one study provided data on the crimes committed by individuals with serious mental illness following their release. Although the majority were misdemeanors, an average of approximately 20% were major crimes as defined in this study. For example, in a study in New York State, 38 of the 133 inmates released (29%) committed a total of 131 crimes resulting in re-arrests. The crimes included three homicides, two attempted homicides, four sexual crimes, 15 felony assaults, and three cases of arson. These 27 serious crimes were 21% of the 131 total crimes and did not include other felony crimes, such as 11 arrests for robbery, 13 for burglary, seven for grand larceny or seven for possession of stolen property.³⁵

In all studies, the majority of the released NGRI individuals with serious mental illness were well known to both the mental health and the criminal justice systems prior to the crime that resulted in the NGRI verdict. In this respect, the individuals are similar to individuals found to

be IST. For example, in one study, 111 male inmates released had 101 previous psychiatric admissions (79 civil and 22 criminal) and 239 previous arrests prior to their index crime; 128 of the 239 previous arrests were for felonies.³⁶ In another study, 107 individuals found NGRI had 24 previous psychiatric hospitalizations and 286 previous arrests, of which 105 arrests were for felony crimes.³⁷ Many of the individuals with serious mental illness who were found NGRI are high utilizers of public services, cycling from hospitals to jails or prisons to homeless shelters. The NGRI verdicts and subsequent hospitalizations in the studies under consideration were merely one stop in the revolving-door cycle.

There is limited research on community supervision and treatment for individuals with serious mental illness who are released from state psychiatric hospitals. The majority of forensic patients released from state hospitals are reported to have been on conditional release for some period, which is defined as partial discharge of a patient from a hospital, conditional on the person's continuing to adhere to a specified treatment plan; however, it is unclear how much supervision, most of which is done by social workers, that entailed. In addition, the handling of discharged patients is done differently in every state. In Maryland, all discharged NGRI patients remain on conditional release for five years. In New York, according to one study, "those who were released to the community were referred for outpatient services to a clinic or other outpatient program operated by the state psychiatric center from which they were released or discharged."³⁸ In Hawaii, discharged NGRI patients are required by the court "to receive some type of outpatient mental health care and be subject to the supervision of an assigned probation officer."³⁹

GUILTY AND SENTENCED TO PRISON OR JAIL

For persons with serious mental illness who have committed major crimes and are sent to jail or prison, five older studies provided data on the follow-up of these individuals. The studies (summarized in Table 1.2) were carried out in Connecticut, New York, Maryland and Washington and included a total of 1,629 individuals.⁴⁰⁻⁴⁴ All individuals were released from prison or jail between 1967 and 1998. An average of approximately 40% of the participants were diagnosed with a psychotic disorder, mostly schizophrenia. The study in which 78% of the participants were diagnosed with schizophrenia was based on a selected sample of individuals who had been transferred from a Maryland state prison to a state psychiatric hospital for treatment, thus being more seriously mentally ill.⁴⁵

It is reasonable to estimate the five-year re-arrest rate for individuals with serious mental illness released from prisons and jails at 60%.

In the two studies that used unselected samples (Washington⁴⁶ and Connecticut⁴⁷), in approximately 25% of the cases, the index crimes that resulted in the incarceration of individuals with serious mental illness were major crimes of violence. In the Maryland study, which used a selected sample, more than half of the individuals had committed major crimes.⁴⁸

All five studies followed the individuals with serious mental illness after release from prison or jail to determine their rate of re-arrest. In the prison studies in Connecticut, 28% had been re-arrested within six months⁴⁹; in New York, 64% had been re-arrested within 18 months⁵⁰; in Washington, 61% had been re-arrested within three years⁵¹; and in Maryland, 73% had been re-arrested within five years.⁵² In the jail study, the re-arrest rate at the end of one year was 54% and, at the end of four years, 69%.⁵³ Based on these studies, it is reasonable to estimate the five-year re-arrest rate for individuals with serious mental illness released from prisons and jails at 60%.

Table 1.2 Follow-up studies of individuals with serious mental illness who had committed major crimes and were later released from prison or jail

STATE, YEARS OF STUDY	NUMBER OF INDIVIDUALS	PSYCHOTIC DIAGNOSES	INDEX CRIMES	LENGTH OF FOLLOW-UP	RE-ARREST RATE	RE-ARREST CRIMES
Maryland, 1967–1978 ⁵⁴	135 mentally disordered offenders released from prison	78% schizophrenic	13% homicide 22% assault 5% rape 26% robbery	5 years	73% (257 total arrests)	9% homicide or rape 31% serious assault or arson 25% attempted robbery or burglary
New York, 1982–1985 ⁵⁵	147 mentally disordered offenders released from prison	N/A	61% homicide, manslaughter, assault, arson or robbery 13% violent sexual crime	18 months	64% (170 total arrests)	28% violent crime
Washington, 1996–1997 ⁵⁶	337 mentally disordered offenders released from prison	31% schizophrenia 17% bipolar 21% depression	3% homicide 26% assault or robbery 15% sexual crime	Average 3 years	61%	41% felonies, including 2% “serious violent felonies” (1 homicide, 2 rapes, 1 assault, 2 robberies)
Connecticut, 1998–2004 ⁵⁷	883 mentally disordered offenders released from prison	N/A	24% violent crime	6 months	28%	N/A
Washington, 1990–1994 ⁵⁸	127 mentally disordered offenders released from jail	50% psychosis 44% mood disorder	28% assault 3% rape	1 year 4 years	54% 69%	13% felony

Four of these studies provided information on the crimes that led to the re-arrest of the individuals with serious mental illness after their release from prison or jail. Among the selected samples, 28% of the re-arrests in New York for violent crimes, not otherwise specified,⁵⁹ and 40% of those re-arrested in Maryland were for violent crimes (homicide, rape, felony assault or arson).⁶⁰ Among the unselected samples, 41% of those re-arrested after release from prisons in Washington committed felony crimes, including 2% said to have committed “serious violent felonies.”⁶¹ The individuals released from jails committed felony crimes in 13% of cases leading to their re-arrest. Based on these studies, it is reasonable to conclude that approximately 20% of the crimes committed by inmates with serious mental illness released from prison were major crimes as defined for the purposes of this study.

In reviewing recidivism rates of individuals with serious mental illness who were released from prisons or jails, a striking finding is their record of past psychiatric hospitalizations and arrests. This finding is identical to the situation described for individuals with serious mental illness found NGRI and those found IST. Among the 147 inmates with serious mental illness released from New York prisons, for example, 63% had had a previous psychiatric hospitalization, and 23% had had three or more such hospitalizations. In addition, 81% had been

previously arrested at least once, with 90% of the arrests for violent crimes. As the author of the study noted: "These are individuals who have had difficulties within both mental health and criminal justice domains all their lives. ... These experiences upon release from prison cannot, therefore, be considered a surprise."⁶²

In summary, in older US studies, the five-year re-arrest rate for individuals found NGRI was approximately 40%. For individuals with serious mental illness released from prison and jails, it was at least 60%. For both groups, approximately 20% of the crimes leading to re-arrest were major crimes, as defined in this report.

Discussion and Recommendations

Corrections departments play an important role in preparing individuals with serious mental illness who have a history of committing major crimes for reentry into communities. These departments will continue to do so as long as there are no substantial changes in relevant practice and policy. Reentry preparation includes any treatment, risk-assessment screening and postdischarge planning provided before jail or prison release. It also includes probation, parole or follow-up support, as well as postrelease programming tailored to those who have serious mental illness. Close cooperation between corrections and mental health departments should be considered a best practice given the similarity in characteristics and needs of those discharged from forensic hospitals and those discharged from prison or jail. A best practice would be to follow the individual throughout the criminal justice and mental health care system into the community to determine longitudinal outcomes on competency and to identify individuals cycling in and out of systems.

CHAPTER 2

Programs to Decrease Reoffending by Individuals With Serious Mental Illness

Chapter 1 detailed what is known about re-arrest rates among individuals with serious mental illness who have committed major crimes. As discussed, if untreated, such persons can become dangerous and are at high risk for recidivism. For this reason, treatment of these individuals should be designated a high priority in the psychiatric treatment system. This chapter describes the results of the literature review on specialized forensic community treatment and supervision programs that some states have developed to try to maintain treatment upon reentry into the community, thereby reducing the reoffending and re-arrest rates of those individuals. Such programs include conditional release, psychiatric security review boards (PSRBs) and forensic community treatment teams. Related factors, such as state civil systems operating in tandem with the forensic system and assisted outpatient treatment (AOT), are also discussed.

Conditional Release

As its name suggests, conditional release is the partial discharge of a patient from a hospital, conditional on the person's adherence to a specified treatment plan. If the person does not comply, he or she can be returned involuntarily to the hospital. Conditional release can be authorized by a court, or the legal authority to enforce a conditional release can be statutorily vested in the director of a hospital or other entity. For more than a century, conditional release has been widely used for psychiatric patients in the United States. In recent years, however, the practice has become much less common, mostly due to concerns that the hospital might be held legally liable for any criminal behavior committed by a patient on conditional release status. In addition, as budgets for outpatient monitoring and treatment have been cut, pressures have mounted to hasten discharge from programs in shorter time frames. This has occurred despite data suggesting that conditional release is effective in promoting treatment adherence in the community and preventing recurrences of symptoms. Since the 1970s, there has been substantial research on the effectiveness of conditional release programs in improving clinical outcomes and reducing recidivism. Although less research has been conducted in more recent years, the effectiveness of this program is unequivocal.

Conditional release programs have been used in several states for individuals with serious mental illness who have committed major crimes. Examples include the following.

MARYLAND

Since 1967, Maryland has routinely used conditional release for individuals with serious mental illness who have been found NGRI.* Although the initial period of conditional release is for five years, it can be extended by the court's Community Forensic Aftercare Program. Monitoring of individuals on conditional release is provided by social workers under this program.

In a study on the follow-up of 356 individuals released on conditional release between 2007 and 2009, more than 71% of individuals had a diagnosis of a psychotic disorder, and 23%

* Maryland phrases NGRI as "guilty, but not criminally responsible."

had a diagnosis of antisocial personality disorder.¹ At the end of three years, the re-arrest rate was 14% (48 of 356), substantially lower than the recidivism rates reported historically. Details on the crimes leading to the re-arrests were not provided.

VIRGINIA

In 2014, a statewide analysis of Virginia's conditional release program was conducted to determine the effectiveness of risk management approaches on individuals found NGRI living in the community.² The authors analyzed 127 individuals found NGRI living in the community in Virginia from 2007 to 2010. Only 96 individuals maintained their conditional release; thus, the three-year re-arrest rate was 24%. The authors also found that previous violent behavior and failure on conditional release predicted revocation. This finding indicates that risk assessment for individuals with serious mental illness on conditional release is important when considering community-based management for such individuals who are involved in the criminal justice system.

CONNECTICUT

Connecticut has long used conditional release in conjunction with its PSRB, which is described later in this section.³ Since the PSRB was established 30 years ago, 177 individuals with serious mental illness determined NGRI have been on conditional release for varying lengths of time. The re-arrest rate for this group while on conditional release was only 2% (4 of 177); the charges in two of the arrests resulted in misdemeanor convictions, and the charges for the other two were dismissed.

CALIFORNIA

In 1975, the California legislature established a conditional release program (CONREP) for individuals with serious mental illness who had been found NGRI for criminal activities. The program consists of mandatory compliance with medication, weekly individual and group therapy, and weekly urine drug screens. The conditional release may last for as long as the maximum term of imprisonment if the person had been found guilty of the underlying crime.

A study was conducted on the follow-up of 190 patients discharged from a state forensic hospital in 1986 and 1987.⁴ Their original crimes included murder/manslaughter (23%), sexual crimes (20%) and assault (35%). At the end of two years, their re-arrest rate was 6% (11 of 190). Because details of the crimes leading to the re-arrests were not provided, it is not known whether each would be considered a major crime under this study's definition. Another CONREP follow-up study assessed 781 individuals with serious mental illness who had been found NGRI and put on conditional release from 1986 to 1992.⁵ During the time they were on conditional release, their re-arrest rate was 8% (59 of 781).

A third evaluation of the CONREP program in 1979–1980 focused only on Los Angeles County.⁶ A total of 79 individuals on conditional release were followed for five years. All except one of the individuals had previously committed felony crimes, two-thirds of which were major crimes as defined for this paper. All except two had been psychotic at the time of their initial crimes. In contrast to the other evaluation studies, the re-arrest rate for this group during their five years on conditional release was 32% (25 of 79), three-quarters of which were for "crimes of violence against persons" (major crimes). The authors of the study suggested that the reason for this comparatively high re-arrest rate while on conditional release was that the Los Angeles County program was being poorly run. Specifically, they noted that many individuals on conditional release "received insufficient supervision and structure," especially regarding medication compliance. In addition, CONREP staff allowed noncompliant and overtly psychotic individuals to remain in the community, despite their his-

Conditional release programs can be very effective in reducing the re-arrest rates of individuals with serious mental illness with a history of having committed major crimes. The effectiveness, however, is directly dependent on the program's quality and especially on the strictness by which medication compliance is enforced.

tory of previously having committed major crimes while psychotic. Compared with other states, California gives counties a greater degree of autonomy to determine how to implement programs, leading at times to disparate results based on local politics and the philosophies of the mental health department's administration staff.

A California Department of State Hospitals evaluation of CONREP in fiscal year 2015 was published in January 2017. In fiscal year 2015, a total of 153 patients were discharged from the CONREP program, in which 71 indi-

viduals were deemed NGRI and 36 individuals deemed a mentally disordered offender. Their re-arrest rate was 19%, with one individual having committed a felony crime and seven individuals being re-arrested for misdemeanors.

In summary, conditional release programs can be very effective in reducing the re-arrest rates of individuals with serious mental illness with a history of having committed major crimes. The effectiveness, however, is directly dependent on the program's quality and especially on the strictness by which medication compliance is enforced.

Psychiatric Security Review Boards

Among the specialized programs that have been developed to decrease the reoffending rate of individuals with serious mental illness who have committed major crimes, the PSRB is widely known.

OREGON

The PSRB was originally developed by the Oregon legislature in 1977 and went into effect in 1978. Following the 1982 verdict of NGRI for John Hinckley Jr., who attempted to assassinate President Ronald Reagan, the American Psychiatric Association (APA) cited Oregon's PSRB as a possible national model for the management and treatment of those found NGRI after a verdict is rendered.⁷ The Oregon PSRB was given the APA's Gold Achievement Award in 1994.⁸ The primary purpose of the Oregon PSRB is to protect the public, as specified by statute and as upheld by the Oregon Supreme Court: "In determining whether a person should be committed to a state hospital, conditionally released or discharged, the Board shall have as its primary concern the protection of society."⁹

The Oregon PSRB is organized as an independent agency with a small staff and five members who are appointed by the governor to four-year terms. Members include a psychiatrist, psychologist, probation or parole officer, lawyer, and member of the public. Following a successful NGRI verdict and finding that the individual acquitted remains mentally ill and dangerous, the trial court assigns the individual to the jurisdiction of the PSRB and determines the length of time for the board's jurisdiction. The PSRB has full authority over the individuals assigned to it by the courts, including decisions regarding the duration of inpatient care, conditional release and discharge. The duration of the PSRB's jurisdiction for any individual, including conditional release, is the sentence that person would have received if he or she had been found to be criminally responsible for the underlying crime.

Virtually all individuals found to be NGRI are assigned to the PSRB. Until 2012, individuals who had committed either misdemeanors or felonies were assigned to the PSRB; since 2012, the PSRB has overseen only those charged with felonies. It should be noted that the

Oregon PSRB does not provide any psychiatric services itself; rather, it assigns the individual to the Oregon State Hospital for inpatient care or to state-funded outpatient programs. Economic analysis of the Oregon PSRB program reported it to be cost-effective by decreasing hospitalizations.¹⁰

An evaluation was carried out on 381 individuals diagnosed with schizophrenia or schizoaffective disorder who were under the jurisdiction of the PSRB between 1978 and 1986.¹¹ During the time they were on conditional release, their rate of re-arrests was 11% (40 of 381); half of the re-arrests were misdemeanors, and half were felonies, including two homicides and one rape. However, after this cohort was discharged and no longer under the jurisdiction of the PSRB, its re-arrest rate increased to 53% (72 of 137), suggesting that the PSRB's effectiveness depends on ongoing supervision. The increase also suggests that Oregon's civil treatment system is inadequate to prevent recurrence of symptoms in the community, as discussed below.

Another evaluation of the Oregon PSRB covered the 34-year period from 1978 through 2011.¹² During that time, 2,558 individuals were committed to the PSRB—72% had a primary diagnosis of psychosis (mostly schizophrenia), 84% had prior psychiatric hospitalizations and 84% had previous arrests. In 80% of cases, the index crime leading to the NGRI plea was a felony, including 5% for murder and another 35% for other felonies including manslaughter, rape and first-degree assault.

From 2002 through 2011, an average of 339 individuals were on conditional release at any given time under the PSRB's jurisdiction. During that 10-year period, only 2.6% were re-arrested for felonies,¹³ suggesting that the Oregon PSRB has been very effective in decreasing major crimes.

CONNECTICUT

Using Oregon as a model, Connecticut established its own PSRB in 1985. The immediate impetus was the publicized case of a man with mental illness who killed his wife, was found NGRI, was hospitalized for three months with a good response to antipsychotic medication and released, and, five years later, was charged with killing his second wife. The PSRB consists of six members appointed by the governor. It has responsibilities similar to those of the Oregon PSRB, except that the Connecticut PSRB does not have the authority to discharge patients; that decision rests with the courts, though the court usually accepts the PSRB's recommendation.

A 2016 study summarized the 30-year experience of the Connecticut PSRB.¹⁴ A total of 215 individuals with serious mental illness who had been found NGRI for major crimes had been supervised by the PSRB and eventually discharged. Their mean length of hospitalization was 9.8 years plus another 3.0 years on conditional release. Thus, the average age of this group at the time they were finally discharged from PSRB supervision was 46.7 years.

Over the 30-year period from 1985 to 2015, 177 of the 215 individuals spent varying lengths of time on conditional release. The re-arrest rate for this group while on conditional release was only 2% (4 of 177); the charges in two of the arrests resulted in misdemeanor convictions, and the charges for the other two were dismissed. Among the 215 individuals discharged from PSRB supervision, 19 died while hospitalized, leaving 196 actual discharges. The re-arrest rate for this group for a mean of 12.5 years after discharge was 16% (32 of 196). Felony charges accounted for 53% (17 of 32) of these first re-arrests, including three cases of assault. The diagnoses of the 32 individuals who were re-arrested included 16 with schizophrenia spectrum disorder and six with bipolar disorder. The authors of the study concluded that the Connecticut PSRB program "appears to be highly effective."

Forensic Community Treatment Teams

Introduced in the 1970s, assertive community treatment (ACT) teams have been widely used in the United States to provide psychiatric care for individuals with serious mental illness in the community, enabling care in a less restrictive setting than inpatient hospitalization. The multidisciplinary teams comprise mental health professionals and paraprofessionals who are assigned a group of patients for whom they are fully responsible. For example, an ACT team of 10 staff persons might be responsible for 100 or more individuals with serious mental illness. The team is responsible for the patients at all times, which means a team member must be on call nights and weekends.

The ACT team model promotes medication compliance but also assists with housing arrangements, money management, job training and other aspects of rehabilitation. ACT teams use assertive outreach, often meeting with patients in their homes. When fully implemented, ACT teams have been shown to decrease rehospitalizations, improve the quality of life and be cost effective.^{15,16}

In recent years, there have been attempts to use the ACT team model for individuals with serious mental illness being released from jail and prisons—a model known as forensic ACT (FACT) teams.^{17,18} FACT teams are similar to ACT teams except that the former include a criminal justice professional and the patients served all have entered the mental health system by way of criminal offenses. One concern is that many of these FACT teams do not include the full complement of ACT components, especially the 24/7 coverage by team members, which is essential for ACT's effectiveness. Indeed, FACT teams have been referred to as "ACT-lite."¹⁹

Despite the extensive research on the effectiveness of ACT teams, there has been limited research on the effectiveness of FACT teams, and many of the studies are methodologically weak.^{20,21} In addition, most of the evidence base is more than 10 years old, which may have limited translation into present systems. Despite the lack of supporting evidence, FACT teams are becoming widely used for individuals with serious mental illness who have committed major crimes living in the community, where "practice has outpaced the evidence base."²² However, insofar as older evidence for FACT program effectiveness is relevant today, there is some evidence to support the effectiveness of FACT teams in reducing re-arrest rates among program participants.

NEW YORK

The first assessment of FACT teams was carried out by Lamberti and colleagues in 2001 in Monroe County (Rochester).^{23,24} The authors reported that a FACT program for individuals with serious mental illness being released by the Monroe County Jail had resulted in a significant reduction in re-arrests, jail days and hospitalizations. Called Project Link, this program received the APA's Gold Award for innovation in 1999.

A second assessment of FACT teams was carried out by Lamberti and colleagues from 2007 to 2009, also in Monroe County.²⁵ The authors reported that 55% of individuals enrolled in the FACT program had a diagnosis of schizophrenia, and 61% of individuals were homeless at time of enrollment. The authors also reported that 23% of individuals enrolled in the FACT program had histories of committing major crimes. Despite the high risk of recidivism among FACT patients, only two of the 15 programs evaluated (13%) reported using a standardized risk assessment tool.

ILLINOIS

In 1998, Thresholds psychiatric rehabilitation center in Chicago set up a FACT team to work with individuals with serious mental illness being released by the Cook County Jail.^{26,27} Arrest records for 24 individuals enrolled in the first year were compared with arrest records for the year prior to entering the program. Re-arrests were reduced from 3.1 to 0.8 per year, and hospital days were reduced from 65 to seven.

In 2007, Angell and colleagues evaluated the engagement processes of FACT teams established for inmates with serious mental illness being released from Illinois's state prison system.²⁸ Individuals had to consent to be included in the study; therefore, only 21 individuals with serious mental illness were included. This study was qualitative in nature and provided no data on re-arrest rates or recidivism.

WASHINGTON

The King County FACT program serves adults with serious mental illness who have a history of homelessness and who have extensive criminal histories with very high use of the King County Correctional Facility. A 2012 evaluation of the program included 252 individuals who generated 3,491 jail bookings and 50,708 days incarcerated during a 33-month period.²⁹ The evaluation reports that FACT participants experienced a 45% reduction in jail and prison bookings in the first year. In addition, average bookings per individual dropped from 5.2 in the year prior to FACT enrollment to 2.9 during the first year of FACT, a statistically significant decline.

Specialized programs for individuals with serious mental illness who have committed major crimes can reduce their re-arrest rate from 40%–60% at five years after release from psychiatric hospitals, prisons or jails to 10% or less.

FACT participants also experienced a statistically significant decline in days incarcerated. Total days in either jail or prison dropped from 5,952 in the year prior to FACT enrollment to 3,664 during the first year of FACT—a 38% reduction. FACT participants also had significant reductions in psychiatric hospitalizations; the total days of FACT participants in the year prior to enrollment was 7,200 days, decreasing to 4,442 days in the first year postenrollment—a 38% reduction.

ARKANSAS

In 1995, Arkansas implemented a FACT program for individuals with both serious mental illness and substance abuse who had been found NGRI for criminal activity.^{30,31} It included a special inpatient unit and a graduated series of step-downs leading to conditional release in the community. Among the first 91 participants in the program, 18% had been charged with murder or manslaughter, 32% with other violent assault, and 12% with kidnapping or sex crimes. Three-quarters were diagnosed with schizophrenia; they also averaged 2.1 state hospital admissions in the previous five years. The six-year re-arrest rate for this group was 5% (5 of 91). Unfortunately, the program was discontinued in 2010 for fiscal reasons.

LOUISIANA

In 1995, Louisiana used the FACT model to set up a forensic aftercare clinic conditional release program for individuals with serious mental illness or developmental disability who had committed major crimes.³² The impetus for the program's creation was a series of five homicides, with their inevitable media coverage, "committed by persons classified as forensic discharges." The initial conditional release in Louisiana is for five years, but it can be extended indefinitely in one-year increments.

The program consists of an interdisciplinary team directed by a forensic psychiatrist. Supervision of the released patients is tight and includes a minimum of one home visit per month, urine or hair sample drug screens, surprise medication blood-level checks, having the patient take medication daily in the presence of a nurse if necessary, and surprise home visits. The program was evaluated after seven years, during which time 123 patients were monitored. Among them, 43% had previously committed major crimes, including 13% who had committed homicides. The re-arrest rate at the end of seven years was 10% (12 of 123)—three with felony charges (burglary, attempted kidnapping and drug charges) and nine with misdemeanors.

A second follow-up of this FACT program covered an additional 193 patients treated from 2002 to 2012.³³ The re-arrest rate at the end of that period was 3% (5 of 193). Three of the arrests were for major crimes (attempted murder, domestic battery and burglary).

CALIFORNIA

There have been two randomized control trials to assess clinical outcomes for FACT interventions on California's Mentally Ill Offender Crime Reduction program. The first study, conducted from 2001 to 2004 in San Francisco, found that FACT participation reduced arrests and jail days for individuals with serious mental illness.³⁴ In addition, the authors found that FACT participation was associated with increased mental health and criminal justice service outcomes, such as medication treatment, lower probability of psychiatric hospitalization and fewer incarcerations. The second randomized control trial of California FACT teams was conducted in a northern California county from 2003 to 2005.³⁵ The authors found that after one year of FACT team enrollment, participants had significantly reduced number of jail bookings and hospital stays, as compared with individuals in the usual care group.

Summary

In summary, the evidence supports the idea that specialized programs for individuals with serious mental illness who have committed major crimes can reduce their re-arrest rate from 40%–60% at five years after release from psychiatric hospitals, prisons or jails to 10% or less. The most effective programs include provisions for ensuring medication compliance, which is inherent in a conditional release. It is not always clear from the FACT program description whether it includes conditional release; some FACT programs, such as those described in Arkansas and Louisiana, do include conditional release, but others may not.

Interplay Between Civil and Forensic Systems

This chapter has focused on interventions specific to outpatient treatment of forensic patients. However, it is important to note that weaknesses in a state's civil treatment system do play a role in the success or failure of forensic patients and discharged inmates reentering the community once the statutory period of supervision has ended. For this reason, it is necessary to assess the capacity and quality of the civil system for each state to obtain a full picture of the factors that may lead to re-arrest for this population. After all, once an individual has been fully discharged from supervision, the same civil system that did not successfully intervene prior to a criminal act will once again be tasked with preventing a return of symptoms.

Assisted Outpatient Treatment

AOT is a court-supervised treatment program in a community setting. AOT programs have been shown to reduce arrests and incarceration among program participants, as well as prevent violent acts associated with mental illness, including suicide and violence against others.³⁶ The new sequential intercept model in the 21st Century Cures Act, which is recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA), is a mapping of intervention points designed to identify where diversion from the criminal justice system could occur. This model places AOT before the first intercept, prior to the involvement of law enforcement, and again at the last intercept of the model within community corrections.³⁷

With the exception of Connecticut, Maryland and Massachusetts, every state and the District of Columbia have enacted laws to authorize the use of AOT.

To be a candidate for AOT, a person must meet specific criteria, such as a prior history of repeated hospitalizations or arrest. The availability of a robust AOT program can help ensure the continued success of an individual upon discharge from conditional release or a FACT program. If adherence to treatment is an issue for an individual, the black robe effect, or the natural tendency people have to accept a judge's order based on the position's authority, is

useful in maintaining treatment within the community. In addition, the AOT order identifies the individual's treatment as a priority for services and adds a layer of accountability for providers to that individual.

With the exception of Connecticut, Maryland and Massachusetts, every state and the District of Columbia have enacted laws to authorize the use of AOT. Despite being a nonforensic program, there is some evidence to show the effectiveness of AOT in reducing recidivism among individuals with serious mental illness who have committed major crimes.

NEW YORK

New York State's version of AOT is called Kendra's Law, named after Kendra Webdale, a young New York City girl who, in 1999, was pushed in front of a subway train to her death by a man with untreated schizophrenia. More than 14,618 individuals have been placed on AOT in New York since 1999, when the program began. New York conducts a continuous process evaluation of its AOT program, available on the state's Office of Mental Health website.³⁸ The evaluation reports data on individuals prior to AOT and their status at most recent follow-up. Overall, New York reports that individuals on AOT have had a 71% reduction in re-arrest rates and a 63% reduction in hospitalization. In addition, individuals with serious mental illness enrolled in AOT have experienced a 68% reduction in homelessness within the state and a 63% reduction in New York City.

CALIFORNIA

In 2002, California passed Assembly Bill 1421, known as Laura's Law, which allows counties within the state to choose whether to implement AOT programming. AOT services in California include intensive case management, housing assistance, vocational and educational services, medication support, and medication education, all with 24/7 support and availability. Telecare is California's largest AOT provider, with six AOT programs throughout the state; Orange County AOT was Telecare's first established program. Telecare reported significant positive outcomes in the eight-month evaluation of its Orange County program. There was a 70% decrease in days of inpatient hospitalization after AOT admission, with a 72% decrease in hospitalization episodes. In addition, there was a 56% decrease in re-arrest after AOT admission and a 75% decrease in number of days incarcerated among program participants.

The San Francisco Department of Public Health launched its AOT program in November 2015. One of a handful of county-led programs in California, the San Francisco AOT model is used to assist and support individuals with serious mental illness. The program promotes both recovery and wellness and is focused on community-based services, with the aim of advocating individuals for voluntary treatment before a court order is requested. A comparison of each individual's monthly averages before and after AOT contact suggests the program has the potential to be successful. However, the program is only a few years old and has been allocated limited resources by the county, thus more research is needed to determine its full effectiveness. During the evaluation period of November 2015 to February 2017, the county found that of the individuals in contact with the AOT program, 87% were successful in reducing psychiatric emergency service use and 74% were successful in reducing incarceration.

Discussion and Recommendations

Insufficient numbers of psychiatric treatment beds create a systemic capacity issue that affects both civil and forensic treatment systems, often in complementary ways. Some states prioritize beds for forensic populations, whereas others prioritize placement for civil populations. In either case, prioritization leads to a bottleneck for the nonprioritized population. This is evident in the nearly universal practice of boarding civil psychiatric patients in hospital emergency departments and the lengthy waits for competency evaluation and restoration for forensic patients in jails. The solution, of course, is not to stop prioritizing but to increase the total number of staffed beds in a state. However, as this is the highest-cost decision for a legislature to make, the trend has continued in the wrong direction.

Civil treatment standards become a potential stumbling point for this population if, after discharge from treatment and supervision, the standards are insufficient to compel a return to treatment before another major crime or conduct that could qualify as such—is committed. To intervene within the civil spectrum, there must be adequate laws to allow timely inpatient treatment during periods of crisis, as well as treatment standards for AOT designed to maintain continued treatment and stabilization.

In analyzing the forensic treatment systems for each state, a secondary set of factors to consider must include (1) the adequacy of the number of psychiatric treatment beds for the state's population, (2) the availability and use of AOT laws, and (3) any other weaknesses within the civil treatment system that could allow individuals being discharged from the forensic system or released from jail or prison after major crimes to slip through the cracks if a recurrence of symptoms occurs.

CHAPTER 3

Magnitude of the Current Problem

Past studies have clearly shown that individuals with serious mental illness who commit major crimes subsequently encounter or create significant problems. Once discharged from hospitals or released from jails and prisons, their rate of re-arrest ranges from 40% to 60%, with approximately one out of five of these new offenses being major crimes as defined in this report. This chapter addresses the question: *How many individuals with serious mental illness who have committed major crimes and have subsequently been released from state psychiatric hospitals, prisons or jails are living in the community today? In short, what is the magnitude of the current problem?*

Patients Discharged From State Psychiatric Hospitals

Individuals who have committed major crimes and who are being released from state psychiatric hospitals consist of two groups. One group comprises individuals who have been found to be incompetent to stand trial, despite clinical efforts to restore their legal competency. As noted in Chapter 1, an estimated 60,000 evaluations for competency to stand trial are conducted in the United States each year.¹ In 10%–20% of these cases, or approximately 9,000 individuals, competency cannot be restored, suggesting that these people have psychiatric disease that resists treatment or have other intractable neurological conditions such as dementia.² Based on published recidivism data, approximately half (4,500) of these individuals have committed major crimes. Such individuals are usually treated for varying periods of time at state psychiatric hospitals and are then released.

The sort of data collected piecemeal by states over the past 40 years illustrates the difficulties faced by those seeking to conduct research or make policy recommendations.

The second group consists of individuals who have, by plea or verdict, been found NGRI and have subsequently been discharged from state psychiatric hospitals after treatment. Because most states do not keep statistics on their release of NGRI patients, there is no complete national database for determining the total number of NGRI individuals released each year. The National Association of State Mental Health Program Directors (NASMHPD) Research Institute reports

that 1,220 NGRI individuals were released from 30 states in 2014, which would be approximately 1,900 individuals if all states had reported.³ This example of the sort of data collected piecemeal by states over the past 40 years illustrates the difficulties faced by those seeking to conduct research or make policy recommendations.

Historical reports from states on their released NGRI populations are consistent with this number. Oklahoma released an average of five NGRI individuals per year in the 1980s, with a population at the time of 3.3 million.⁴ Projected nationally, this rate would now translate to approximately 500 NGRI individuals discharged per year. Maryland released an average of 10 NGRI individuals per year from 1967 to 1976, with a population of 4.2 million.⁵ Projected nationally, this rate would translate to approximately 800 NGRI individuals discharged per year. Missouri released an average of 18 NGRI individuals per year from 1987 to 1996, with a population of 5.1 million.⁶ Projected nationally, this rate would translate to approximately 1,150 NGRI individuals discharged per year. Finally, Hawaii released an average of 16.5 NGRI individuals per year from 1970 to 1976, with a population of 886,000.⁷ Projected nationally, this rate would translate to approximately 1,950 NGRI individuals discharged per year.

What percentage of this group had committed major crimes as defined in this study? The studies of those found NGRI and discharged from psychiatric hospitals described in Chapter 1 suggest that approximately two-thirds of such discharges followed major crimes. Given the evidence developed over an extended period, it can be conservatively estimated that approximately 1,500 individuals with serious mental illness who have committed major crimes are released from state psychiatric hospitals each year, and approximately 1,000 of these had committed crimes of violence against persons.

Inmates Released From Prisons

According to data available from the US Department of Justice, a total of 636,346 prisoners were released from federal and state prisons in 2014.⁸ This number included 54,529 prisoners released from federal prisons and 581,817 from state prisons. According to a previous analysis, the released prisoners would have been 89% male and 40% white, 40% African American, and 18% Hispanic.⁹ In terms of ages, 37% would have been 29 or younger; 31%, ages 30–39; and 32%, age 40 or older.

What percentage of these 636,346 inmates released from prison had committed major crimes against persons? According to a 2005 analysis, 26% of them had committed violent crimes, defined as including homicide, robbery, assault or sexual assault, or other felony crimes against persons.¹⁰ Another 30% had committed crimes against property (e.g., burglary, larceny, motor vehicle theft, arson, fraud, forgery), 32% had committed drug offenses, and 12% had committed crimes against public order (e.g., parole violation, obstruction of justice) or the crime was not specified.

What percentage of these 636,346 individuals released from prison had a serious mental illness? There have been multiple attempts to answer this question over the years. In 1998, Lamb and Weinberger reviewed several late-20th-century studies and concluded that “10 to 15% of persons in state prison have severe mental illness.”¹¹ Subsequent studies are consistent with this estimate.

- ◆ 1998: A US Department of Justice survey estimated that 16% of individuals in state prison were “estimated to be mentally ill,” based on inmate self-report of symptoms or having been psychiatrically hospitalized.¹²
- ◆ 2000: The APA estimated that approximately 20% of prisoners were seriously mentally ill, with 5% being actively psychotic at any given time.¹³
- ◆ 2002: The National Commission on Correctional Health Care estimated that 17% of state prison inmates had schizophrenia, bipolar disorder or major depression.¹⁴
- ◆ 2003: Based on interviews and visits to federal and state prisons, Human Rights Watch estimated that approximately 20% of prisoners were seriously mentally ill.¹⁵
- ◆ 2004: In one study, 18,185 federal and state prisoners were interviewed using a “computer-assisted personal interview.” Among federal inmates, 2% were diagnosed with schizophrenia and 4% with mania. Among state inmates, 5% were diagnosed with schizophrenia and 10% with mania.¹⁶
- ◆ 2006: A US Department of Justice survey, based on a selected sample of state prison inmates, reported that 15% “reported at least one symptom of a psychotic disorder.”¹⁷
- ◆ 2007: A study of all 79,211 inmates admitted in one year to the Texas prison system reported that 10% were diagnosed with “major depressive disorder, a bipolar disorder, schizophrenia, or a non-schizophrenic psychotic disorder.”¹⁸

Based on these studies, it is conservative to estimate that at least 10% of federal and state prison inmates have a serious mental illness, narrowly defined as conditions with psychosis (schizophrenia, bipolar disorder with psychotic features or major depression with psychosis). Therefore, among the 636,346 federal and state prisoners released in 2014, approximately 64,000 would have had a diagnosis for an illness that includes the potential for psychosis. Based on the study of released prison inmates referred to earlier, approximately 26% of these would have previously committed major crimes against persons. Multiplying 26% by 64,000 means that approximately 16,000 individuals with serious mental illness and with previous convictions for major crimes were released from federal and state prisons in 2014. This is a conservative estimate, since studies have reported that state prison inmates with mental illness are more likely to have committed major crimes than state prisoners without mental illness.¹⁹

Inmates Released From Jails

According to the US Department of Justice, local jails in the United States held 738,975 prisoners in mid-2014.²⁰ During the preceding 12 months, a total of 11.4 million individuals were released from the jails, including many repeat offenders who were released two or more times within the 12-month period.

The vast majority of jail inmates have been charged with misdemeanor offenses; a minority of those inmates have been charged with felonies.²¹ The percentage of jail inmates who have serious mental illness has been increasing in recent years.²² A 2002–2006 survey of jail inmates reported that 15% of male and 31% of female inmates had a serious mental illness, defining this term to include major depression and illnesses characterized by psychotic episodes.²³

Approximately 16,000 individuals with serious mental illness and with previous convictions for major crimes were released from federal and state prisons in 2014.

How many jail inmates who have a serious mental illness have committed major crimes? In 1983, Dr. Richard Lamb carried out a study in the Los Angeles County Jail.²⁴ He sampled 224 inmates in jail awaiting competency evaluation or restoration. These inmates had been charged in 92% of cases with felonies; in two-thirds of cases, they were crimes of violence, including murder, attempted murder, armed robbery, rape and assault with a deadly weapon. The psychiatric diagnoses

of these individuals included schizophrenia in 85% of the cases and major affective disorder in 7%. Lamb followed up this sample of violent inmates with serious mental illness two years later and reported that 42% of them “had simply been released (time expired, charges dropped, or on own recognizance) with no provision for postrelease treatment.”²⁵

Another illuminating study was carried out in the 90-bed psychiatric unit of the King County Jail in Seattle, Washington.²⁶ In 1990, there were 5,600 bookings and discharges of 1,500 unduplicated individuals. Half of the 1,500 were diagnosed with psychosis, 21% were charged with felonies, 39% had been charged with crimes of violence and 83% were under the age of 40. One-third of these individuals had had previous felony arrests. Given the population of King County at that time (1.5 million), insofar as King County was representative of all jails, there would have been a total of approximately 20,000 inmates with psychosis and felony charges in all US jails. Although there are limitations in extrapolating local data to be nationally representative, these data represent a conservative national estimate. Despite these limitations, the data are useful because there is so little information available, and what is available is not widely known. Other studies have reported that jail inmates with serious

mental illness are more likely to have committed a violent crime than are non-mentally ill jail inmates;²⁷ in addition, most individuals with mental illness are released from jail without any follow-up care.²⁸

If approximately 20,000 individuals with psychosis and felony charges are in the nation's jails and 11.4 million jail inmates are released each year, what is a reasonable estimate of how many of the 20,000 would be released? Lamb, in his study of the Los Angeles County Jail, reported that 42% of those being held in jail pending competency evaluation or restoration had been released by the end of two years. A significant overlap between individuals with serious mental illness in jail and those in state psychiatric hospitals and prisons is likely, as those eventually restored to competency and tried will be convicted, found NGRI or acquitted. Individuals who are being examined for competency to stand trial, therefore, will often be admitted to both a jail and a state psychiatric hospital in the same year. In addition, individuals with serious mental illness in prison may be found NGRI within the same year. Conservatively, it thus seems reasonable to estimate that 2,000 unduplicated individuals with serious mental illness who had committed felony crimes may be released from the nation's jails each year.

Summary

What is the magnitude of the present problem? It has been estimated that each year, the following individuals with serious mental illness who have committed major crimes are released to live in the community:

- ◆ 4,500 patients from state psychiatric hospitals who have been deemed incompetent to stand trial
- ◆ 1,000 patients from state psychiatric hospitals who have committed major crimes deemed not guilty by reason of insanity
- ◆ 16,000 inmates from state prisons
- ◆ 2,000 inmates from county and city jails

All of these individuals have committed major crimes, and most of those have been crimes of violence against persons. Even allowing for some duplication of individuals being released from two hospitals or correctional facilities in a single year, the total number of such inmates released to the community is at least 20,000.

How many such individuals are living in the community today? The numbers cited above represent only those individuals with serious mental illness who have been released during a single year. Such individuals, of course, accumulate in the community over many years, with their total number dependent on several factors. The most important factor is how long such individuals are actually living in the community and not back in jail or prison, psychiatrically hospitalized, or deceased. According to a 2005 study of individuals with serious mental illness released from prisons, more than half (57%) had been re-arrested within a year following their release.²⁹

The age at time of release and the death rate of these individuals are also important in determining how long they spend in the community. According to previously cited studies, two-thirds of those released from prison and 83% of those released from jails were under age 40 at the time of their release.^{30,31} As individuals age, their rate of committing crimes decreases. It is also well known that individuals with serious mental illness, especially those diagnosed with schizophrenia, die prematurely.³²

Given all of these factors, what is a reasonable estimate for the total amount of time that individuals with psychosis, after being released from psychiatric hospitals, prisons or jails, are likely to live in the community and thus be in a situation in which they could theoretically commit new crimes? Given the ages of those being released, 10 years seems like a reasonable estimate. Therefore, if 20,000 such individuals are released from psychiatric hospitals, prisons and jails each year and they are available to commit new crimes for 10 years, the total number of individuals with serious mental illness who have already committed major crimes, mostly violent crimes against persons, and who are currently living in the community would be approximately 200,000.

The 200,000 individuals with serious mental illness who have committed major crimes and are living in the community are approximately 2% of the total number of people with serious mental illness.

What percentage of all Americans with serious mental illness is 200,000 individuals? The National Institute of Mental Health estimates that 1.1% of adults have schizophrenia and 2.2% have “severe” bipolar disorder, which together totaled 8.2 million individuals in 2016.³³ Using a broader definition of serious mental illness, SAMHSA reported that 9.8 million US adults had serious mental illness in 2015.³⁴ The 200,000 individuals with serious mental illness who have committed major crimes and are living in the community are thus approximately 2% of the total number of people with serious mental illness.

Discussion and Conclusions

Although only 2% of the total, this subgroup of individuals with serious mental illness must be prioritized for treatment by state mental health authorities. These individuals have already demonstrated that, when untreated, they are a danger to others and to themselves. They have committed major crimes, most of which involve violence against persons. To place these individuals in the community without providing for adequate treatment puts them and the public unnecessarily at risk. Most of these individuals have also had multiple psychiatric hospital admissions and incarcerations.³⁵

The quality of life for individuals undergoing repeated psychiatric hospitalizations and incarcerations is dismal. Such repeat hospitalizations and incarcerations are also very expensive. Thus, this revolving-door subgroup of individuals with serious mental illness uses a significant proportion of federal and state mental health expenditures that would be better spent on timely treatment to break the cycle. This vulnerable subgroup of individuals with serious mental illness who have committed major crimes should be prioritized and treated for both humane and economic reasons and to increase public safety.

This raises the next important question: *How are the states doing in this task?*

CHAPTER 4

Methodology

Given the comparatively large number of individuals with serious mental illness who have committed major crimes and returned to the community after being incarcerated or hospitalized, we undertook a survey to ascertain the scope and diligence of state practices in providing follow-up care for this population. Providing such care is important to promoting successful reentry, minimizing re-arrest, reducing the likelihood of hospitalization and/or incarceration, and protecting the public.

We began by collecting all publicly available information on the forensic services provided by each state to patients who enter the treatment system by being arrested for a crime. This included surveying published studies, questionnaire replies published by the NASMHPD Research Institute, websites of the state mental health authorities and media reports. If updated numbers were not available, forensic bed numbers were obtained from the Treatment Advocacy Center's 2016 report *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds*.

We then sent a questionnaire to the director of forensic services in each state. The instrument solicited the number of forensic beds available for this population as of the date of inquiry; the number of defendants deemed incompetent to stand trial; the number of defen-

Major crimes, as defined in this report, are serious crimes against persons.

dants found not guilty by reason of insanity or its equivalent; the availability of conditional release, PSRBs and/or FACT teams; and procedures used by the state to follow individuals after hospital discharge. Forensic directors were asked to reply by email or by telephone interview. Two follow-up requests were sent to nonresponders.

The forensic directors and the commissioners of mental health in 40 of the 50 states (80%) responded. The nonresponding states, as one would predict, included many states that the initial survey of public information suggested had very few forensic services, but it also included Maine, one of the most highly rated states. In three of the nonresponding states, an alternative to the director of forensic services was identified and solicited, and that person responded to the questionnaire.

To obtain information about follow-up care for individuals with serious mental illness being released from prisons and jails, we solicited information from the director for each state's department of corrections. These officials were asked to identify any programs or practices beyond probation and parole that were in place in their states to reduce reoffending among individuals with serious mental illness released from correctional facilities. A total of 15 states provided such information.

The grading of each state was conducted by consensus of the two senior authors after all information had been received. The following grading system was used. It should be emphasized that the grades apply exclusively to the follow-up care for individuals with serious mental illness who had committed major crimes.

A: To receive a rating of A, the state must have fully developed most or all of the following practices or policies.

1. Designation of individuals with serious mental illness and a past history of having committed major crimes, usually felonies and especially violent crimes against persons, should have been made by state officials as a priority population for services—This could include statements on the prioritization of forensic patients by state officials or the designation of individuals as priority patients within the treatment systems.
2. Operation of a designated body at the state level to organize and enforce the delivery of services to these individuals—A PSRB, such as is found in Oregon, Connecticut and Arizona, is an example of this.
3. Operation of an adequate number of forensic inpatient beds.
4. Use of conditional release, with clear instructions regarding the conditions under which release can be revoked.
5. Provision for the indefinite continuation of conditional release when needed.
6. Provision of psychiatric and rehabilitative services to individuals on conditional release by special forensic teams—A FACT team specifically targeting individuals with felony charges is one example of this. The use of ordinary community psychiatric services by forensic patients often results in these patients being relegated to a lower priority for services.
7. Use of risk assessment, before release, to identify individuals with serious mental illness who, because of their previous violent crimes, are at heightened risk for future violent acts, with those found to be potentially dangerous referred for civil commitment.
8. Operation of AOT to ensure continued treatment in the community and to reduce the likelihood of reoffending, including violent reoffending.
9. Data tracking of re-arrest rates (considered to be the most important outcome) in the target population.
10. Annual reporting to the state legislature on follow-up care to the population, including the number of individuals on conditional release and the re-arrest rate of individuals with serious mental illness.

B: To receive a rating of B, the state must have many of the criteria substantially developed.

C: To receive a rating of C, the state must have several of the criteria substantially developed.

D: To receive a rating of D, the state must be making efforts to develop some of the criteria.

F: To receive a rating of F, the state must have shown little or no interest in developing any special services for this priority population.

CHAPTER 5

Grading of the States

The following are the results from our state survey and individual state assessments.

NOTE: Appended to some state narratives are quotes from news articles identifying incidents in which an individual diagnosed with a serious mental illness, as defined in this report, was involved in an incident that would meet this report’s definition of a major crime following a prior instance of a major crime by the same individual. The purpose is to illustrate some patterns of re-arrest and to give examples of the failure of certain state systems to provide sufficient support services to prevent second instances of major crimes after a person’s reentry to the community. Where charges have not been finally adjudicated, we remind the reader that all individuals retain the presumption of innocence.

State grades address the availability of forensic beds; however, it is important to note that forensic beds are not to be considered a substitute or in lieu of civil beds. See Chapter 2 for more information.

Alabama

GRADE: D

Alabama had 115 designated forensic beds as of April 2017, and it only conducts treatment and evaluation at one facility—Taylor Hardin Secure Medical Facility in Tuscaloosa. The state’s forensic treatment system has been the subject of civil rights litigation and has faced allegations that individuals routinely endure waits of eight months or more in jails before being transferred to an open bed at Taylor Hardin for competency evaluation and restoration services. In this survey, no data were provided on programming for forensic patients with a history of committing major crimes. Alabama practices conditional release and allows for indefinite supervision if needed. The statutory language concerning revocation is unambiguous, clearly delineating the authority and procedure for revocation proceedings and what constitutes a violation of conditional release terms. The state does not collect or analyze data on recidivism for individuals released into the community, including those with serious mental illness who have committed major crimes.

Alabama does not use a statewide PSRB. Law enforcement is tackling a tremendous increase of individuals in jails and prisons with untreated mental illness; this increase is attributed to sharp cuts in mental health spending. AOT laws are fairly strong and are routinely used in some parts of the state; however, implementation is not consistent across the state, and the majority of the state has no such programs.

SUMMARY: Alabama should first focus on putting out fires in its system, starting with prioritizing forensic patients and individuals discharged from jails or prisons with severe mental illness who will return to society and are at high risk for recidivism. If the state chooses to continue cutting its mental health spending, it will inevitably discover how much costlier these services are when would-be patients arrive in jail or prison and cannot be turned away.

RECOMMENDATIONS

- ◆ Systematically collect, analyze and report data on people with mental illness in correctional settings
- ◆ Establish a state PSRB to provide statewide supervision of forensic services offered to individuals who have committed major crimes
- ◆ Increase funding for evidence-based forensic programs
- ◆ Increase the number of forensic hospital beds to address long waits for competency evaluation and restoration

Alaska

GRADE: F

In April 2017, Alaska had only 10 beds for forensic patients at the Alaska Psychiatric Institute, one of the lowest numbers of beds per 100,000 in population of any state. The state practices conditional release, but its duration is limited to the length of the sentence the person would have received. Oversight of patients on conditional release is provided by local community mental health centers (CMHCs), many of which prioritize “wellness” programs over programs for serious mental illness, as was uncovered during the tragedy in Ft. Lauderdale, Florida, in January 2017 (see discussion that follows).¹

Alaska does not use a statewide PSRB. In addition, although there is statutory authority, there is very little AOT implementation throughout the state. An ongoing forensic workshop of the Division of Behavioral Health, organized to improve the system, has not produced significant results to address these problems.

The case of Esteban Santiago illustrates structural weaknesses in Alaska’s mental health system. Santiago walked into the Anchorage FBI office complaining that the CIA was controlling his mind, trying to make him become a terrorist and join ISIS. He said he had a gun and was hearing voices; he was talking incoherently. The FBI correctly took his gun away and sent him to the Alaska Psychiatric Institute for evaluation and treatment. However, the hospital merely gave him anti-anxiety medication and released him after five days without follow-up. Esteban then retrieved his gun and flew to Ft. Lauderdale, where he now stands accused of killing five and wounding six in the airport baggage claim area.

SUMMARY: Alaska is doing virtually nothing to help individuals with serious mental illness who have committed major crimes succeed or prevent reoffending, thus putting them and the public at risk.

RECOMMENDATIONS

- ◆ Systematically collect, analyze and report data on people with serious mental illness in correctional settings
- ◆ Establish a state PSRB to provide statewide supervision of forensic services offered to individuals who have committed major crimes
- ◆ Create policies for increasing services for individuals with severe mental illness
- ◆ Increase the number of forensic hospital beds

In 2007, Brian Galbraith, diagnosed with paranoid schizophrenia, was accused of stabbing to death a 32-year-old mental health worker and subsequently pleaded guilty after being restored to competency in 2010. He had previous convictions in 1983 and 1989 for assault and kidnapping.

—S. Friedman, “Murderer Brian Galbraith sentenced to at least 20 years in prison,” *Fairbanks Daily News-Miner*, April 25, 2011.

Arizona

GRADE: C

Arizona's greatest forensic asset is its PSRB, one of only four states in the United States to adopt such a body. As of April 2017, the PSRB has jurisdiction over 99 individuals with serious mental illness who have committed crimes and have been found guilty except insane (GEI). When individuals are discharged from Arizona State Hospital on conditional release, the duration of the release is limited to the length of the sentence the individual would have received for the underlying crime. The individual is then followed by the local CMHC, which produces different results depending on the geographic region and availability of services within the state.

As discussed in Chapter 2, these individuals would benefit from working with dedicated FACT teams that are focused on individuals who have committed major crimes. However, the three FACT teams in Maricopa County, under Community Bridges, are targeted at drug abusers, individuals experiencing homelessness and those who have committed misdemeanors. These teams may be fine for those populations, but they do not meet FACT program fidelity criteria. At the time of this report, only one PSRB patient was being followed by a FACT team in Maricopa County.

For inmates with serious mental illness released from prison, the state Department of Corrections has a release planner conduct an evaluation for each inmate. This planner sets up an initial appointment with a case manager under the inmate's regional behavioral health authority to ensure continuity of care, especially for those on medication. Inmates who are believed to be potentially dangerous can be sent, upon release, to a community psychiatric hospital to have a court-ordered evaluation and, three days later, a court hearing to determine whether court-ordered treatment is required. If required, the person can be hospitalized under civil commitment for additional treatment. Overall, the Department of Corrections is making a significant effort to identify and seek treatment for potentially dangerous inmates with serious mental illness at the time of release; according to state officials, however, there is minimal coordination between the Department of Corrections and the Department of Health Services, especially in comparison with other states.

Survey responses revealed significant problems in how Arizona handles individuals with serious mental illness who have committed misdemeanor or felony crimes and have been found NCTST. These individuals exist in limbo, being passed back and forth between the state hospital, which is funded by the state, and the jails, which are funded by the county; most individuals are eventually released without quality follow-up treatment. In addition, the state hospital has very few forensic beds, at 2.2 beds per 100,000 population, and the state legislature is reluctant to spend the money necessary to create robust programming to aid successful community reentry.²

SUMMARY: Arizona's PSRB has the chassis of a potentially good forensic system. The state now needs to pay for some tires that will allow it to move forward.

RECOMMENDATIONS

- ◆ Refocus FACT teams to work with appropriate forensic populations under the PSRB's jurisdiction
- ◆ Identify ways for corrections and mental health departments to collaborate more effectively for NGRI and NCTST populations
- ◆ Grant jurisdiction to the state PSRB of NCTST individuals who have been charged with major crimes but cannot be tried

In 2015, Kenneth Wakefield, diagnosed with a serious mental illness, was charged with killing his wife, as well as maiming himself and killing the family's two pet dogs. Initially found incompetent to proceed, Wakefield was restored to competency in 2016 with court-ordered treatment. His criminal case is still pending. In 2002, he had been found guilty but insane for the attempted murder of his mother by stabbing. He spent 10 years in Arizona State Hospital and had only been released by the PSRB in 2014.

—“Phoenix man accused of decapitating wife found to be mentally fit,”
The Arizona Republic, April 16, 2016.

In 2013, Michelle Price, diagnosed with schizoaffective disorder, pleaded guilty to killing an elderly woman who had invited Price to stay with her. In 2008, Price had been convicted of stabbing her ex-boyfriend. She had been released from a psychiatric hospital approximately two weeks before the 2013 homicide and was still on probation for the 2008 offense.

—S. Wasu, “Convicted killer warned counselor she wasn’t ready to be released,”
Tucson News Now, October 11, 2014.

Arkansas

GRADE: C

In April 2017, Arkansas had 143 forensic beds in the state hospital in Little Rock; this is an average number of forensic beds per capita in the United States. The state practices conditional release, which can be extended indefinitely by the courts in five-year increments. As of April 2017, Arkansas had 485 individuals with serious mental illness on conditional release, which, for a population of three million, is the second largest number of individuals on conditional release per adult population in the country. Some of these individuals have been on conditional release for more than 20 years. Individuals with serious mental illness who are on conditional release are followed in the community by the 16 regional CMHCs through specially trained social workers who are distributed regionally and instructed to keep in regular contact. The Division of Behavioral Health Services explicitly states on its website that “populations served through the public mental health system” are prioritized in the following order:

1. Individuals found NGRI
2. Individuals committed by the courts for dangerousness to others
3. Other forensic patients

Arkansas is one of the only states to explicitly state that it prioritizes forensic populations.

Unfortunately, Arkansas used to have an even better program. From 1995 until about 2010, it had a forensic continuum-of-care program that focused on the sickest individuals with serious mental illness who were involved in the criminal justice system, all of whom also had substance abuse problems. A seven-year follow-up of 91 offenders reported only five re-arrests, with only one being re-incarcerated. Unfortunately, when the money ran out for the program, it was discontinued.

SUMMARY: For a chronically underfunded state, Arkansas uses conditional release very effectively. Restarting the forensic continuum-of-care program for the most difficult patients would decrease the likelihood of future tragedies and better enable individuals to succeed in the community upon reentry.

RECOMMENDATIONS

- ◆ Reprioritize forensic patients by funding evidence-based programs that have worked in the past, such as the forensic continuum-of-care program
- ◆ Collect data on recidivism and costs for the interval since the forensic continuum-of-care program ended to establish the impact of the program’s loss on re-arrest rates and costs
- ◆ Establish a state PSRB to provide consistent state-level oversight for individuals with serious mental illness who have committed major crimes

California

GRADE: B

California had 4,412 dedicated forensic beds as of April 2017, a much larger number per capita than most other states. These beds are located within five state hospitals—Atascadero, Coalinga, metropolitan Los Angeles, Napa and Patton. California also has three psychiatric programs operated at correctional facilities in Vacaville, Salinas Valley and Stockton. Data from early 2017 show a 28% increase in forensic referrals over the past three years, with the vast majority (82%) coming from a rapid upswing in IST referrals.³

California's Department of State Hospitals (DSH) is tasked with managing the nation's largest single forensic mental health system, with both inpatient and outpatient components. Six legal classes determine length of stay and eligibility for discharge to community-based care. Forensic classes include those found not guilty but insane (NGI), IST, sexually violent predators (SVPs), mentally disordered offenders and inmates with serious mental illness in the California Department of Corrections and Rehabilitation's facilities. Mentally disordered offenders are those who have a severe mental disorder and have committed a violent crime; the status provides for continuing care at parole through the DSH. Once stabilized, individuals are eligible for California's conditional release program (CONREP). AOT is available in California, but only if the county in which the individual settles has adopted the Laura's Law ordinance. Currently 17 of the 58 counties have adopted such ordinances, accounting for 63% of the state's population.

As noted in Chapter 2, CONREP is practiced in California for individuals found NGI, IST or mentally disordered; there is also a specialized program for sexually violent predators (CONREP-SVP). Some parolees are also eligible for CONREP services. CONREP is a statewide program with services sometimes provided by DSH but more frequently subcontracted to the counties in which the discharged individuals settle after release. There is no PSRB in California; instead, individuals are referred to the CONREP program after both the medical director of the treating facility and the CONREP community program director make a recommendation to the court that treatment in the community can be safe and effective. Clear statutory guidance exists for revocation. Services are provided by what the state calls specialized forensic mental health clinicians, although it is not clear how this compares with FACT teams. The courts review the status of patients in CONREP to determine whether they should continue in the program, return to a DSH facility or be discharged from supervision. Between 2015 and 2016, 142 patients were discharged from CONREP, of which 34 were IST patients, 65 were NGI and 43 were mentally disordered. Of this group, only 42% (59) were successful discharges based on a determination that they no longer posed a threat to the community; some were discharged due to revocation or rehospitalization, while others simply reached their maximum commitment period or were deemed not restorable to competency in the near future.

The average length of time in CONREP was 3.9 years. Between 2013 and 2016, there was a 9% re-admission rate and a 19% recidivism rate, including seven felonies and 14 misdemeanors. The legal requirements and length of time for supervision under CONREP differ by class. For the IST class, some are unable to be restored to competency and can only be held for three years or the maximum term of imprisonment for the underlying crime, whichever is less. The courts commit individuals found NGI to DSH for a maximum term of commitment equal to the longest sentence that could have been imposed.

Compared with other states, California does a superior job of collecting data on its forensic patients, particularly in its CONREP program. However, there are gaps in some of its data collection. Due to the lack of statutory access to criminal and court databases, the DSH does not currently have the ability to track IST individuals after their court cases and cannot meaningfully assess continuum-of-care issues for the population. In addition, data are currently not collected on recidivism rates for NGI, IST, mentally disordered and SVP populations unless they are discharged through CONREP or CONREP-SVP.

SUMMARY: California has the potential for an exemplary system. It is one of the only states to screen individuals in the corrections system for necessary treatment prior to discharge. However, a recidivism rate of 19% suggests that the state may not be using the tools at its disposal as aggressively as it could.

RECOMMENDATIONS

- ◆ Close gaps in data collection, including outcomes and effectiveness, in order to monitor individuals through the entire criminal justice and mental health care system
- ◆ Establish a state PSRB to increase each county's accountability
- ◆ Increase the number of psychiatric hospital beds, both civil and forensic, throughout the state to prevent harmful bottlenecks

Ofiu Edwards Foto, diagnosed with paranoid schizophrenia, was found IST after he severely beat two workers in his group home in 2008, causing one individual death and severe brain damage in the surviving worker. Foto had been convicted in 2006 for another beating, also in a group home, after which he was placed in a mental health facility under a conservatorship.

—A. Furillo, "Sacramento homicide spotlights gap in mental health care,"
Sacramento Bee, November 23, 2008.

Michael Wyatt, diagnosed with schizophrenia, was convicted of killing his roommate in 2012. He had previously killed another roommate in 1995 but was found NGRI on manslaughter charges.

—M. Fraley, "Hayward man convicted of murdering schizophrenic roommate,"
Times Standard, February 20, 2015.

Colorado

GRADE: B-

Colorado has 72 designated forensic beds at the Colorado Mental Health Institute in Pueblo and 471 non-classified psychiatric beds at the Colorado Mental Health Institute at Fort Logan, all of which can be used for forensic patients if needed. Like many states, Colorado has seen a recent increase in individuals found IST, which, in Colorado, is called incompetent to proceed (ITP). In fiscal year 2016, there were 627 such patients. The increase in ITP individuals is one reason for the increase in individuals with serious mental illness in jails, which is a major problem in Colorado and the subject of a State Department of Human Services task force.

Conditional release is available and may be continued indefinitely. The state does not have a PSRB, but it does have a disposition committee, consisting of a psychiatrist, psychologist and the director of forensic community services. This committee has many duties similar to those of a PSRB. The disposition committee makes decisions regarding community placement (a type of intermediate conditional release) and when the patient should be placed on conditional release. When patients are on conditional release, they are served by one of two forensic community-based services (FCBS) teams, consisting of psychiatrists, psychologists and case managers. These teams are located in Pueblo and Denver, in conjunction with the local CMHC. The FCBS team and CMHC have regular quarterly meetings to discuss the status of forensic patients.

Colorado is ranked third in the United States of states with high clozapine use, an indicator of good psychiatric care, as seen in the Treatment Advocacy Center's 2015 report, *Clozapine for Treating Schizophrenia: A Comparison of the States*.

SUMMARY: Colorado has a robust system for monitoring individuals with serious mental illness who have committed major crimes and are being discharged from the hospitals. However, we do not know the effectiveness of these programs in reducing recidivism among this population. In addition, Colorado is lacking strong coordination of programming for individuals with serious mental illness involved in the criminal justice system.

RECOMMENDATIONS

- ◆ Collect and analyze robust data on rehospitalization and recidivism rates to evaluate the effectiveness of current discharge practices
- ◆ Establish evidence-based corrections programming, such as postdischarge AOT, for community reentry
- ◆ Disseminate an evidence-based program statewide to reduce the challenges associated with disparate populations in some areas of the state

In Denver in 2008, Audrey Cahow, diagnosed with bipolar disorder, was accused of stabbing to death a 62-year-old man. Between 1987 and 2004, she had either pleaded guilty to or was convicted of assault for a number of prior incidents.

—K. Mitchell, "Fatal knife attack not a shock," *Denver Post*, June 15, 2008.

In 2007, Kenton Astin, diagnosed with schizophrenia, was found NGRI after repeatedly stabbing a student at the University of Colorado with a steak knife. In 2001, Astin had previously been found NGRI for stabbing another individual in an unprovoked attack. He was treated at the Mental Health Institute in Pueblo for four years and then released.

—V. Miller, "Accused CU-Boulder stabber Kenton Astin found not guilty by reason of insanity," *Daily Camera*, September 17, 2010.

Connecticut

GRADE: B

Connecticut has a long history of researching programs for individuals with severe mental illness who have committed major crimes, for which follow-up and recidivism studies have been published since 1980. As of April 2017, the state had 232 forensic beds in the Whiting Forensic Institute, part of Connecticut Valley Hospital. This is slightly above average for forensic beds per adult population in the United States. In 2016, 51 patients were admitted as not competent/not restorable, Connecticut's version of IST.

Connecticut was the second state to develop a PSRB, doing so in response to a highly publicized case of a man who killed his wife, was found NGRI, was hospitalized and treated successfully with antipsychotic medication, but then killed his second wife five years later. The Connecticut PSRB was patterned after that of Oregon, except that it only takes individuals accused of the most serious felony crimes; in addition, the court, not the PSRB, must approve all discharges. The PSRB is an independent state agency. An average of six individuals are put on conditional release by the PSRB each year and remain on conditional release for an average of three to four years, although there is no limit to how long they can remain on that status.

When released, individuals with serious mental illness are followed by one of the six state-sponsored CMHCs; seven other nonprofit CMHCs are not sponsored by the state. Each individual discharged has an assigned conditional release supervisor who monitors treatment compliance and reports quarterly to the PSRB. A 2016 follow-up study of individuals with serious mental illness involved in the criminal justice system on conditional release, summarized in Chapter 2, reported a re-arrest rate of only 2%; it concluded that the program appears to be highly effective. Connecticut is ranked second in the United States of states with high clozapine use, an indicator of good psychiatric care, as seen in the Treatment Advocacy Center's 2015 report *Clozapine for Treating Schizophrenia: A Comparison of the States*.

One strength of Connecticut's program is the close working relationship between the Department of Corrections and the Department of Mental Health and Addiction Services. Department officials meet monthly to identify inmates with serious mental illness who will be released from one of the state's 16 correctional facilities. The Department of Corrections established the Connecticut Offender Reentry Program (CORP) for inmates with serious mental illness. Inmates may begin this program 18 months prior to prison discharge; it consists of supervision, life skills reentry training and group planning sessions. In 2016, 47 individuals entered the CORP program. A 2012 follow-up of CORP trainees reported that the program had reduced recidivism by 50%, compared with inmates who did not go through the program.

For individuals released on parole, the Department of Corrections also has five parole officers specially trained in mental health who can, for example, conduct a mental status exam. Each parole officer has a caseload of 25–30 individuals with mental illness and functions as a de facto case manager. Most of the top leadership in the Department of Corrections has worked with inmates with serious mental illness in the prisons.

Connecticut lacks a provision for AOT, one of only four states without statutory authority for such programs. Such a program could be very useful for selected individuals with serious mental illness being released from prison who meet commitment standards to keep them on their treatment plan and help them succeed in the community.

SUMMARY: Although Connecticut has one of the best state forensic programs, it has limitations in its civil system.

RECOMMENDATIONS

- ◆ Enlarge the CORP program
- ◆ Consider passing statutory authorization for AOT, particularly for inmates with serious mental illness who may not be subject to parole or probation

Delaware

GRADE: D+

As of April 2017, there were 42 forensic beds at the Delaware Psychiatric Center in New Castle, which is about average per capita in the United States. For a geographically small state with slightly fewer than one million people, Delaware's forensic services are unnecessarily decentralized. The Delaware Psychiatric Center completes about 200 competency evaluations per year; evaluations may also be conducted by private providers in the community. The Delaware Psychiatric Center, operated by the Delaware Division of Substance Abuse and Mental Health, reports completing about 15 competency restorations each year, with each taking as little as three months and as long as eight years. In addition, only one or two individuals are found NGRI each year. Most strikingly, each court system appears to adopt its own forensic policies, with each court setting its own conditions for release and supervision. There is no central monitoring or accountability system, making it difficult to assess the system's effectiveness. While living in the community, forensic patients receive psychiatric services from two state-operated CMHCs in Kent and Sussex counties or from a variety of state-contracted providers. Delaware does not use FACT teams or other forensic community service team models.

The Department of Corrections also has programs designed for inmates with severe mental illness. In October 2016, the Department of Corrections substantially revised discharge planning for the population, including the use of discharge planners. Inmates who are observed closely for psychiatric symptoms and considered to be a danger to themselves or others at the time of release must be assessed by a psychiatrist or certified mental health screener and, if indicated, referred for immediate psychiatric hospitalization. In addition, the Department of Corrections is planning to hire an individual to help coordinate all discharge planning for inmates with serious mental illness, a new position that was made possible by a grant from the John D. and Catherine T. MacArthur Foundation.

SUMMARY: Overall, Delaware has a disjointed forensic system. Despite the efforts of the Department of Corrections, the system could be much improved by the use of evidence-based programs of proven effectiveness.

RECOMMENDATIONS

- ◆ Establish a state PSRB with statewide supervision of forensic services offered to individuals who have committed major crimes
- ◆ Adopt FACT programs to assist forensic populations with community reentry

Florida

GRADE: D

As of April 2017, Florida had 1,652 forensic beds in six state hospitals, placing Florida among the top 10 states in the number of forensic beds per adult population. However, three of the six state hospitals—South Florida State Hospital, South Florida Evaluation and Treatment Center, and Treasure Coast Forensic Treatment Center—are run by Correct Care Solutions, a for-profit company that operates many US for-profit prisons. Often, private companies can increase profits in operating psychiatric facilities by paying low wages, which results in high staff turnover. In addition, they sometimes provide fewer costly services for the sickest and most difficult patients, which often include individuals with serious mental illness who have committed major crimes.

In fiscal year 2016, 1,510 individuals were committed to the state hospitals as ITP, and 79 individuals were adjudicated NGRI. Florida has a provision for conditional release that may be of indefinite duration for individuals found NGRI, but it is usually dismissed after three years for nonviolent offenses or after five years for violent offenses.

Once released into the community, individuals with serious mental illness who have committed major crimes become the responsibility of the outpatient mental health system. The state has recently created five forensic multidisciplinary teams (FMTs), which are similar to FACT teams. The teams are located in the major population centers: Dade, Broward, Hillsborough, Orange and Duval counties. The FMTs, each of which has a staff of six and a caseload of 45 patients, provide 24/7 coverage. In an effort to decrease rehospitalization rates, they also provide community coverage for individuals found to be ITP or NGRI.

SUMMARY: Florida has created some effective elements for a forensic care system, but they are inadequately funded. In addition, Florida continues to cling to a number of practices likely to perpetuate substandard care and poor outcomes, such as the use of for-profit companies for mental health managed care.

RECOMMENDATIONS

- ◆ Increase wages for forensic staff working with this population to prevent rapid staff turnover and increase quality of care
- ◆ Improve outpatient mental health services and ensure that services specific to forensic populations are provided
- ◆ Review the practice of subcontracting to for-profit companies for mental health managed care

In 2012, Jerry Tyson, diagnosed with schizophrenia, was charged in the stabbing death of a stranger in a McDonald's fast food restaurant. In 2000, Tyson had stabbed another man to death in a similar incident. After being found IST for the 2000 incident, he had been restored to competency and pleaded no contest to a manslaughter charge. Tyson had been released from prison just four days before the second incident.

—H. P. Curits, "McDonald's stabbing suspect has history of knife attack,"
Orlando Sentinel, December 27, 2012.

In 2009, Ficien Joseph, diagnosed with paranoid schizophrenia, attacked his next-door neighbors with a machete. In 2004, Joseph had stabbed an elderly man in the neck in a supermarket and was found to be IST. In 2003, Joseph had been charged with assault on a police officer.

—D. Ovalle, "Man not guilty by reason of insanity in two gruesome attacks,"
Miami Herald, November 16, 2011.

Georgia

GRADE: B-

As of April 2017, Georgia had 641 dedicated forensic beds in three state hospitals—Central State Hospital in Milledgeville, East Central Regional Hospital in Augusta and Georgia Regional Hospital in Atlanta. By national standards, this is an average number of beds per capita for the state’s 10 million people. Approximately 525 people are found IST annually, and about 20 individuals are found NGRI. Georgia practices conditional release and has statutory authority for the potential indefinite extension of supervision for those found NGRI. Clear statutory guidance exists for revocation. For individuals found IST, supervision can be extended for up to five years or the maximum sentence of the underlying crime, whichever is shorter. Georgia uses the recommended practice of releasing individuals who are IST and nonrestorable on outpatient civil commitment orders and has highly rated AOT laws, though it is unclear if the program is practiced statewide.

Georgia does not have a PSRB; instead, it uses forensic review committees at hospitals to consider whether conditional release is appropriate, in which case, a state-level review is required prior to release for certain offenses. The hospital-based review committee does not retain supervisory authority but is involved solely with the determination of whether to place the individual on conditional release. Following conditional release, Georgia uses both FACT teams and regular ACT teams. The state also employs forensic community coordinators if monitoring is part of the court order for release; these are bachelor- or masters-level positions specifically focused on tracking and working with individuals found IST or NGRI who are on conditional release.

Georgia has a statewide monitoring program for individuals involved in outpatient restoration services. The program’s structure is commendable, though there are a number of vacant positions, suggesting gaps in the skilled workforce pool or inadequate compensation to engage strong candidates. Still, the existence of state coordinators to work with local community service boards to assist with reintegration and monitoring keeps an element of accountability at the local level that compares favorably with other states.

SUMMARY: Georgia’s system has a good structure and appears to be effective in monitoring individuals at risk for reoffending in the community. Without comprehensive data on recidivism or revocation rates, it is difficult to assess whether the system is well funded or whether there are geographical gaps in services.

RECOMMENDATIONS

- ◆ Collect, analyze and report data to test the system’s effectiveness at preventing recidivism
- ◆ Establish a state PSRB to ensure consistent statewide oversight
- ◆ Evaluate and ensure that quality and availability of services are uniform throughout the state, as disparities are common in states that use a community service board model of service

Hawaii

GRADE: B+

All 202 beds in Hawaii State Hospital and the 46 additional contracted psychiatric care beds in the community are available for forensic patients if needed, giving Hawaii one of the highest numbers of forensic beds per adult population among all states. In 2016, 186 individuals were found IST, and 10 individuals were found NGRI and admitted to the state hospital. Hawaii relies heavily on conditional release; approximately 500 individuals were on conditional release at the time of this survey, the highest number per population of any state. Conditional release can be of indefinite duration for all major crimes.

Once in the community, individuals on conditional release are monitored by forensic coordinators, who are psychologists assigned to each of the CMHCs on the six islands. The forensic coordinators are expected to provide oversight and participate in treatment planning for all patients with criminal justice involvement. The website for each CMHC clearly lists the available forensic services, indicating its importance and prioritization in the programs. The website of the Adult Mental Health Division states that providing services to adults with severe mental illness is the department's core mission.

SUMMARY: Hawaii has superior forensic services compared to most states. However, without data on recidivism, it is not possible to determine the effectiveness of forensic coordinators as compared with FACT teams.

RECOMMENDATIONS

- ◆ Collect and analyze data on recidivism and rehospitalization in order to evaluate the effectiveness of used programs
- ◆ Establish a state PSRB to ensure services are provided statewide

Idaho

GRADE: F

In 2017, Idaho had 55 forensic beds at State Hospital South in Blackfoot, which is below the national average for forensic beds per population. The state eliminated the insanity defense in 1982 and has no provisions for conditional release, one of only seven such states. If a person is found IST, restoration services can be ordered, followed by civil commitment if restoration cannot be achieved. However, since there is no insanity defense, nonrestorable individuals may potentially be trapped in legal limbo indefinitely, with no resolution of charges. Thus, most individuals with severe mental illness who have committed major crimes in Idaho end up in jail or the state prison—for men, in Boise, and for women, in Pocatello. Once released, these individuals must rely on the seven regional behavioral health centers, which are under regional behavioral health boards. These boards are noted on the Division of Behavioral Health website to be currently “in a period of transition.”⁴ Since 2013, the behavioral health centers have been managed by Optum Health, a for-profit company that has come under fire in other markets for keeping a significantly larger percentage of taxpayer funds for administrative costs than public service providers do.⁵

Idaho does appear to use FACT teams in some parts of the state, such as in Ada County, though it is unclear how many teams exist and in what locations. Idaho does not use a state PSRB.

SUMMARY: Idaho’s laws and policies do not offer assistance to individuals with severe mental illness who have committed major crimes to succeed in the community.

RECOMMENDATIONS

- ◆ Increase the number of forensic beds to reach national standards
- ◆ Provide statutory authority for conditional release, including clear direction for its use and revocation
- ◆ Provide robust services, including reentry services, for inmates with severe mental illness in corrections settings
- ◆ Collect, analyze and report data to the legislature to begin to monitor outcomes for this population and its impact on public resources

In 2003, Sandy Kevin Nanney, diagnosed with schizophrenia, sent letters containing white powder, which he claimed was anthrax, to 32 hospitals, businesses and government offices. He pleaded guilty to threatening to use weapons of mass destruction and was sentenced to 10 years in prison. In 2013, five months after being released from prison, he was convicted of third-degree arson for having set fire to a store.

—“Boise man who once terrorized Boise with fake anthrax mailings convicted again,” *Idaho Statesman*, June 27, 2014.

Illinois

GRADE: C

As of April 2017, Illinois had 802 designated forensic beds, an average number of beds per population by national standards. These beds are in the Alton, Elgin, Chester, Choate and McFarland mental health centers. Illinois practices conditional release, in which the statutory regulations require an initial period of five years, renewable in five-year increments up to the maximum sentence that would have been available for the underlying crime, with time subtracted for good behavior. Statutory authority and direction for revocation are clearly delineated. Illinois has a verdict of guilty but mentally ill (GBMI), which requires the Department of Corrections to make periodic reports regarding the mental health treatment received by the inmate. In some circumstances, transfer to a psychiatric hospital may occur. By statute, the Department of Corrections notifies the Secretary of Human Services of the sentence's expiration so that assessment can be made regarding whether a petition for commitment is appropriate.

The Department of Corrections also participates in the Projects for Assistance in Transition From Homelessness program, designed to assist with discharge planning for inmates with mental health issues who are at risk for homelessness. As of April 2017, 70 people were on conditional release, and 50 individuals were restored outpatient and found unfit to stand trial.

Illinois does not use a PSRB. Decisions on whether conditional release is warranted are based upon recommendations from the facility director made to the court that retains jurisdiction. Illinois appears to have some FACT teams, such as the team set up by Thresholds in Chicago (see Chapter 2), but it is unclear whether such programs are available statewide. Illinois has exemplary AOT laws but is slow in program implementation. A number of innovative corrections-based programs, such as the medication program and discharge unit run by Sheriff Tom Dart at the Cook County Jail, show a commitment by corrections and law enforcement to address gaps for this population.

SUMMARY: Without comprehensive data on recidivism or revocation rates, it is not possible to evaluate the effectiveness of existing programs. The Illinois GBMI verdict appears to provide a good statutory regime to ensure continued treatment after a sentence is served. In addition, Illinois has a clear protocol to ensure compliance with treatment plans in the community via probation, commitment and community services.

RECOMMENDATIONS

- ◆ Collect, analyze and report data to test the system's effectiveness at preventing recidivism
- ◆ Establish a state PSRB to add top-down supervision and accountability to existing programming
- ◆ Make full use of the state's exemplary AOT laws to assist with community reentry for forensic populations

John Grinston's conditional release was revoked when he beat his child's mother in 2010. He was sent back to the mental hospital to which he had been committed for murdering his wife in 1997 after being found NGRI. Grinston was less than a year away from freedom for his wife's murder when St. Clair County prosecutors filed a petition to revoke his conditional release.

—"One-time suspect in wife's death faces new charges,"
Chicago Daily Herald, July 12, 2010.

Indiana

GRADE: F

Although Indiana does not specifically designate psychiatric beds for forensic patients, in 2016, it had a yearly average of between 235 and 250 forensic patients in five state hospitals (Evansville, Larue, Logansport, Madison and Richmond). The rate of individuals referred to the state hospital system as IST has steadily increased over the past few years, with 195 referrals in 2016. Between two and five people are found NGRI annually. Indiana does not practice conditional release and does not collect or analyze data on recidivism for individuals with severe mental illness released into the community after having committed major crimes.

Indiana does not use a statewide PSRB. However, each of the five state hospitals has a review board tasked with reviewing whether individuals are ready to be discharged for community treatment. Indiana does not have FACT teams. Due to mental health funding cuts in recent years, most localities do not have ACT teams, though they try to follow the model as funding permits. Care following discharge from psychiatric hospitalization or release from jail or prison involves referral to local CMHCs, after which state officials report little state-level supervision or accountability. Although AOT laws are fairly strong, commitments last only 90 days and are nonrenewable.

SUMMARY: Indiana has no dedicated resources for helping individuals with severe mental illness who have committed major crimes to succeed in the community upon reentry. Past programs, such as ACT teams, have been eliminated due to funding cuts, and there have been no attempts to measure the effects of these cuts on recidivism rates.

RECOMMENDATIONS

- ◆ Conduct a needs assessment to identify weaknesses and gaps in the forensic mental health system
- ◆ Facilitate coordination of care for forensic patients between corrections and mental health departments
- ◆ Increase funding to the depleted mental health services in the state
- ◆ Collect, analyze and report data to assess the impact of programming gaps

Iowa

GRADE: D–

Iowa does not specifically designate forensic beds and ranks last among the states in total number of psychiatric care beds per capita, with 1.2 beds per 100,000 adult population in 2016. In addition, since the collection of state psychiatric bed data, Iowa has closed two of its four state hospitals, exacerbating the bed shortage even more. Iowa practices conditional release, called conditional discharge; however, no data are available to suggest how frequently it is used, and the state did not respond to survey inquiries. Neither did Iowa answer survey questions about conditional release in the 2014 Forensic Mental Health Services Survey from NASMHPD.⁶

Iowa has a long history of delegating the financial responsibility of mental health services to counties. However, legislation passed in May 2017 may help alleviate some of the counties' financial burden for mental health services.⁷ Despite this effort, there is little state-level information regarding formal programming to supervise or treat individuals with severe mental illness who have committed major crimes. In addition, the state does not collect or analyze data on recidivism for these individuals. Individuals with serious mental illness found IST can be treated for up to a maximum of 18 months, depending on the charges for the underlying crime; then they must be either civilly committed or discharged.

Iowa does not use a statewide PSRB. The state does have FACT teams, but they are only available in some locations. A community health provider in Des Moines does use FACT teams; however, there is no listing for a statewide program, so it is difficult to know where such services are available. Care following release from jail or prison or discharge from psychiatric hospitalization is dependent on meeting civil commitment criteria for dangerousness, after which there appears to be little state-level community support or supervision. AOT laws exist using standards for dangerousness or grave disability and are used routinely in some parts of the state.

SUMMARY: Iowa's system does not prioritize forensic patients or inmates with severe mental illness in its mental health treatment systems. Only some parts of the state provide specialized FACT teams and robust AOT programs.

RECOMMENDATIONS

- ◆ Create a centralized mental health system to ensure that evidence-based programs are consistently available throughout the state
- ◆ Increase the number of psychiatric beds, both civil and forensic
- ◆ Collect, analyze and report data to assess the effectiveness of specialized programs

Daniel Ellis, diagnosed with bipolar disorder, killed a man in 1998 with his car in a high-speed crash five years after being found NGRI for attempted murder and kidnapping when he jumped into a river with a 3-year-old boy. He was found NGRI in the 1998 incident as well.

—“Collision Course,” *CBS News 48 Hours*, November 4, 2000.

Kansas

GRADE: D+

For 2017, Kansas reported having 200 forensic beds in the state security hospital, which is part of Larned State Hospital. However, the majority of these beds are occupied by individuals in the sexual predator treatment program, resulting in a severe shortage of forensic beds for other patients. Overall, Kansas has a severe shortage of public psychiatric beds, with 15.5 civil and forensic beds per 100,000 adults, as reported in the Treatment Advocacy Center's 2016 *Going, Going, Gone: Trends and Consequences of the Closure of State Psychiatric Hospitals*. Kansas is one of four states that eliminated the insanity defense; instead, it has a statute allowing for not guilty by lack of mental state. Kansas allows for unlimited time on conditional release, but there is no special forensic follow-up at the state's 26 chronically underfunded CMHCs. In general, mental health services under the state Behavioral Health Services Commission are grossly inadequate. As a 2017 editorial in the *Kansas City Star* noted, "The state's mental health system is underfunded, its employees overworked, and its facilities substandard."⁸

In contrast to the state's Behavioral Health Services, the Kansas Department of Corrections is making an effort to reduce recidivism by providing services for inmates with serious mental illness. Corrections programs provide assistance with applications for Medicaid and other benefits and connect individuals with their local CMHC. In three counties, the Department of Corrections provides concentrated case management for those with chronic mental illness or substance abuse issues or for those at risk for homelessness. The Department of Corrections also uses specialized parole officers in major urban areas. The Sedgwick County Jail in Wichita, for example, employs two social workers to assist inmates with mental illness upon release and provide follow-up care for 90 days after release. In 2015, the Council of State Governments Justice Center recognized this program as being a model of mental health care for parolees.⁹ The Department of Corrections reports that such efforts have reduced the recidivism rate from 75% to 35% over the past 10 years.

SUMMARY: Efforts by the Department of Corrections in Kansas are commendable, though the mental health system continues to lag behind in creating and funding specialized programs.

RECOMMENDATIONS

- ◆ Exclude long-term sexual predators from other forensic populations when making policies for forensic bed needs
- ◆ Increase funding for the starved mental health budgets to improve state-operated and community services
- ◆ Use FACT teams for individuals with mental illness who have committed major crimes
- ◆ Facilitate cooperation between the mental health and corrections departments to allow the success of corrections officials to inform programming for mental health

Kentucky

GRADE: C

Kentucky does not have designated forensic beds, but any of its total 499 publically funded psychiatric beds that were available throughout the state in 2017 can be used for forensic patients. Such patients, including those found NGRI, GBMI or IST, can also be treated at the Kentucky Correctional Psychiatric Center in LaGrange. Kentucky practices conditional release, but the criteria for its use and for revocation are not clearly defined in statute. The GBMI verdict, which was applied to 58 individuals in 2016, enables courts to require treatment for either conditional release or probation.

Although Kentucky had an AOT law, previous standards were unworkable for outpatient treatment due to dangerousness being required for any compelled treatment. A much-improved AOT law (SB 91) passed the legislature in 2017. Although Governor Matt Bevin vetoed the bill, the legislature overrode the veto with a nearly unanimous vote. This wide support indicates that the commonwealth is committed to fixing the failing aspects of its treatment system. Although there was no appropriation of funds to create new programs, the new statutory structure makes federal funding possible to implement the AOT law.

Kentucky provides step-down residential housing for both men and women released from forensic settings, a crucial community support for those with severe mental illness who are discharged from psychiatric hospitals or released from prison or jails. One unique innovation developed by the commonwealth is the Kentucky Jail Mental Health Crisis Network, which established consistent jail screening instruments, telephonic triage services, follow-up consultations with local CMHCs, and statewide management and quality control. The program won an innovation award from the Council of State Governments in 2006 and is a model for other states as a practical way to better assess, manage and divert individuals with mental illness from the criminal justice system at an early intercept point.

There is no PSRB, and much of the supervision and monitoring in the community is handled by the same court mechanisms and service providers as used for civil-system individuals. Kentucky has started to use FACT teams, but so far only in one location. Other programming for forensic offenders includes prerelease screening for civil commitment, support for continuation of psychotropic medication, vocational assistance and transportation.

SUMMARY: Kentucky's forensic services for GBMI inmates are stronger than for those found NGRI or IST. Without data on recidivism or revocation rates, however, it is not possible to assess whether the services are reducing re-arrest or otherwise improving outcomes.

RECOMMENDATIONS

- ◆ Establish a state PSRB for centralized administration and decision making
- ◆ Implement robust AOT programs for both civil and forensic populations using the newly passed Tim's Law (SB 91)
- ◆ Codify conditional release and conditional discharge in statute, including requirements for annual data collection and reporting

Louisiana

GRADE: B

As of April 2017, Louisiana had 455 forensic beds in the Eastern Louisiana Mental Health System (ELMHS) in Jackson; this is well above the average number of forensic beds per capita for the United States. In 2016, 276 individuals who had been found ITP were admitted to ELMHS for competency restoration efforts, and an additional 26 ITP individuals received jail-based competency restoration. An additional 14 individuals were admitted to ELMHS after being found NGRI. When individuals are ready to be discharged from ELMHS, they go through a two-stage step-down process, initially living in a group home on ELMHS grounds and then in one of two group homes in the community. Conditional release is available for those found NGRI and is of indefinite duration.

New Orleans has had a forensic aftercare clinic since 1995. The clinic uses a team approach, making staff available 24/7, with an average caseload of 55 individuals who have been found ITP or NGRI. The clinic is thus the equivalent of a FACT team. Follow-up studies conducted in 2002 and 2012 reported a low rate of re-arrest for aftercare clinic clients (see Chapter 2). However, the clinic only covers Orleans Parish, which makes up only 10% of Louisiana's population. The remaining population must rely on 16 district forensic coordinators (DFCs) under the community forensic services. These DFCs include social workers, professional counselors, nurses and psychologists who provide case management for individuals found NGRI and discharged on conditional release by the court. The DFCs maintain regular communication with the court regarding the status of these individuals. DFCs may also be involved in competency restoration efforts for individuals who are ITP in regional jails.

In Louisiana, the Department of Corrections is making significant efforts to decrease the re-arrest rate of inmates with mental illness being released from state prisons. Prior to release, the prisoners connect via videoconference with their case managers, sign up for Medicaid and are given an outpatient appointment. If an inmate is not stable at the time of release, Department of Corrections officials take him or her to an emergency room for assessment and possible transfer for psychiatric hospitalization. Through an innovative cooperative agreement between the Department of Corrections and the Office of Behavioral Health, the medication formularies are coordinated so that medications used in prison are also available in the community. Members of the two departments meet twice monthly to discuss individuals with severe mental illness scheduled for release.

The Department of Corrections also uses some specially trained probation and parole officers for caseloads of inmates with serious mental illness—for example, Baton Rouge employs one parole officer who holds a degree in psychology. Mental health issues are also included in the justice reinvestment task force, currently meeting in an effort to reform the state's prison system. Despite these positive signs, Louisiana has self-identified a crisis of inadequate treatment for individuals with serious mental illness within prisons and jails and poor conditions in corrections settings.¹⁰ Although Louisiana receives a fairly high grade for having the elements for a good program in law and policy for forensic aftercare, the state still lags behind others in implementing the laws and using the tools at its disposal.

SUMMARY: Louisiana is making genuine efforts to decrease the re-arrest rate among individuals with severe mental illness who have committed major crimes to succeed in the community upon reentry.

RECOMMENDATIONS

- ◆ Extend the forensic aftercare clinic to other parts of the state
- ◆ Increase implementation of the state's excellent AOT laws, including for community reentry at discharge from jail or prison

In 2015, Alvin Richardson, diagnosed with schizophrenia, was charged with shooting and killing a friend. In 1989, Richardson had shot a New Orleans police officer. After that charge, he was initially found incompetent to proceed to trial and pleaded guilty to attempted murder after his competency was restored. He had been sentenced to five years in prison.

—B. Oreskes, “Accused Broad Street killer has violent past, history of mental illness,” *New Orleans Advocate*, March 17, 2015.

Maine

GRADE: B+

As of April 2017, Maine had 44 designated forensic beds, which is far below average per capita compared with other states. The beds are located in the Riverview Psychiatric Center in Augusta, a troubled facility that lost its national hospital accreditation in 2013. Governor Paul LePage proposed transferring forensic patients to the state prison, as is done in New Hampshire, but the legislature rejected this idea. More recently, in the fall of 2016, LePage proposed building a new forensic facility and bidding it to private companies.

Despite these deficiencies, Maine has extensive community treatment programs. Services provided by these programs were upgraded significantly in 1985 after a forensic psychiatric patient on a four-hour leave from the hospital killed a teenage girl. This led to the creation of the State Forensic Service, a state organization that conducts psychiatric evaluations for the court system and maintains other oversight functions. According to state officials, in the 30 years since the reform, no major crimes have been committed after an individual has been released into the community. The state practices a robust conditional release program with strong statute-mandated community-based services administered at the state level. Following the 1985 reforms, Maine was recognized by the National Alliance on Mental Illness (NAMI) for notable successes, such as the story of Chuck Petrucelly, who was found not criminally responsible after killing his brother in 2008 during a period of psychosis. Petrucelly spent 4.5 years in a psychiatric hospital and now lives in a supervised apartment. Approximately 5% of state criminal cases result in a not criminally responsible verdict, in which case the focus shifts to rehabilitation of the individual and protection of the public.

The State Forensic Service operates in a similar manner to a PSRB, with a specific statutory regime for supervision by the courts and the Department of Health and Human Services. Maine has strong AOT laws, and the program is used routinely in some parts of the state. Statutory provisions exist for treatment and possible transfer to psychiatric facilities for inmates with severe mental illness in corrections settings. However, it is unclear whether Maine uses FACT teams. Recidivism rates are collected and analyzed internally by the state, but the data are not publicly available.

Notwithstanding the strength of the forensic treatment system, the weaknesses in the civil treatment system fail to provide opportunities for treatment before entry into the criminal justice system, thus promoting criminalization. Stresses in the civil system and inadequate use of available treatment tools may increase demand of the forensic system and erode the strength and effectiveness of these programs.

SUMMARY: Maine's outpatient forensic services for individuals with severe mental illness who have committed major crimes are among the best in the country. Data show that the programming for forensic patients is effective in preventing recidivism.

RECOMMENDATIONS

- ◆ Increase the number of civil and forensic psychiatric beds available
- ◆ Resist efforts to move forensic populations to corrections settings for treatment
- ◆ Create programming for civil patients that are similar to the existing programs for forensic patients to prevent the criminalization of individuals with mental illness

Paul Addington was found not criminally responsible for a rape charge and was committed to a state psychiatric hospital in Augusta. In 1985, while on a four-hour pass from the treatment facility, Addington killed a teenaged girl. He was convicted and found criminally responsible in 1986. This incident led to reform of the system in Maine.

—W. Drash, “Questions hound Maine program: How do you know they won’t kill again?” *CNN*, August 15, 2014.

Maryland

GRADE: C

As of April 2017, Maryland had 853 forensic beds, mostly in the Clifton T. Perkins Hospital Center (a maximum security forensic facility) and the Spring Grove Hospital Center, both near Baltimore. This puts Maryland with a higher-than-average number of forensic beds per adult population in the United States. However, essentially all of Maryland's state hospital beds are forensic; the state contracts with private hospitals to treat civil patients.

Maryland has the statutory regulations for conditional release, which can be continued indefinitely. Maryland has more individuals per population on conditional release than any other state except Hawaii and Arkansas. In 2014, state officials reported placing 148 individuals on conditional release; the state currently has 620 total on that status. As noted in Chapter 2, a follow-up study of patients on conditional release for 2007–2009 reported a re-arrest rate of 14% after three years.

When inmates with serious mental illness are released to live in the community, their care is overseen by social workers who work for the Community Forensic Aftercare Program. The social workers act as monitors, reporting to the courts any issue of noncompliance with the conditions of release; they also conduct training for community providers in how to work with forensic clients. However, Maryland's outpatient mental health system often overlooks forensic patients. This was made explicit by a 2016 forensic services workgroup convened in response to severe hospital overcrowding, which described how the forensic patients "struggle to get the services they need in the community" and called the outpatient clinics the "bottleneck" in the system.¹¹

No information was discovered during the survey regarding prerelease mental health programs in Maryland prisons. Maryland is one of only four states without a provision for AOT, which could be used for individuals with serious mental illness who have committed major crimes to encourage them to follow treatment plans.

SUMMARY: Maryland has the start of a good system. Addition of some of the missing elements of a model system could fill significant gaps and provide a more complete continuum of care, thus giving greater value to the elements of the system that are already strong.

RECOMMENDATIONS

- ◆ Adopt and implement AOT laws
- ◆ Strengthen data collection and analysis to evaluate existing programs so it can be determined which programs are effective and where improvements can be made

In 2011, Antoinette Starks, diagnosed with paranoid schizophrenia, pleaded guilty to attempted first-degree murder. The judge ruled that she was not criminally responsible. Starks had stabbed a woman multiple times as the woman was loading packages into her car outside a department store. In 2005, Starks had previously stabbed two women multiple times in another department store, after which she was found guilty of attempted second-degree murder but was determined not to be criminally responsible and was committed to a psychiatric hospital. The 2011 attack occurred two months after Starks had been released from the hospital for the 2005 attack.

—D. Morse & M. P. Flaherty, "Women again accused of stabbing shoppers,"
Washington Post, October 31, 2011.

Massachusetts

GRADE: F

For more than half a century, forensic psychiatric services in Massachusetts have been known for “Titicut Follies,” the 1967 documentary about the poor psychiatric conditions at Bridgewater State Hospital, the state forensic facility run by the Department of Corrections. As of April 2017, Massachusetts had 350 designated forensic beds, which is an average number per adult population in the United States. Repeated exposures of conditions at Bridgewater have been followed by repeated promises by governors to fix it, with the latest being Governor Charlie Baker’s announced plans to improve care and move management from the Department of Corrections to the Department of Health and Human Services. Massachusetts is one of only seven states without a provision for conditional release and one of only four states with no provision for AOT. It is the only state with neither of these basic programs to reduce recidivism.

In addition, Massachusetts does not have statutory authority for commitment for competency restoration. Massachusetts sends all individuals awaiting evaluation or competency restoration to hospitals, rather than awaiting these services in jails; the transfer is made regardless of bed availability. Obtaining a Rogers order for guardianship is the only way to mandate treatment short of inpatient emergency evaluation or inpatient commitment. Massachusetts provides discharge and reentry planning that includes assessments and recommendations for mental health services; however, without the statutory authority of conditional release, these services remain essentially voluntary.

Massachusetts does not use a state PSRB. The same court mechanisms and service providers used for civil-system individuals are also used to monitor individuals with severe mental illness who have committed major crimes in the community. Massachusetts does use FACT teams, a recommended element of a model program. Other programming for these populations includes support for continuation of psychotropic medication, vocational assistance and transportation, all of which are voluntary programs.

Massachusetts has little programming for inmates with severe mental illness released from prison, which results in high re-incarceration rates, as described in the *Boston Globe’s* Spotlight series of November 25, 2016. Within three years, 37% of individuals with serious mental illness released from prison were re-arrested and re-incarcerated, resulting in high costs to the state—incarceration costs the state \$50,000 per individual.

SUMMARY: Having chosen not to adopt or use many of the effective laws or programs known to help this population succeed, Massachusetts ranks near the bottom for its forensic services for individuals with severe mental illness who have committed major crimes. The institutional bias against any form of involuntary treatment for outpatients leads to a situation in which neither the public nor the individual can be protected.

RECOMMENDATIONS

- ◆ Adopt and implement AOT and other evidence-based forensic programs
- ◆ Establish a conditional release statute to reduce re-arrest rates among individuals with serious mental illness
- ◆ Collect, analyze and report data on outcomes for individuals with serious mental illness who have committed major crimes to allow lawmakers to assess the efficacy of state laws in reducing re-arrest and re-incarceration among this population

Diane Huggins, diagnosed with major depressive disorder with psychotic features, attempted to stab a mother and her two children in 2012, after having stabbed a woman in a very similar incident in 1993. She had been found NGRI for the earlier incident.

—S. N. Mattero, “West End woman charged with attacking woman, two small children,” *Boston Globe*, July 20, 2012.

Bodio Hutchinson, diagnosed with paranoid schizophrenia, stabbed two Boston park rangers in 2014 after an extensive history of similar violent acts toward strangers that resulted in 17 convictions but never led to long-term treatment.

—A. Walker, “Why couldn’t anyone stop Bodio Hutchinson?”
Boston Globe, October 17, 2014.

Michigan

GRADE: C+

As of April 2017, Michigan had 240 designated forensic beds, having recently increased the total by opening a new inpatient unit. Even with the additional beds, however, the state is below the national average for forensic beds per 100,000 adult population. Forensic patients, including those found NGRI or IST, are treated at the Center for Forensic Psychiatry in Ann Arbor. The state also has a GBMI verdict, which adds required treatment as a condition of probation by statute if recommended by the Center for Forensic Psychiatry. Since 2009, Michigan has reported a dramatic increase in individuals referred by the courts for competency evaluation and/or restoration, increasing from 273 to 441 cases in seven years.

The state practices conditional release, called *provisional release*, through the direct community placement program. This entity arranges for the transfer of an individual to the community, though the patient is technically transferred to a regional hospital as a community placement for that facility. Programming is then provided by the designated community provider, who assumes responsibility for tracking the individual, reporting failure to comply and initiating revocation proceedings. One unique Michigan feature involves the use of multiple on-ground and off-ground leaves of absence, with supervision before community placement is approved. This program is designed to test the patient's ability to live in the community before the decision is finalized.

The Center for Forensic Psychiatry's NGRI committee operates in a similar manner to a PSRB in determining whether patients should be recommended for provisional release, with supervision then shifting to the local CMHCs. For individuals charged with murder or sexual assault, a second administrative review is required prior to discharge to the community. Provisional release is limited to five years of authorized leave status, during which time progress reports are made to the NGRI committee. In early 2017, Michigan improved its AOT laws, and AOTs are routinely used in parts of the state. Michigan community providers use ACT teams but not specialized FACT teams. Based on 2014 survey data from NASMHPD, 9% of individuals on provisional release are rehospitalized annually, and 75% of those individuals have their release revoked. However, the decision to return revoked individuals to the community lies with the CMHC rather than with a return to court or the Center for Forensic Psychiatry's NGRI committee.

SUMMARY: Michigan's forensic services include many components of a model system, making the relatively high rate of revocation unexpected. It may be due to gaps at the local community level in funding and the actual services provided.

RECOMMENDATIONS

- ◆ Increase funding for local community-based providers
- ◆ Create state-level programming tailored to the needs of forensic populations, such as by implementing FACT teams
- ◆ Discontinue the policy of allowing facilities, instead of the NGRI committee, to determine whether a person is ready to be released back into the community to ensure that the safeguards in place are not circumvented

Former police officer Paul Harrington was convicted in 2000 of killing his wife and 3-year-old son in 1999, after having been found NGRI for killing his first wife and two daughters in 1975. He was released after two months at a forensic hospital in 1977.

—“Killer of his first family is guilty of killing anew,”
New York Times, November 2, 2000.

Minnesota

GRADE: B-

Minnesota has 395 forensic beds budgeted for fiscal year 2017, though the census of forensic patients was at 404 in April 2017. The number of beds occupied by forensic patients is slightly above average per population for the United States. According to a statutory requirement, criminal detainees deemed by a court to be in need of psychiatric services must be admitted to a hospital within 48 hours. The requirement has created an acute bed shortage, which has made the 48-hour rule nearly impossible to comply with; inmates found IST continue to languish in jails.

In 2016, the state reported 212 individuals requiring evaluation for competency and 118 individuals who were found IST. Forensic patients, including those found NGRI or IST, are treated at the Minnesota Security Hospital in St. Peter or the Anoka-Metro Regional Treatment Center.

Conditional release, called *provisional discharge* or *provisional release*, is regularly practiced. The state also uses a unique status called mentally ill and dangerous (MI&D), which is a potential statutory model for other states. As of April 2017, there were 507 individuals classified as MI&D, with 274 individuals hospitalized and 233 on provisional discharge. The statute (M.S.A. 253B.18) is detailed and lays out a clear structure for identifying, treating, monitoring and managing risk for priority individuals who may pose a risk to the public. However, a stakeholder group convened in 2013 to identify issues and recommend changes found insufficient timeliness and resources built into the system, lack of periodic review of persons civilly committed as MI&D, and persistent failure of the state and counties to develop and implement necessary community elements. Other factors identified were difficulties with staffing levels and a dire shortage of appropriate community placement options and services for individuals ready for discharge but in need of greater levels of care than exist in traditional group home settings.

A special review board operates in a similar manner to a PSRB in determining whether patients should be recommended for provisional release, with service responsibility shifting to local community-based providers. The report from the stakeholder group identified county case management with varying degrees of quality and capacity. Provisional release is of indeterminate length for individuals deemed MI&D. FACT teams are available in the state but are not available in some areas. Although Minnesota has good AOT laws, called *court-ordered early intervention*, AOT is practiced infrequently in many parts of the state and allows only for 90-day orders that are nonrenewable. The state has adopted the Interstate Compact on Mental Health (M.S.A. 245.51) and enacted laws so that individuals under provisional release who leave the state without authorization may be returned.

SUMMARY: Minnesota's forensic services have many of the recommended elements of a model program, and the quality of the state statutes is high in terms of addressing the needs for individuals with severe mental illness who have committed major crimes. However, high-profile failures indicate that community-level care does not always rise to the level contemplated by the legislature.

RECOMMENDATIONS

- ◆ Increase funding for implementation of evidence-based civil and forensic programs
- ◆ Standardize community-based services across counties to ensure that useful statutory tools translate to quality care by county providers, regardless of geographical location
- ◆ Facilitate better coordination and cooperation between the mental health and corrections departments to eliminate the piecemeal quality of current care systems

Mark Scott Meihofer, diagnosed with schizophrenia, was arrested and charged in 2016 for kidnapping and sexually assaulting a 7-year-old girl after being found NGRI in 2011 for soliciting sex from a child. He had legally changed his name between charges (to August James Ruthaferd). Meihofer remains under a competency restoration order for treatment at the Minnesota Security Hospital in St. Peter.

—T. Cooney, "Suspect in Cathedral Hill child abduction ruled mentally unfit for trial,"
St. Paul Pioneer Press, August 22, 2016.

Burton James Ewing was found NGRI after stabbing his mother in 2012 while on a day pass from the Minnesota Security Hospital. In 1998, Ewing was found NGRI after beating his sister to death with a hammer.

—D. Nienaber, "Judge: Ewing not guilty by reason of mental illness,"
Mankato Free Press, September 27, 2013.

Mississippi

GRADE: F

As of April 2017, the Mississippi State Hospital at Whitfield had 35 forensic beds out of a total of 451 psychiatric beds in the state. For a population of three million people, this is among the lowest per capita forensic bed rates in the United States. In 2015, the Mississippi State Hospital requested funds for a 60-bed forensic services facility, in part because the Whitfield facility is inadequately secure for the needs of forensic patients. In addition, hospital officials identified the shortage of beds as the most significant factor in delayed evaluation and treatment of forensic patients, in addition to a shortage of qualified psychiatrists, psychologists and other mental health professionals in the state.¹²

Conditional release with the possibility of indefinite extension is authorized. However, because there are only six to 10 individuals on this status at any given time, the practice is rarely used. There are also no specialized forensic outpatient services; individuals with severe mental illness who have committed major crimes must get their psychiatric care at one of the 14 regional mental health centers, which are overburdened by children, adolescents, substance abusers and adult behavioral health clients, in addition to forensic patients. Mississippi has eight PACT teams (Program of Assertive Community Treatment, sometimes used as another phrase for an ACT program), but it is unclear whether any specialized FACT programs exist. Mississippi does not have a PSRB.

SUMMARY: With the lowest median household income of any state, Mississippi has even fewer economic resources to invest in its mental health system than other states. The state has very few elements of a model program and does not track data in a manner that would enable evidence-based analysis of its few efforts.

RECOMMENDATIONS

- ◆ Conduct a needs assessment to identify weaknesses and gaps in the forensic mental health system
- ◆ Increase use of the conditional release statute
- ◆ Increase funding for evidence-based forensic programs
- ◆ Increase the number of forensic psychiatric hospital beds

Missouri

GRADE: B+

Missouri's interventions for individuals with serious mental illness who have committed major crimes have long been a subject of study. As early as 1966, two mental health professionals at Fulton State Hospital published a paper entitled, "Follow-Up of Discharged Psychiatric Offenders"; studies by various other authors were published in 1999 and 2001. As of April 2017, forensic patients occupied the majority of the 840 adult psychiatric beds in the Fulton, Northwest Missouri, Southeast Missouri and St. Louis psychiatric hospitals, putting the state above average of all states in the availability of forensic beds per population. There are 253 additional designated beds for sex offenders.

The state authorizes conditional release of indefinite duration. At the time of the survey, 480 individuals were enrolled, which is also among the highest number per population in the United States. Once in the community, these individuals are overseen by 11 forensic case monitors assigned to 25 service regions. Although the monitors work at CMHCs, they report to the state director of forensic services. The state contract with the regional CMHCs explicitly states that forensic patients are a priority population.

Places for People, a nonprofit organization in St. Louis, has sponsored a FACT team since 2011. It consists of a team of eight professionals who oversee 65 individuals with serious mental illness, including those with felony charges who have been discharged from state hospitals or released from state prisons. This is part of the close working relationship between the state Department of Mental Health and the Department of Corrections.

SUMMARY: Missouri is doing a commendable job in providing follow-up and aftercare for individuals with severe mental illness who have committed major crimes upon re-entry to the community.

RECOMMENDATION

- ◆ Set up additional FACT teams throughout the state

Montana

GRADE: D–

With one million people spread out over a large geographic area, delivering any human services in Montana is a challenge. In April 2017, the state had 103 forensic beds—49 in the state hospital at Warm Springs and 54 in a new secure forensic annex four miles away. This is well above average for the United States per adult population. Very few people are found IST in Montana—only six in all of 2016—and even fewer are found not guilty by reason of mental illness (NGMI), which no individuals were deemed in the past five years.

The forensic beds in the state hospitals are occupied by inmates with mental illness transferred from the overcrowded county jails and, in a few cases, from state prison. The paucity of IST and NGMI individuals highlights that those with mental illness who commit major crimes in Montana go directly to jail and only are transferred to Warm Springs if they severely deteriorate and have significant psychiatric distress. Very little psychiatric care is available in the jails.

The few forensic patients who are hospitalized at Warm Springs and then discharged receive quality follow-up care. Individuals discharged are followed by forensic social workers who stay in telephone contact with the local mental health centers and parole officers. If a patient deteriorates in the community, he or she can be returned to Warm Springs for civil commitment. Conditional release is available only for patients found NGMI and is limited to five years. For a majority of inmates with mental illness who are released from Montana’s jails and state prison, there is no special program for ongoing psychiatric care or monitoring.

SUMMARY: Montana has adopted policies resulting in the criminalization of individuals with serious mental illness. The state has very few services or supports for individuals with serious mental illness to succeed in the community.

RECOMMENDATIONS

- ◆ Establish a state PSRB to coordinate services for the most at-risk populations
- ◆ Collect, analyze and report data to assess recidivism and program effectiveness
- ◆ Adopt prison-discharge AOT programs to provide assistance for reentry into the community

Jordan Carlson, diagnosed with a serious mental illness, was convicted of strangling his girlfriend to death in 2014. He acknowledged that he was not taking his prescribed medication at the time. In 2009, he had been convicted of arson and reckless endangerment when he set fire to his apartment and it spread to the entire building. He was incarcerated at the Montana State Hospital and State Prison and had been released on parole six months before the homicide.

—P. Dragu, “Carlson gets life sentence for murder,”
Havre Daily News, March 3, 2016.

Nebraska

GRADE: D

As of April 2017, Nebraska had 150 forensic psychiatric and sex offender beds in the 240-bed Lincoln Regional Center. This is below average for forensic beds per population in the United States. The state has two other regional centers—one in Norfolk, primarily for sex offenders, and another in Hastings, which specializes in substance abuse. In 2016, 71 defendants were found IST, and eight individuals were found not responsible by reason of insanity. Conditional release is available and can be of indefinite duration; however, the survey data are unclear regarding how often it is used. When forensic patients are discharged, they become the responsibility of local mental health providers, who are designated by the six behavioral health region boards. Although some boards have ACT teams that serve forensic patients, there are no FACT teams. As is true elsewhere, local mental health providers regard forensic patients as a low priority unless they are explicitly prioritized by state authorities.

There is agreement between the Division of Behavioral Health and the Department of Correctional Services that improvement is needed in psychiatric services for individuals with severe mental illness who have committed major crimes. In 2014, the Department of Corrections created a proposal to renovate 200 beds at the Hastings Regional Center for inmates with mental illness to increase the forensic treatment capacity and reduce the chances of reoffending in the community when they were released. Unfortunately, the proposal did not come to fruition.

SUMMARY: Nebraska has made some effort in prioritizing individuals with mental illness who have committed major crimes for treatment, but the effort remains nascent.

RECOMMENDATIONS

- ◆ Conduct a needs assessment to identify weaknesses and gaps in the forensic mental health system
- ◆ Adopt evidence-based forensic programs such as FACT teams or a PSRB
- ◆ Follow through with plans to increase the number of psychiatric hospital beds

Nevada

GRADE: C–

Nevada had 153 designated forensic beds in April 2017, which is close to the national average per population for a state of 2.9 million people. The majority of these beds are in the Lake's Crossing Center forensic hospital near Reno and in the Stein Building at the Rawson-Neal Psychiatric Hospital in Las Vegas. The majority of these beds are occupied by pretrial inmates receiving competency restoration services. However, 16 of these beds are used for long-term hospitalization of individuals who cannot be restored and are deemed dangerous. Conditional release is available; although it can be of indefinite duration for individuals found NGRI, for others it is limited to 10 years or the maximum sentence available for the underlying crime.

Forensic outpatient services are in the early stages of development. A caseworker and three social workers under the forensic hospital provide some coverage. Attempts to set up FACT teams north in Reno and south in Las Vegas have been unsuccessful to date, though both regions have forensic teams, which are similar to FACT teams that coordinate forensic services. There is also discussion of using the AOT law for forensic patients.

Until recently, little was done to support inmates with severe mental illness upon release from jail or the two state prisons in Ely and Indian Springs. In 2016, a task force was set up to connect individuals released with Medicaid benefits and psychiatric services. The state plans to appoint a deputy director for mental health for the prison system, though these plans may not come to fruition if the governor's current plan for reducing the mental health budget is enacted by the legislature.

SUMMARY: Nevada has made great efforts, but the state has a long way to go to implement recommended program elements for this population.

RECOMMENDATIONS

- ◆ Continue efforts to grow a more robust forensic services system
- ◆ Seek legislative and institutional buy-in to implement recommendations from its task force for inmates with mental illness leaving prison
- ◆ Establish a state PSRB to provide state-level supervision.

New Hampshire

GRADE: C–

New Hampshire had 66 designated forensic beds in April 2017, an average number per population for the United States. Rather than being located at the New Hampshire State Hospital in Concord, they are located across town at the Secure Psychiatric Unit. This unit is part of the New Hampshire state prison for men; however, the unit houses both men and women and is under the authority of the Department of Corrections. Individuals found NGRI or IST and those in the prison or jail system with mental health needs are placed for treatment at the Secure Psychiatric Unit, which is the state’s only secure facility. The New Hampshire State Hospital also transfers its civil patients requiring secure placement to the Secure Psychiatric Unit. Individuals committed under the criminal statutes to the Secure Psychiatric Unit can be committed for a period of up to five years at a time.

New Hampshire practices conditional release, called *conditional discharge*, in renewable five-year increments of civil commitment. The process for revocation is clear and established. It is unclear whether individuals in the Secure Psychiatric Unit must first be transferred to the New Hampshire State Hospital to be eligible for conditional discharge. No data are readily available to suggest how frequently conditional discharge is used, as the state did not respond to survey inquiries and did not answer questions about conditional release in the 2014 Forensic Mental Health Directors Survey from NASMHPD. New Hampshire does not use a statewide PSRB.

New Hampshire, according to its website, is in the process of rolling out an intensive outpatient treatment program that will consist of structured group treatment, medication management and group activities. The state operates a small number of residential treatment units for individuals released from the Secure Psychiatric Unit. It does not appear to currently use FACT teams, though such teams may be used as part of the outpatient treatment program when it begins. Care following discharge from jail, prison or psychiatric hospitalization is dependent on meeting civil commitment criteria for dangerousness, after which there appears to be little state-level monitoring or tracking. AOT laws exist using the recommended need-for-treatment standard and are routinely used in some parts of the state.

SUMMARY: By vesting psychiatric care and treatment to the Department of Corrections, New Hampshire is criminalizing individuals with severe psychiatric disease. Very little programming is focused on treatment for individuals with severe mental illness who have committed major crimes after discharge. The promised intensive outpatient programming will be a welcome addition to the continuum of care, but its success will depend on robust implementation on a long-term basis.

RECOMMENDATIONS

- ◆ Collect data on recidivism to measure the success of evidence-based programs— Since the outpatient programming has not yet started, it would be ideal to collect baseline data now in order to measure effects from the new programming after implementation.
- ◆ Transfer jurisdiction for the NGRI, IST and inmates with severe mental illness at the Secure Psychiatric Unit to the Department of Health and Human Services
- ◆ Increase the number of psychiatric treatment beds to expand system capacity and continue legislative efforts to construct a new secure facility or add a secure wing to the New Hampshire State Hospital

New Jersey

GRADE: D

New Jersey had 471 forensic beds as of April 2017, an average number per 100,000 in population for the United States. The Ann Klein Forensic Center in Trenton, a secure forensic facility, contains 200 of these beds, with the remaining distributed among three state hospitals—Ancora, Trenton and Greystone Park Psychiatric Hospital. For individuals with severe mental illness discharged from the state hospital, New Jersey has created 58 supportive housing beds, a modest beginning for a state of nine million people. However, the state Division of Mental Health and Addictive Services has little to offer in what it classifies as “Justice Involved Services.” Conditional release is available but only for the maximum length of the sentence the person would have received for the underlying crime. For ongoing community psychiatric care, the population must rely on the 120 contracted nonprofit agencies, many of which do not appear to emphasize forensic or postcorrections services.

There is no state PSRB. The state uses many ACT teams, mostly under Catholic Charities USA and Bridge-way Rehabilitation Services, but has not created any FACT programs. The Department of Corrections has expressed interest in reducing recidivism among inmates with mental illness released from state prisons, and officials meet weekly with state officials from the Division of Mental Health and Addiction Services. One encouraging development is the recent placement of inmates with severe mental illness into an AOT program after release from jail or prison.

SUMMARY: New Jersey has relatively few of the recommended elements for a model program.

RECOMMENDATIONS

- ◆ Implement FACT teams to prevent forensic populations from being overlooked in services
- ◆ Strengthen cooperation between the mental health and corrections departments
- ◆ Establish a state PSRB to ensure uniformity of programming and supervision for forensic populations

New Mexico

GRADE: F

The state psychiatric hospital, the New Mexico Behavioral Health Institute in Las Vegas, had 116 dedicated forensic beds in April 2017, an average number per population for the United States. However, the state has little to offer once patients are discharged. New Mexico is one of only seven states without statutory authority for conditional release. Discharged patients are returned to their counties of origin under the jurisdiction of the local courts. Referrals for care are made to the local mental health centers, and quality varies throughout the state. The University of New Mexico Health System provides some jail diversion services, but such opportunities are not available for individuals who have already been convicted of felony crimes. The state does not use conditional release; however, in 2016, it passed an AOT law that included authorization for court-ordered treatment in the community for inmates with severe mental illness being released from corrections facilities.

SUMMARY: The adoption and implementation of AOT is the only successful evidence-based program in reducing re-arrest for individuals with serious mental illness in New Mexico. The state otherwise offers very few of the elements recommended for an effective forensic services program.

RECOMMENDATIONS

- ◆ Establish a conditional release statute, including procedures for use and revocation and mandatory data collection
- ◆ Use the AOT law for individuals with severe mental illness who have committed major crimes
- ◆ Conduct a needs assessment to assess priorities of treatment needs for this population and to determine what data should be collected for program evaluation

New York

GRADE: B-

New York state has a long history of evaluating forensic and postcorrections outcomes for individuals with severe mental illness. In the early 1980s, researchers published studies on recidivism rates (see Chapter 1); more recently, they have published studies on issues such as the effect of length of hospitalization on the re-arrest rate of patients with serious mental illness.

As of April 2017, the state had 720 forensic beds in facilities at New York, Mid-Hudson, Marcy and Rochester, slightly below average per population for the United States. In 2016, 1,441 individuals were found IST. Of these, half were arrested for misdemeanor crimes and half for felonies. An additional 45 individuals were found to be not responsible by reason of mental disease or defect, the state's version of NGRI. Such individuals are usually stepped down from a forensic facility to a nonforensic psychiatric hospital prior to discharge.

New York's Office of Mental Health (OMH) and Department of Corrections collaborate and coordinate to a degree not commonly found. OMH operates the Central New York Psychiatric Center, a 220-bed maximum-security inpatient facility at Marcy exclusively for inmates with mental illness who are transferred from state prisons and upstate jails. OMH also operates 28 outpatient clinics and 205 crisis beds within the state prisons. In addition, all inmates with serious mental illness are screened for dangerousness and possible civil commitment prior to release. They may also be referred for placement on AOT, which New York uses more extensively than any other state.

Compared to New York's strong inpatient and prison forensic programs, the outpatient forensic programs are weak. Conditional release is available and of indefinite duration; the program contained 446 discharged patients at the end of 2016. In the community, individuals with severe mental illness who have committed major crimes are mostly followed by one of the 66 outpatient clinics owned and operated by the state, rather than one of the other approximately 250 clinics licensed by the state but run by local mental health agencies. New York state has also pioneered the development of FACT, with the Rochester FACT team playing a leadership role. In addition, New York City has five FACT teams, which were started in late 2016. Each team employs a staff of 13, including a criminal justice liaison, and serves 68 individuals, a favorable staff-to-client ratio.

SUMMARY: New York has a strong program for treating individuals with severe mental illness in hospitals and prisons but does not have a robust system to help this population succeed in the community.

RECOMMENDATIONS

- ◆ Extend FACT programs throughout the state
- ◆ Prioritize supporting individuals with severe mental illness who have committed major crimes within the community when making policy and funding decisions

In 2015, Latisha Fisher, diagnosed with paranoid schizophrenia, was indicated for murder after she allegedly killed her 1-year-old son in the bathroom of a restaurant. In 2011, she had been convicted of stabbing her aunt and sentenced to participate in a program for mentally ill offenders after receiving a positive psychiatric evaluation just six months before the death of her son.

—J. C. McKinley, "Woman smothered son, 1, in Manhattan restroom, prosecutors say," *New York Times*, April 8, 2015.

In 2014, Tara Anne McDonald, diagnosed with schizophrenia, was charged with attempted kidnapping when she allegedly grabbed a baby carriage from a nanny. She was ordered to Bellevue Hospital for treatment. She had previously been convicted in 1997 for felony kidnapping of an infant, spending more than a year in prison.

—E. Calabrese & K. Bonielle, "Attempted baby kidnapper has long history of illness," *New York Post*, April 20, 2014. M. Frost, "Brooklyn Heights baby kidnapper arrested in NYC," *Brooklyn Daily Eagle*, April 20, 2014.

North Carolina

GRADE: D–

North Carolina had 84 dedicated forensic beds as of April 2017, which is among the lowest number per population of any state in the nation. Between 2011 and 2015, an average of 223 individuals were found IST per year, and an average of 4.4 individuals were found NGRI per year. However, seven individuals had been admitted under NGRI status as of April 2017, when this study was conducted. All individuals found NGRI are admitted to the forensic services unit of Central Regional Hospital in Butner. The state does not use conditional release and has no PSRB.

North Carolina has highly rated AOT laws. However, in recent years, there has been a sharp decline in the implementation of AOT, and many programs have been discontinued due to inadequate funding, despite past excellent results. This is consistent with the severe deterioration of all mental health services in North Carolina over the past two decades. The state uses FACT teams in some regions. A comprehensive aftercare plan is developed prior to discharge; upon discharge, however, care and monitoring shift to local service providers. Neither the courts nor the forensic hospital maintain jurisdiction to provide formal monitoring of released forensic patients in the community. The court may impose conditions for mental health treatment at discharge, but only if the patient's criminal charges are active. This is not typically the case for individuals found IST who are nonrestorable, those whose sentences have been fully served or those found NGRI.

SUMMARY: North Carolina has very little in place to assist forensic patients to succeed in the community or to protect the public. It does not collect comprehensive data on recidivism.

RECOMMENDATIONS

- ◆ Establish conditional release with data collection and reporting requirements
- ◆ Establish a state PSRB
- ◆ Re-invigorate use of AOT, including for forensic populations at discharge or for post-corrections populations at release from jail or prison

In 2015, Brady Hines stabbed the manager of a QuikTrip convenience store that he frequented and was shot by a responding police officer. Both he and the manager survived. He had previously been convicted of killing his mother in 1998 and spent 15 years in prison before becoming homeless upon release.

—L. Baheri, "Where should they go? How housing affects mental stability, wards off violence," *Gaston Gazette*, September 12, 2015.

North Dakota

GRADE: D+

There are 75 counties in the United States with a larger population than the state of North Dakota, which has a population of about three-quarters of a million people. The state's small population is an asset in providing services for individuals with severe mental illness who have committed major crimes. Often the mental health, corrections and court personnel have gone to school together, and everybody knows everybody else. This informal network acts as an early warning system if patients are clinically deteriorating. Individuals with serious mental illness who have committed major crimes and need psychiatric hospitalization are treated in one of the 100 general psychiatric beds in 2017 at the state hospital in Jamestown. Once discharged, the individuals are put on conditional release, which can last as long as the maximum sentence for the underlying crime. These individuals are followed by one of the eight state-controlled regional human service centers. Each patient is assessed annually by the state hospital and the courts, which must approve any change in privileges. Individuals who have committed major crimes and who are IST are usually referred to the court for civil commitment.

A 2013 assessment by the state Department of Human Services reported that forensic services constitute the largest growth area for the department; it named evaluation and treatment services for those facing criminal charges who have mental health issues as a significant unmet need. North Dakota does not use a PSRB and does not appear to use community-based forensic treatment teams. Community forensic services appear to be primarily geared toward treatment of substance abuse and of sex offenders.¹³

SUMMARY: In small-town and insular North Dakota, an informal monitoring system works reasonably well but would not work in a more populous or urbanized state.

RECOMMENDATIONS

- ◆ Establish a state PSRB, which would work well in a low-population state such as North Dakota
- ◆ Collect, analyze and report data to allow for program evaluation
- ◆ Explore what other evidence-based forensic interventions work well in other states with nondense population regions

Ohio

GRADE: B

As of April 2017, Ohio had 1,081 psychiatric treatment beds, but it does not specifically designate beds for forensic patients. Unlike many states, individual courts in the state's 88 counties keep data on IST and NGRI individuals, but the state does not collect it. Thus, it is not possible to obtain statewide data through the forensic services department. Forensic patients, including those found NGRI or IST, are treated at the Summit Behavioral Healthcare Hospital in Cincinnati and the Twin Valley Behavioral Healthcare Hospital in Columbus. The state practices conditional release, with jurisdiction continuing for the maximum sentence for the single most serious offense charged, inclusive of time in the hospital and time in the community. If a life sentence is used for the underlying crime, conditional release can be indefinite, with court hearings held every two years to assess whether commitment criteria continue to be met. As noted in Chapter 2, Ohio set up a FACT team as early as 1996 in Cuyahoga County; after implementation, it resulted in great success in reducing re-arrest rates. Currently, Hamilton County, including Cincinnati, has two FACT teams. Individuals on conditional release are entered into the national Law Enforcement Automated Data System for easy identification by out-of-state law enforcement entities.

The state does not use a PSRB but does use a forensic review team. The team conducts a number of reviews and assessments prior to approval for discharge, including a violence risk assessment instrument (HCR-20-V3). Ohio mandates a universal risk assessment tool used by all Department of Corrections officials. The multiple reviews and assessments are referred to the court for final decision. In the community, Ohio funds forensic monitors to track the treatment of each individual and provides liaison services for the state hospital, the treatment provider, the court, the local board and sometimes the housing provider. Forensic monitors are not state employees but rather are contractors for the local boards or providers. However, the forensic monitors are overseen by the state, which hosts three annual meetings and an annual conference on risk assessment and management. The Department of Mental Health and Addiction Services is responsible for oversight. However, although the structure is encouraging, the state reports that about 20% of individuals on conditional release are re-admitted to a hospital within one year, suggesting that conditional release may be occurring too rapidly or that the monitoring of individuals in the community is not sufficiently rigorous. Ohio's AOT laws are very strong and widely implemented throughout the state.

SUMMARY: Ohio's forensic services have most of the recommended elements of a model program, combined with a fairly strong civil treatment system. The state has demonstrated an interest in recent years in improving mental health treatment laws and has seen them funded and implemented.

RECOMMENDATIONS

- ◆ Broaden the use of FACT teams
- ◆ Conduct more targeted research and analysis to determine whether longer inpatient treatment might decrease rates of rehospitalization and, in the long term, recidivism
- ◆ Facilitate better coordination of county-to-county transfers of forensic releases, which was a factor in the death of Deputy Sheriff Suzanne Hopper (see box)

Thomas A. Wallace, diagnosed with paranoid schizophrenia, was found NGRI after stabbing a man to death in 2013. He had been convicted of attempted murder in 1986.

—J. Fuddy, “Judge: Homeless killer is poster child for problems in mental health system,” *Columbus Dispatch*, December 4, 2013.

Michael Ferryman fatally shot Clark County deputy sheriff Suzanne Hopper in 2011 after being released from a mental hospital and found NGRI for a very similar incident in 2001. Ferryman was killed during a standoff with law enforcement after the 2011 shooting.

—“Man accused of killing deputy sparked similar confrontation in 2001,” *Columbus Dispatch*, January 3, 2011.

Oklahoma

GRADE: C+

Oklahoma had 200 designated forensic beds as of April 2017, an average number of forensic beds per population for the United States. It conducts treatment and evaluation at Oklahoma Forensic Center in Vinita. The state did not respond to survey inquiries regarding programming for individuals with serious mental illness who have committed major crimes. Oklahoma practices conditional release and allows for indefinite supervision if needed. Statutory direction for revocation is clear, as are the criteria to be considered. In the 2014 Forensic Mental Health Director Survey from NASMHPD, the state reported a 10% rate of rehospitalization following conditional discharge. About 80 NGRI patients are placed inpatient at the Oklahoma Forensic Center during any given year. The forensic review board is responsible for overseeing NGRI discharge decisions; this panel of seven individuals is appointed by the governor and consists of four mental health professionals, one attorney, one retired judge and one at-large member. The board receives annual reports on individuals with serious mental illness, both inpatient and on conditional release, and retains jurisdiction until final discharge from supervision is granted. Upon discharge, service is conducted by county-level local mental health providers.

PACT teams are relatively common in some parts of the state, though it is unclear whether FACT teams exist or whether counties offer specialized forensic services. AOT laws were vastly improved in 2016, and the Oklahoma Department of Mental Health and Substance Abuse Services received a \$1 million multiyear grant from SAMHSA to implement AOT programs statewide. Oklahoma's mental health services previously suffered from massive funding cuts over several fiscal years, so this grant may result in significant improvements in Oklahoma's civil and forensic mental health systems.

SUMMARY: Oklahoma has adopted a number of the recommended practices to prioritize forensic patients. However, the system has suffered from many years of legislative neglect in funding, so it may take time to recover some services necessary to ensure consistency throughout the state. The recent attention paid to outpatient treatment needs may be an indicator that Oklahoma's legislature is prepared to reassess the value of dedicating state funds to mental health services.

RECOMMENDATIONS

- ◆ Prioritize funding for forensic programs and postcorrections reentry services
- ◆ Establish specialized FACT teams for forensic populations
- ◆ Use the state's new AOT statute for qualifying individuals in corrections and forensic settings at community reentry points

Oregon

GRADE: B+

Oregon had 416 dedicated forensic beds as of April 2017, higher than average among all states in the United States for forensic beds per adult population. Forensic patients, including individuals found IST or GEI, are treated at Oregon State Hospital, which has campuses in Salem and Junction City. An average of 43 individuals are found GEI each year, with about 440 individuals evaluated for competency. Of those individuals, about 71 (or 16%) are eventually deemed not restorable. Oregon was an early model for best practices in risk management and treatment for individuals with severe mental illness who have committed major crimes. As noted in Chapter 2, the PSRB model originated in Oregon, and the state has been a leader in producing research and scholarship on forensic programming.

Conditional release is widely practiced for individuals found GEI or IST and is run as a statewide program, with services provided by community mental health programs or their contracted provider agencies. Supervision under the program can extend indefinitely for the maximum sentence for the underlying offense or until the individual no longer meets criteria for having a mental disease or defect that, when active, makes him or her a danger to the public. Clear statutory guidance exists for revocation of conditional release. The PSRB exercises intensive oversight with monthly reporting. The use of FACT teams, called forensic intensive case management, is widespread.

Oregon's legislature has invested in specialty programming for forensic populations, which extends to highly supportive residential homes, supportive and independent housing, nursing care, employment support, and clinical support at various levels. Notably, the ratio of monitors to individuals on conditional release is only 1:15, much lower than in comparably sized states. These intensive community supports and continued oversight from the PSRB have been highly effective, leading to a recidivism rate of only 0.5%, compared with a 20% recidivism rate for corrections populations.

The state has statutory authority to charge individuals absconding from the state with an escape charge, enabling extradition more easily than by relying on civil interstate cooperation. Oregon does a superior job of collecting data on its forensic patients, both inpatient and on conditional release. The state has usable AOT laws, though 180-day orders are not renewable and implementation is not uniform. Recent studies point to major barriers preventing civil patients from being admitted based on courts' faulty interpretation of admission criteria.¹⁴

In December 2016, Governor Kate Brown shocked Oregonians by proposing to permanently close the Junction City campus of the Oregon State Hospital, which had just been constructed 18 months previously at a cost of \$134 million dollars. The governor cited budget concerns and a preference for deinstitutionalization. The plan has been met with opposition from the legislature; however, as of April 2017, it is unknown whether the campus will remain open. The possibility of the loss of these beds in an already-stressed system, combined with major gaps in the civil system, is cause for concern. Oregon's exemplary forensic system will inevitably be affected by the weakness of its civil system if the legislature does not address the imbalance soon.

SUMMARY: Oregon's forensic mental health system remains one of the strongest in the country and should be considered a model for other states to look at, particularly for its excellent PSRB structure and practice.

RECOMMENDATIONS

- ◆ Resist attempts to cut funding or eliminate beds from what has historically been an excellent model for forensic treatment
- ◆ Address gaps in the civil treatment system to maximize efforts to divert individuals from the criminal justice system and to prevent harmful bottlenecks
- ◆ Conduct a needs assessment to examine the interplay between the civil system and the forensic system

Brent Redd pleaded guilty except insane after stabbing a mental health worker to death in 2012 after being found GEI for attempting to kill his mother in 2005.

—S. Phiel, “Redd pleads guilty in death of mental health worker,”
The St. Helens Chronicle, February 12, 2013.

Pennsylvania

GRADE: D

In 2017, Pennsylvania had 236 dedicated forensic beds in its state hospitals at Norristown and Torrance. However, Norristown is scheduled to close all civil beds in 2017, keeping only those in the forensic unit. The number of forensic beds per population, as well as the total number of publically funded psychiatric beds per population, is among the lowest in the United States. In 1955, the state had 41,000 public psychiatric beds for 10.9 million people, whereas it now has just over 1,000 beds for the state's 2016 population of 12.8 million people. The state's severe shortage of inpatient beds, as well as the paucity of outpatient services for individuals with severe mental illness (including civil, postcorrections and forensic discharges), has resulted in many of its local jails (called *prisons* in Pennsylvania) being overcrowded with individuals who are IST and who are waiting to be transferred to Norristown or Torrance. Such waits can be as long as 18 months and recently led the American Civil Liberties Union to sue Pennsylvania, calling the situation among the worst in the country. Pennsylvania is one of only seven states without a provision for conditional release for patients being discharged from state hospitals. A possible alternative mechanism to conditional release is AOT; although Pennsylvania has such a statute, the state's strict criteria for qualifying for AOT make it virtually unusable.

Like many large states, Pennsylvania has a decentralized mental health service system, with services overseen at the county level. Thus, there are 48 county mental health administrators, some of whom cover two counties; they contract with local providers to provide services. Some of the providers are for-profit companies, which have come under fire for avoiding treating patients with the most serious mental illnesses because these individuals often are the most expensive to treat.

Pennsylvania does use FACT teams in the city of Philadelphia and in Beaver, Delaware and Montgomery Counties. All of these programs only include individuals who have felony charges. Pennsylvania has invested heavily in ACT teams, with 41 such teams in all. These teams are very effective for individuals with serious mental illness who are not involved in the criminal justice system; however, as discussed in Chapter 2, they are less effective for forensic populations. Some ACT teams in Pennsylvania do include a forensic liaison or forensic case manager. For example, in Beaver County, the majority of clients for the ACT team have criminal charges; this team essentially operates as a FACT team. However, this arrangement may only be effective in small counties such as Beaver.

In addition to the FACT teams, Pennsylvania's Department of Corrections has made some efforts for this population. For inmates with serious mental illness being released from prison, the Department of Corrections sets up an appointment with the county mental health program, helps identify appropriate housing and provides two months of medication. If individuals are on parole, they are eligible to initially stay in one of the Department of Corrections' community corrective centers, which provide housing, rehabilitation and treatment. In 2015, the Department of Corrections created the first community corrective center exclusively for former inmates with serious mental illness.

SUMMARY: For individuals with serious mental illness who have committed major crimes, Pennsylvania has less to offer than many other large states, providing only a few of the recommended elements of a model program.

RECOMMENDATIONS

- ◆ Immediately halt the closure of facilities and the loss of psychiatric treatment beds
- ◆ Establish conditional release by statute, including clear procedures for use and revocation and provisions for the collection of data
- ◆ Encourage collaboration between the Department of Corrections and the mental health department
- ◆ Extend FACT teams throughout the state

In 2012, Frederick Pisano, diagnosed with schizophrenia, was convicted of assaulting a police officer. In 1992, Pisano had killed his mother, pleaded guilty but mentally ill and been sentenced to 10 to 20 years in prison.

—S. Marroni, “Carlisle man sentenced for assaulting officer at Carlisle’s Halloween parade,” *Patriot News*, December 17, 2013.

Rhode Island

GRADE: C–

Rhode Island maintains a range of 40 to 50 beds for forensic patients in the hospital at Cranston, an average number per population for the United States. At times, because of the large number of forensic patients, the hospital cannot admit nonforensic patients, which puts a strain on the civil treatment system and results in psychiatric boarding in emergency rooms. In 2016, the hospital admitted 198 individuals who were IST. When these patients are placed in the community, they are monitored by the six regional nonprofit mental health centers; if the patients relapse, they can be returned to the hospital. Due to the small geographic area of Rhode Island, the vast majority of the population lives within one hour's drive of the hospital.

The state's Department of Corrections has an active program intended to reduce reoffending by inmates with serious mental illnesses who are released from prison. Six to nine months prior to their release date, risk assessment screening is completed, followed by possible referral to specialized mental health discharge planners, who assist with arrangements for housing, Medicaid coverage, Supplemental Security Insurance and psychiatric outpatient follow-up. The discharge planner can arrange for a special release time to enable released inmates to go from prison directly to their first psychiatric outpatient appointment.

SUMMARY: Rhode Island is ideal for statewide implementation of evidence-based forensic programs and is using some innovative programs for its corrections population with severe mental illness.

RECOMMENDATIONS

- ◆ Establish FACT teams for use statewide
- ◆ Collect, analyze and report data to assess program effectiveness
- ◆ Increase collaboration between the mental health and corrections departments

South Carolina

GRADE: C

As of April 2017, South Carolina had 215 designated forensic beds, which is slightly below average per population by national standards. The state conducts treatment and evaluation at the G. Werber Bryan Psychiatric Hospital in Columbia. The hospital also operates an NGRI outreach clinic for outpatient treatment. South Carolina practices conditional release and allows for indefinite supervision if needed, limited to the maximum sentence for which the underlying offense would have been eligible. The average daily census of NGRI patients on conditional release is approximately 150 individuals. South Carolina also uses the GBMI verdict, which allows for screening at the state hospital prior to placement in a corrections setting. The status makes it possible to impose treatment compliance as a condition of probation and appears to provide authority for better follow-up care eligibility for inmates at discharge. Statutory direction for revocation is relatively clear. In the 2014 Forensic Mental Health Services Survey from NASMHPD, the state reported a 15% rate of rehospitalization following one year on conditional discharge. South Carolina does not use a PSRB, though it appears that the NGRI outreach clinic performs some of the same functions.

Upon discharge, treatment is performed by community service providers and local mental health providers at the county level. ACT teams are relatively common in some parts of the state, though it is unclear whether FACT teams exist. The NASMHPD survey indicates that the state uses specialized forensic community service providers, similar to FACT teams. South Carolina's AOT laws are very strong and are routinely practiced throughout the state.

SUMMARY: South Carolina's forensic treatment system has many recommended elements of a model program for individuals with severe mental illness who have committed major crimes. However, it is not possible to evaluate the effectiveness of programming without detailed information about recidivism. The rehospitalization rate of 15% indicates that weak community services or premature conditional release may be a possibility.

RECOMMENDATIONS

- ◆ Improve data collection and analysis for the purposes of evaluating current programming
- ◆ Endow the NGRI outreach clinic with oversight powers, such as PSRBs have, to strengthen the ability to ensure proper community treatment

Alice Boland, diagnosed with schizophrenia, was committed to a federal prison hospital after attempting to shoot two faculty members at a prep school in 2013. The gunlock was on and did not fire. She had previously pleaded NGRI in 2005 with threatening to assassinate George W. Bush and members of Congress. She was released after spending four years in a psychiatric facility.

—A. Knapp, "Committed for mental illness, would-be Charleston school shooter Alice Boland wants release date," *The Post and Courier*, January 29, 2017.

South Dakota

GRADE: D

Although the 295-bed Human Services Center in Yankton does not have designated forensic beds, individuals who have been found IST can be admitted to the hospital and stay for up to a year for competency restoration. Individuals with severe mental illness convicted of felony crimes are not sent to the state hospital but to the prison in Sioux Falls, where the Behavioral Health Division of the Department of Social Services provides care. This procedure is similar to what is done in New Hampshire and is not considered to be good therapeutic practice. South Dakota has both an NGRI plea (29 cases in 2015) and a GBMI plea (13 cases in 2015).

The person primarily responsible for the release of mentally ill individuals from prison is the Resource Coordinator, who is an employee of the Division of Behavioral Health. He/she works closely with the Department of Corrections Case Managers and Parole Agents as well as with the mental health center. The United Judicial System coordinates conditional release which may be continued indefinitely. Mentally ill individuals being released from county jails are the responsibility of the jail staff and county officials. South Dakota is ranked first in clozapine use among all states, an indicator of good psychiatric care, as seen in the Treatment Advocacy Center's 2015 report *Clozapine for Treating Schizophrenia: A Comparison of the States*. In 2016, South Dakota set up a three-month task force on community justice and mental illness early intervention to assess the state's needs of individuals with serious mental illness in the criminal justice system. One recommendation was to evaluate the need for and feasibility of creating FACT teams. An additional recommendation was to connect inmates with mental illnesses leaving jail to mental health services, a recommendation that will hopefully extend to inmates with mental illness leaving the state prison. In early 2017, Governor Dennis Daugaard announced that he would accept the task force's recommendation. Psychiatric services in the community are provided by 11 regional nonprofit CMHCs.

SUMMARY: South Dakota relies heavily, for inpatient services, on the Department of Corrections to care for individuals with mental illness who have committed major crimes.

RECOMMENDATIONS

- ◆ Implement the recommendations of the task force, including the use of FACT teams and connecting inmates with severe mental illness to mental health services at discharge from jail or prison
- ◆ Establish a state PSRB to oversee consistent programming throughout the state
- ◆ Study the possibility of shifting care from corrections settings to mental health settings by encouraging interdepartmental collaboration, while also adopting corrections-based programming that has succeeded in other states

Tennessee

GRADE: B

Tennessee does not designate its psychiatric beds; however, as of early 2017, it had a total of 562 beds available statewide. The state conducts treatment and evaluation for patients requiring a secure setting at the Middle Tennessee Mental Health Institute in Nashville. Unlike most states, Tennessee provides forensic competency evaluation and restoration services largely on an outpatient basis, unless secure placement is necessary for public safety reasons. By providing nearly all evaluations at CMHCs and regional institutes, a 2016 bed census showed only 100 of the 562 beds were used for forensic patients, thereby allowing more capacity in the system for civil admissions. Having a large cadre of qualified forensic evaluators allows for shorter wait times for such evaluations, a persistent problem for other states.

Approximately 100–110 individuals are found IST annually, and between 30 and 60 individuals are found NGRI. Tennessee practices conditional release and allows for indefinite supervision if needed, limited to the maximum sentence for which the underlying offense would have been eligible. The average daily census of NGRI patients on conditional release is approximately 150 individuals. Statutory direction for revocation is clear.

An additional unique practice in Tennessee is that, according to the 2014 NASMHPD survey, 40% of individuals found NGRI are immediately placed on conditional release, and 15% are released on a mandatory outpatient treatment (MOT) order; this is much higher than in other states. However, the rehospitalization rate for conditional release is only 10%, which is lower than most states. Of those rehospitalized, only 20% have their status revoked. Reliable conclusions would require additional study, but the results suggest that outpatient forensic services for conditional release in Tennessee are working fairly well and are achieving results on par with inpatient-focused models.

The risk management review committee operates like a PSRB in assessing dangerousness for conditional release; however, it does not have statutory authority as in Oregon's or Connecticut's model. Upon discharge, treatment is performed by community service providers. PACT teams are relatively common and occasionally include forensic patients, although there are no dedicated FACT teams. Tennessee's system is more integrated at the state level than most states and has greater uniformity of service available throughout the state. Tennessee does not have a traditional AOT law, but its MOT statute performs many similar functions and allows treatment for both civil patients stepping down from inpatient treatment and forensic patients being discharged to the community. With one or two minor changes, either statutory or regulatory, the MOT law could be used to implement AOT programs. A statewide MOT coordinator is based in the Office of Forensic Service and is tasked with monitoring the progress of each patient released on MOT.

SUMMARY: Tennessee's model uses community-based treatment, including within the forensic system. Despite the potential concerns for treatment quality, the state's rehospitalization rates are not higher than in other states. It is hoped that future data collection might lead to a more detailed analysis of whether recidivism is unaffected by the high rates of community-based evaluation and community treatment.

RECOMMENDATIONS

- ◆ Revise the MOT statute for use in AOT programs by providing an avenue for community referrals

Texas

GRADE: F

Texas had 1,042 dedicated forensic beds as of April 2017, which is below average per population compared to other states. These beds are spread between nine facilities (Austin State Hospital, Big Spring State Hospital, El Paso Psychiatric Center, Kerrville State Hospital, two campuses of North Texas State Hospital, Rusk State Hospital, San Antonio State Hospital and Terrell State Hospital). Inpatients requiring maximum security placement are treated at the Vernon campus of North Texas State Hospital, while intermediate forensic patients are treated at the other campus in Wichita Falls. The average daily census for forensic patients is 1,310 of the total number of publically funded psychiatric beds of 2,232, an average number of beds per population as compared with other states. Due to the complexity and size of the Texas system, not all IST determinations are captured at the state level; since 2014, however, there have been an average of 2,364 admissions for individuals found IST at state-operated facilities. In the past five years, the state averaged about 49 NGRI admissions per year.

Texas does not practice conditional release. The legislature has contemplated adopting the practice by statute, but as of April 2017, there was no statutory authority. There is no state PSRB, though the state does use a dangerousness review board in the maximum security unit to assess potential patient dangerousness. If patients are no longer manifesting dangerous behavior, they can be moved to a lower-security facility, though this only applies to inpatient transfers and is not related to community placement.

Texas has highly rated AOT laws, which are routinely used in some areas of the state, such as in Bexar County. However, other parts of the state have not implemented AOT programs. The state uses FACT teams in some areas, a recommended element of a model program.

SUMMARY: Texas has few meaningful safeguards in place to enable individuals with serious mental illness who have committed major crimes to succeed in the community, whether they are being released from corrections settings or discharged from hospitals. Some programming exists to assist the forensic population in the community, but without conditional release and revocation, there is little recourse if an individual does not follow a treatment plan and symptoms decompensate. Without having comprehensive data on recidivism or revocation rates, it is not possible to fully assess the effectiveness of community supports.

RECOMMENDATIONS

- ◆ Establish a conditional release statute with data reporting requirements
- ◆ Establish a state PSRB
- ◆ Make a legislative priority of proper supervision and community treatment for individuals with serious mental illness who have committed crimes and are reentering the community

Kristal Locke was found IST for the 15th time since fatally stabbing her neighbor in 2003. Locke has not been able to be restored to competency. She had previously shot another woman in 1982 based on the same delusional belief that the two women she attacked were trying to steal a man with whom she was obsessed. Locke was found IST for the attempted murder charge in the 1982 offense.

—D. Ramirez Jr., “Hurst woman, 91, accused in murder is found incompetent for 15th time,” *Ft. Worth Star-Telegram*, June 14, 2016.

Kenneth Pierott, diagnosed with schizophrenia, was convicted of suffocating his girlfriend’s son in 2004. He had previously been found NGRI for bludgeoning his bedridden sister to death in 1996, after which he had been released after four months of hospital treatment.

—P. Easton, “Detective testifies boy’s killer made no sense,” *Houston Chronicle*, May 11, 2005.

Utah

GRADE: C–

In early 2017, Utah had 100 designated forensic beds out of the 252 total beds available at the Utah State Hospital in Provo, which is a number below average per population for the United States. In fiscal year 2015, 148 individuals were found IST. Utah is one of four states that eliminated the insanity defense and instead uses GBMI, in which approximately one person each year is so designated. After Oregon pioneered the use of a PSRB, there was some discussion in the 1990s of creating one in Utah, but it did not come to fruition.

Once discharged from the hospital or released from jail or prison, individuals with severe mental illness who have committed major crimes must rely on the local mental health authorities for their care; quality of treatment and implementation of programs vary widely throughout the state. Conditional release is available and of indefinite duration but, until recently, was not used often. A jail diversion outreach team at Valley Mental Health consists of a psychiatric nurse, a social worker, a case manager and peer counselors who oversee 60 inmates with severe mental illness, with a goal to decrease recidivism. National Alliance on Mental Illness (NAMI) –Utah is a partner in this program. As in other states, for-profit companies provide some of the state’s outpatient psychiatric services, which is problematic to the extent that such entities tend to increase profitability by deprioritizing the sickest patients who are the most costly to treat.

An important legislative development in Utah has been HB 348, a bill passed by the legislature in 2015 to specifically reduce recidivism rates for jail and prison populations with severe mental illness. It requires the Division of Substance Abuse and Mental Health and the Department of Corrections to establish minimum standards of treatment for these populations. These standards include the most current practices and procedures demonstrated by scientific research to reduce recidivism. The bill requires the collection of data on recidivism rates and on cost savings associated with the reduced recidivism. The bill also mandates that local mental health authorities give priority services to inmates with mental illness being released from jails and prisons. This legislation was put together with support from the Pew Charitable Trust and Community Resources for Justice and should be used as a model for other states.

SUMMARY: Like its neighbor, Nevada, which also has three million people, Utah is a work in progress for individuals with severe mental illness who have committed major crimes. There have been some recent promising new initiatives and laws.

RECOMMENDATIONS

- ◆ Increase use of conditional release
- ◆ Collect, analyze and report data to enable evaluation of program effectiveness
- ◆ Encourage interdepartmental collaboration to relay practices and procedures adopted to reduce jail recidivism to forensic patients discharged from state hospitals

Vermont

GRADE: D

When flooding permanently closed the 54-bed Vermont State Hospital in 2011, the state initially tried to manage with no public psychiatric beds. Unfortunately, the experiment failed, and the state is still paying the price. Although the state has no dedicated forensic beds, the new 25-bed hospital, which opened in 2014, takes forensic patients, while the state contracts for additional psychiatric beds in private and community hospitals. Once an individual is discharged from the hospital, the primary responsibility for oversight rests with the Office of the Attorney General. Oversight is largely accomplished by orders of nonhospitalization (ONHs), which are similar to conditional release orders. The initial ONH is for 90 days but can be renewed indefinitely for a year at a time.

Regional mental health centers, called designated agencies, are primarily responsible for providing services for forensic populations; this has proved problematic. The Vermont Department of Mental Health deemphasizes programming for individuals with severe mental illness, including forensic populations, which leads to a lack of prioritization for services and funding.

SUMMARY: Vermont offers few of the recommended elements of a model program for this population and emphasizes voluntary treatment at the expense of individuals with the most severe mental illnesses.

RECOMMENDATIONS

- ◆ Clarify the procedure for obtaining an ONH, for which it is currently difficult to find reliable instructions
- ◆ Use FACT teams for forensic populations
- ◆ Collect, analyze and report data on recidivism and rehospitalization to enable program evaluation

Virginia

GRADE: B-

Virginia does not designate forensic beds, but it does operate one maximum security forensic unit with a 111-bed capacity at Central State Hospital in Petersburg. The majority of the lower-security forensic placements are at Eastern State Hospital in Williamsburg or Western State Hospital in Staunton. Of the state's 1,526 psychiatric beds, forensic patients typically occupy about 38%, placing the state slightly above the national average in the availability of forensic beds per population. In 2016, 805 people were found IST, of which 610 individuals were treated inpatient and 195 individuals were treated outpatient for competency restoration. During the same period, 88 individuals were found NGRI. The state reports an average of 68 new NGRI acquittals per year, with an increase in recent years.

Virginia practices conditional release and has statutory authority for potentially indefinite extension of supervision for those who continue to meet criteria. Clear statutory guidance exists for revocation, and an expedited emergency process for revocation is available. Individuals on conditional release who abscond can be charged with a class-six felony, which enables more expeditious extradition.

Treatment services are provided by community service boards (CSBs), which are mandated to report to the court every six months. Rehospitalization rates reported in the 2014 NASMHPD survey were approximately 10% for those on conditional release within one year. There is no PSRB. There is a FACT team in the Roanoke area, and the state reports providing supplemental funding to some CSBs with PACT teams to target inclusion of forensic populations. The state provides risk assessment and risk management training, as well as ongoing consultation services to CSBs. Virginia has laws enabling AOT, called MOT, which are used regularly in some parts of the state. However, there are flaws with the statute—it requires voluntary participation, and orders only last for 90 days.

Virginia provides a superior range of services and programming for individuals with mental illness in the corrections system, both during incarceration and at release. Those who have been convicted of serious felonies are supervised by state probation services, which often contract with CSBs for the provision of behavioral health services. The programming for inmates with severe mental illness includes the evidence-based decision-making pilot project, which emphasizes cognitive program services as a method of curbing recidivism. The state report on these programs has been positive; the state plans to expand as funds allow. Effective Practices in Community Supervision II (EPICS-II) training for corrections officers is also implemented by the state corrections system as a method of lowering recidivism through different techniques of supervision. The state is also redesigning the current diversion programming to be in line with the Community Corrections Alternative Program model, an evidence-based approach that will include a central referral unit to identify enrollment and ensure consistency in assessment.

SUMMARY: Virginia's system includes many of the recommended elements of a strong forensic program for individuals with severe mental illness who have committed major crimes. Of particular note is the strong, evidence-based programming available from the Department of Corrections to decrease recidivism and help corrections populations succeed postrelease in the community. The primary issue with Virginia's forensic service model is its reliance on CSBs to provide services for NGRI and IST individuals, despite the well-documented inconsistency in quality of services provided by different CSBs and uneven funding throughout the state. This leads to large pockets of the state receiving inferior care. The legislature has long debated increasing funds to reform the CSB model, which would lead to improved continuity of care for all Virginians, civil and forensic alike.

RECOMMENDATIONS

- ◆ Overhaul the CSB system, including funding and accountability methods
- ◆ Establish a more top-down approach to local systems of care
- ◆ Reform MOT laws to make programs more effective and easier to implement

Bruce Williams, diagnosed with schizophrenia, was convicted of stabbing two women to death in separate incidents in 2011, 20 years after being convicted of strangling a woman in Virginia Beach. He served seven years in prison for that crime.

—J. Bryant, “Man convicted in fatal stabbing in Portsmouth,”
The Virginian-Pilot, January 23, 2013.

Kenneth Baker pleaded guilty to killing a woman in 1998 after several years of being IST. His competency was reevaluated after Baker was arrested for sexual assault for fondling a wheelchair-bound individual at his assisted living facility in 2009.

—T. Gonzalez, “Man charged again for 1998 murder,”
The News Virginian, July 27, 2009.

Washington

GRADE: B

In 2017, the state had 410 funded, dedicated forensic beds—285 at Western State Hospital in Lakewood and 125 at Eastern State Hospital in Medical Lake. This is about average for forensic beds per population in the United States. In 2016, of the 2,892 individuals evaluated for competency, 1,525 were found IST. During the same period, there were 24 new NGRI admissions and a total of 250 NGRI patients treated in the state psychiatric hospitals. Washington practices conditional release and has statutory authority for potentially indefinite extension of supervision as recommended. Clear statutory guidance exists for revocation.

The state does have a PSRB similar to those in Oregon, Arizona and Connecticut, but it is not endowed with the same level of statutory authority and is more advisory in nature. A bill (SHB 1355) was introduced in 2017 to more closely follow those models and make Washington's PSRB quasi-judicial in its authority; however, it did not pass and was opposed by NAMI-Washington. There is a FACT team in King County but no others throughout the state. NGRI conditional release plans are developed at the state level. Washington has laws enabling AOT, which are used regularly in some parts of the state. Upon discharge, individuals are monitored by the hospital in coordination with community correctional officers. Conditional release plans allow for spontaneous drop-ins and drug screens. Washington provides screening and programming for individuals with mental illness in the corrections system, both during incarceration and at discharge. There is statutory authority (RCW 72.09.370) for treatment, including support services, of individuals with serious mental illness believed to be potentially dangerous postrelease.

SUMMARY: Washington's system includes many of the recommended elements of a strong forensic program for individuals with severe mental illness who have committed major crimes. The state has demonstrated a commitment to continued treatment to enable individuals to remain in the community without rushing them from oversight.

RECOMMENDATIONS

- ◆ Expand use of FACT teams throughout the state
- ◆ Give jurisdictional control to the state PSRB
- ◆ Implement AOT consistently throughout the state, including with corrections populations at discharge where appropriate

Anthony Garver was found IST after allegedly stabbing a woman to death in 2013. He had previously been convicted in 2006 of threatening to blow up government buildings. Garver escaped from Western State Hospital in 2016, remaining at-large for two days before being recaptured. Charges have been refiled for the 2013 murder.

—“Murder charge refiled against psychiatric hospital escapee Anthony Garver;”
The Spokane-Review, January 26, 2017.

West Virginia

GRADE: C-

West Virginia had 66 designated forensic beds as of April 2017, which is significantly below average per population for the United States. The state only conducts treatment and evaluation at the William R. Sharpe Jr. Hospital in Weston. In 2016, the state admitted 71 people for competency restoration, compared with an average of 55 individuals annually for the five years preceding. Of this group, six individuals were found not restorable in 2016, compared with nine individuals on average for the preceding five years. There were five NGRI verdicts in 2016, compared with an average of 10 verdicts annually for the preceding five years.

West Virginia practices conditional release and has statutory authority for potentially indefinite extension of supervision for those who continue to meet criteria, bounded by the maximum sentence available for the underlying offense charged. Clear statutory guidance exists for revocation. Prior to discharge, forensic services assess clinical dangerousness using an independent forensic evaluator for all IST-NR and NGRI patients. Assessments include various risk factors and appropriateness for conditional release. Conditional release plans include a provision for re-admission to adjust medications within 30–90 days. A waiver of extradition is included in the release plan, which aids in returning individuals who abscond across state lines. The state has also adopted the Interstate Compact on Mental Health. After discharge, treatment is provided by community mental health providers, which are also tasked with periodically reporting to forensic services regarding an individual's stability and compliance.

There is no PSRB, and the state does not currently use FACT teams. Although West Virginia has laws enabling AOT, they are rarely used, and there are significant flaws in the statute. A bill for an improved AOT law was introduced in 2017 but was not passed and will need to be reintroduced in the next session.

SUMMARY: West Virginia has incorporated some of the recommended elements of a model program into its statutory scheme, but there are gaps in services for successful community reentry for this population. Without any data, it is not possible to assess the efficacy of the state's conditional release programming.

RECOMMENDATIONS

- ◆ Improve data collection and annual reporting to assess whether efforts are effective in reducing re-arrest rates and to assist individuals with severe mental illness who have committed major crimes to reintegrate safely and avoid recidivism
- ◆ Improve AOT laws, as has been contemplated
- ◆ Conduct a needs assessment to make recommendations for prioritization of this population

Wisconsin

GRADE: B

Wisconsin had 349 dedicated forensic beds as of April 2017, about average per population for the United States. Inpatient placements for forensic patients are made at Mendota Mental Health Institute in Madison and Winnebago Mental Health Institute in Winnebago. The most recent data provided for this survey was from 2015, during which there were 114 new conditional release placements and 137 NGRI verdicts. The state performs the vast majority of competency evaluations on an outpatient basis; 1,355 individuals were evaluated outpatient, compared to only 92 inpatient evaluations conducted in 2015. Competency restoration for those found IST is also often conducted in the community.

Wisconsin practices conditional release and has statutory authority for extension of supervision up to two-thirds the sentence for which the individual would have been eligible for the underlying charge. Clear statutory guidance exists for revocation. The estimated daily census of individuals on conditional release is 400. In 2015, there was a revocation rate of about 13%, or 57 clients. Of the crimes leading to commitment, 54% were violent felonies, and 25% were violent misdemeanors. One-year rehospitalization rates reported in the 2014 NASMHPD survey were approximately 70% for those on conditional release, with 40% of those hospitalizations leading to revocation, which is much higher compared to other state averages. The survey also reported that 60% of individuals found NGRI are placed on conditional release immediately after the verdict, indicating that many individuals may be released to the community earlier than is clinically advisable.

There is no state PSRB. The state uses a court liaison service program to ensure that courts follow statutory time frames. FACT teams and other specialty forensic community service providers are widely used, and case management services are delivered regionally within the state. State forensic specialists cover specific regions and have general oversight of about 13 case managers, whereas the case manager client ratio is 1:14. Wisconsin has excellent AOT laws that are used regularly in some parts of the state.

Wisconsin provides a superior range of services and programming for individuals with mental illness in the corrections system, both during incarceration and after release. The programming for inmates with severe mental illness includes the Opening Avenues to Reentry Success program, which provides intensive case management, housing assistance, resources for medication and treatment access, access to local transportation, budgeting and financial resources, and access to structured activities such as employment and education. The state administers the Disabled Offenders Economic Security program, which gives access to civil legal services, including benefit application and advocacy. Wisconsin has implemented the Community Corrections Employment Program model statewide, which assists with employment and the development of employment skills.

SUMMARY: Wisconsin's system includes most of the recommended elements of a strong forensic program for individuals who have committed major crimes. Of particular note is the strong, evidence-based programming available from the Department of Corrections to decrease recidivism and assist inmates with mental illness succeed in the community. In addition, the state conducts extremely detailed data collection and analysis. However, the high rate of rehospitalization and the emphasis on controlling costs and moving clients to less restrictive, and therefore less costly, settings raises the question of whether Wisconsin's forensic services might have become more focused on short-term savings than on long-term success for this population.

RECOMMENDATIONS

- ◆ Refocus the state's forensic programming to incentivize long-term results
- ◆ Restore funding to the successful forensic evidence-based programs to maintain low revocation and rehospitalization rates

John A. Wood, diagnosed with paranoid schizophrenia, was found NGRI for killing his father-in-law in 1978 and was hospitalized until 1991. He was then found NGRI in 1998 after sexually assaulting a female patient at a hospital. Wood has consistently fought being medicated, claiming he is not dangerous within the facility.

—*State of Wisconsin v. John A. Wood*,
323 Wis. 2d 321, 780 N.W.2d63 (2009).

Wyoming

GRADE: F

Wyoming's mental health system reports a sharp rise in involuntary psychiatric hospitalization. Since 2013, the annual cost for such hospitalizations has increased from \$4.0 million to \$10.3 million per year. Consequently, the 200 beds available in 2017 at the state hospital in Evanston, including 28 forensic beds, are always full. This results in long waits for individuals needing competency services, with individuals with mental illness sitting in local jails for up to six months waiting for a psychiatric bed. Conditional release is available but not often used. Wyoming does not appear to use community-based forensic treatment teams and does not have a PSRB.

The local CMHCs have been resistant to giving priority services to individuals who are most seriously ill, which includes those with severe mental illness who have committed major crimes. In the past, the state Department of Health proposed legislation to prioritize services for forensic populations, but the mental health centers strongly resisted and opposed the legislation, resulting in the state legislature being unable to pass the bill. In 2016, Wyoming State Hospital reported to the legislature its concerns over needing more evaluators and of potentially unconstitutional wait times for evaluation and treatment of individuals with mental illness.¹⁵ As of April 2017, nothing has come of this issue.

SUMMARY: Wyoming offers very few of the elements of a model forensic treatment system, nor has the Department of Corrections adopted any innovative programming for individuals with serious mental illness.

RECOMMENDATIONS

- ◆ Use conditional release for forensic populations
- ◆ Establish FACT teams to ensure prioritization of forensic and postcorrections populations with severe mental illness
- ◆ Collect, analyze and report data on recidivism to enable evaluation of programming

CHAPTER 6

Findings and Best Practices From the State Survey

Treat or Repeat: A State Survey of Serious Mental Illness, Major Crimes and Community Treatment was undertaken to assess each state's capacity to promote the success of individuals with serious mental illness who have committed major crimes and have returned to the community after incarceration or hospitalization. Research shows that this small subgroup, if discharged or released into the community without adequate follow-up treatment for mental illness, is at high risk for recidivism due to unmanaged psychiatric symptoms, including new offenses for major crimes. The evidence shows that this population can live successfully

The evidence shows that this population can live successfully in the community with proper treatment; individuals participating in evidence-based programs have a reduced risk for re-arrest, from an average rate of 40%–60% to only 10% or less.

in the community with proper treatment; individuals participating in evidence-based programs have a reduced risk for re-arrest, from an average rate of 40%–60% to only 10% or less. This study is the first comparative analysis of state practices for individuals with serious mental illness who have committed major crimes that informs both state and national understanding of data and programs on re-arrest and recidivism among these individuals.

We first identified each state's structures of laws, policies and programs to aid in community reentry and to provide long-term success for individuals with severe mental illness who have committed major crimes. We next assessed each state based on the degree to which it has adopted evidence-based laws, interventions and supports. Finally, based upon our findings, we made substantive recommendations for each state and identified exemplar states for specific programs or interventions to serve as models for other states.

Major Findings

We identify three major findings from the survey of the states:

- 1. The majority of states do not provide adequate support in the community for individuals with serious mental illness who have committed major crimes, resulting in higher re-arrest rates and all the attendant human and economic costs of re-incarceration.** No state received a grade of A. Only 16 states received a grade of B, indicating that they either use or have the ability to enact most of the evidence-based practices associated with lower re-arrest rates for criminal justice-involved individuals with serious mental illness. An additional 13 states were graded C and use some of the practices. The remaining 21 states were graded D or F, indicating little or no evidence-based practices for reintroducing this population to the community with the follow-up and supports that have been demonstrated to reduce their risk of re-arrest. Table 6.1 lists the states by grade.
- 2. States vary greatly in how they address reentry from hospitals, jails and prisons into the community for individuals with serious mental illness who have committed major crimes.** Although some states have similar programs, no two states implement these programs in the same way, nor do states allocate resources to these programs uniformly. There are also major differences in the way states organize their forensic services. In most states, such services are the responsibility of the state department of mental health, but the process can vary. In Vermont, for example, the

Office of the Attorney General plays a major role. These variations can lead to broad differences in the treatment process. Whereas in one state, all incompetent to stand trial (IST) examinations are carried out in a state forensic inpatient facility, another state may authorize such examinations in a community mental health center as an outpatient. A third state may do the majority of IST examinations in county jails. One consequence of this diversity is that it is difficult to obtain comparable numbers from state to state.

- 3. Data indicate that the magnitude of the problem is getting worse.** Many state respondents noted significant increases in the number of individuals with serious mental illness involved in the criminal justice system in recent years. For example, Colorado reported that the number of court orders to restore competency for mentally ill individuals who have been found IST has been increasing overall annually. Los Angeles County reported a 350% increase in the number of IST cases referred for evaluation between 2010 and 2015; although this increase primarily involved misdemeanor offenses, the stress on the system for all forensic and civil patients has been extreme.¹

Table 6.1 Grading of states on efforts to create a system to decrease re-arrest by individuals with serious mental illness who have committed major crimes

A	State is making an excellent effort and has most components of a model program.	A	No state received an A grade.
B	State is making a commendable effort and has many components of a model program.	B+	Hawaii, Maine, Missouri, Oregon
		B	California, Connecticut, Louisiana, Ohio, Tennessee, Washington, Wisconsin
		B-	Colorado, Georgia, Minnesota, New York, Virginia
C	State is making a modest effort and has some components of a model program.	C+	Michigan, Oklahoma
		C	Arizona, Arkansas, Illinois, Kentucky, Maryland, South Carolina
		C-	Nevada, New Hampshire, Rhode Island, Utah, West Virginia
D	State is making a small effort and has few components of a model program.	D+	Delaware, Kansas, North Dakota
		D	Alabama, Florida, Nebraska, New Jersey, Pennsylvania, South Dakota, Vermont
		D-	Iowa, Montana, North Carolina
F	State is making almost no effort.	F	Alaska, Idaho, Indiana, Massachusetts, Mississippi, New Mexico, Texas, Wyoming

Note: The grade refers specifically to the state’s forensic services and corrections programs for individuals with serious mental illness. Other aspects of the state’s mental health services program may be rated higher or lower than this grade.

The four states that received the best grades under this study—Hawaii, Maine, Missouri and Oregon—are all models that other states should look to for various aspects of their successful programming. Apart from these states, we found a number of laws, programs and practices in individual states that we recommend as models for other states to consider to improve outcomes for individuals with severe mental illness who have committed major crimes. These exemplar state programs and practices can be found in Table 6.2. Specific information on named programs is available in the state narratives of Chapter 5.

Table 6.2 Exemplar state programs and practices

LAW/PROGRAM/INTERVENTION	MODEL STATES OR COUNTIES	DESCRIPTION
Central oversight authority	Connecticut, Oregon	These states use a statewide PSRB model vested with oversight authority for the program, which is staffed with professionals with specialized expertise.
Forensic community oversight	Colorado, Hawaii, Missouri	Colorado uses community-based service teams; Hawaii assigns a forensic coordinator to every CMHC; Places for People in St. Louis, Missouri, is a model FACT team.
Integrated data collection	California, Oregon, Utah, Wisconsin	These states are models for collecting detailed information and make some attempt to collect data on individuals with severe mental illness and violent histories, regardless of whether the individual is under the jurisdiction of the Department of Corrections or the Department of Mental Health.
Mentally disordered offender designation	California	California’s statutory designation for those in prison with serious mental illness who have committed major crimes enables prioritization of services for those most in need of them in the corrections setting. It is a useful designation that may prove helpful for other state departments of corrections.
Specialized corrections programming for individuals with severe mental illness	Connecticut, Louisiana, Rhode Island, Virginia, Wisconsin	Connecticut’s Offender Reentry Program has significantly reduced recidivism; Louisiana coordinates its drug formulary between the Office of Behavioral Health and the Department of Corrections; Rhode Island uses special release times, so that individuals released can be taken directly to initial CMHC appointments; Virginia has piloted or employed a number of programs for the severely mentally ill population in prison; Wisconsin offers a superior range of programs to prepare inmates with severe mental illness for discharge and community reentry.

Table 6.2 Exemplar state programs and practices, continued

LAW/PROGRAM/ INTERVENTION	MODEL STATES OR COUNTIES	DESCRIPTION
Private foundation funding	Delaware, Utah	Delaware was awarded a grant from the MacArthur Foundation to fund a position for coordination of discharge planning in its corrections department; Utah obtained funding from the Pew Charitable Trust and Community Resources for Justice to develop legislation designed to prioritize services for people with mental illness released from jails and prisons.
Statewide forensic coordination	Georgia, Louisiana, Missouri, Ohio, Tennessee, Wisconsin	Each of these states administers community-based forensic services at the state level, leading to more consistency for the population statewide and encouraging uniform data collection and services.
Guilty but mentally ill (GBMI) designation	Illinois, Kentucky, South Carolina, South Dakota, Utah	Setting aside the controversy associated with the GBMI verdict and its relation to criminalization, the designation can be helpful if the statute includes or is revised to include a mandate and procedure to prioritize treatment, if it enables treatment in a hospital setting, and if it triggers inclusion of mental health treatment as a condition of parole in discharge planning.
Integration of services across departments	California	California is one of the few states to explicitly recognize the appropriateness of including corrections inmates in its conditional release program (CONREP), providing a model for other states to “de-silo” these two populations and consider them as parallel and related.
Pre-criminal justice diversion	Florida (Miami-Dade County), Texas (Bexar County), Virginia (Fairfax County)	These programs (county based, rather than state based) are excellent models for robust diversion efforts to decrease criminalization on the front end of the continuum.
Jail-based postrelease programs	Illinois (Cook County), Kansas (Sedgwick County), Rhode Island	Cook County uses a successful discharge unit and employs a mental health liaison; Kansas’s Sedgwick County Jail program won an award from the Council for State Governments; Rhode Island uses specialized discharge planners.
Jail mental health crisis network	Kentucky	Kentucky’s jail mental health crisis network provides individual-specific background information to members of the jail network for better tracking and diversion; it won an award from the Council of State Governments.
Residential step-down programs	Louisiana, Kentucky, Pennsylvania	These states offer discharge planning with residential components, enabling more time for stabilization on reentry.

Table 6.2 Exemplar state programs and practices, continued

LAW / PROGRAM / INTERVENTION	MODEL STATES OR COUNTIES	DESCRIPTION
Forensic aftercare clinics (FAC)	Louisiana	Louisiana’s FAC program, serving Orleans Parish, has significantly improved community reentry, resulting in a re-arrest rate of only 3% for participating individuals.
Leave-of-absence test programs	Maine, Michigan	Both Maine and Michigan require test periods in the community at decreasing levels of supervision to ensure individuals are ready for reentry prior to discharge to the next level of autonomy.
“Mentally Ill and Dangerous” statute	Minnesota	Minnesota’s statute (M.S.A. 253B.18) provides enhanced tracking and more intensive risk assessment and services for individuals with severe mental illness and histories of violence.
Interstate Compact on Mental Health	Minnesota, West Virginia	These states have explicitly adopted the interstate compact, providing a clear statutory basis for addressing absconding of patients under supervision.
Extended network of forensic evaluators	Tennessee	Tennessee’s practice of training larger numbers of forensic evaluators may be helpful for other states with perpetual shortages and long waits for evaluations.
Outpatient forensic services	Tennessee, Wisconsin	Both Tennessee and Wisconsin conduct large numbers of forensic evaluations, restoration services, and treatment for individuals found NGRI and IST on an outpatient basis. As a potential way to provide treatment outside of jails and to aid with bed shortages, these programs could be models for other states to follow if they are shown to be effective in preventing new crimes while patients are treated outpatient.
Extradition measures	Oregon, Virginia, West Virginia	Virginia makes absconding a class-six felony, making extradition simpler; West Virginia’s conditional release plans include a waiver of extradition; Oregon’s laws allow for an escape charge (a misdemeanor), which assists with extradition.
Explicit prioritization of forensic populations for treatment	Arkansas, Missouri	Arkansas’s website for the Division of Behavioral Health contains such a statement of priority; Missouri contracts directly with CMHCs for prioritized forensic services.

Framework of a Model System

Communities that have adopted the evidence-based laws, policies and programs identified in *Treat or Repeat* have succeeded in lowering re-arrest rates for individuals with serious mental illness who have committed major crimes. The following practices are common among these states and provide a sound basis for a model system.

- 1. *Prioritization:*** Since the 2% of individuals with serious mental illness who have committed major crimes have a demonstrably higher risk for similar conduct if untreated, they should be officially designated as a priority population for state services. Maintaining consistent treatment for the protection of the individual and for the public is the most important goal of treatment for this small subgroup. As stated by Dr. Katherine D. Warburton, the medical director for California's state hospitals:

"It is critical to identify a treatment philosophy that strikes a balance between individual rights and public safety and includes clear treatment goals."

– H. Richard Lamb, MD, "Community treatment of severely mentally ill offenders under the jurisdiction of the criminal justice system: A review." *Psychiatric Services*.

"Modern forensic treatment should not be primarily focused on recovery from a mental illness, but instead on reducing violence and meeting forensic discharge criteria in order to eventually return patients to recovery environments in the community."² Similarly, Dr. Richard Lamb and colleagues described the process as follows: "It is critical to identify a treatment philosophy that strikes a balance between individual rights and public safety and includes clear treatment goals."³

Very few states have explicitly designated forensic patients with serious mental illness as a priority population for treatment and, thus, deserving of investment of state resources. Yet prioritization is one practice known to reduce the risk of re-arrest. Arkansas is one of the few states that has done so, clearly stating on the website of the Division of Behavioral Health Services that the regional CMHCs should prioritize services for those individuals found NGRI, individuals committed by the courts for dangerousness to others and other forensic patients. Similarly, in Missouri, the state contract with the regional CMHCs states that forensic patients are a priority population. Legislation recently passed in Utah should have a similar effect.

- 2. *Centralization of forensic authority:*** PSRBs and similar centralized forensic authorities are associated with lower reoffense and re-arrest rates for individuals reentering the community from forensic settings, including forensic hospital beds and jails and prisons. Among other benefits, this survey found that states with PSRBs were more likely to use standardized release criteria and treatment plans, both of which promote treatment adherence and recovery. Widely replicating the review process used in such states as Arizona, Connecticut, Oregon and Washington would expand those benefits nationwide.
- 3. *Adequate number of forensic beds:*** Without an adequate number of inpatient forensic beds, individuals with serious mental illness cannot be treated long enough to be stabilized because there is always pressure to discharge. Under such circumstances, most such individuals are held in jail while awaiting a forensic bed. One can easily assess the adequacy of forensic bed numbers in any given state simply by counting the number of inmates with serious mental illness in jails waiting for a treatment bed. At this time, the states that come closest to having an adequate number of forensic beds are California, Hawaii, Maryland, Missouri and Oregon. However, it is important to note that even states with an adequate number of forensic beds may be grossly deficient in nonforensic psychiatric inpatient beds, creating a perverse incentive to criminalize those in need in order to ensure their care.

- 4. *Conditional release:*** A legal mechanism such as conditional release is necessary to ensure treatment plan compliance for individuals with serious mental illness who have committed major crimes and are living in the community. All except seven states have a statutory provision for conditional release, although many underutilize it. However, because some states have demonstrated better success than others, it is worth comparing results among conditional release programs to find best practices and adjust accordingly. The states that presently have the most individuals per capita with serious mental illness involved in the criminal justice system and on conditional release are Arkansas, Maryland and Missouri. By contrast, Idaho, Indiana, Massachusetts, New Mexico, North Carolina, Pennsylvania and Texas do not even have statutes allowing for conditional release. Ideally, conditional release should be renewable indefinitely for those who need it. The majority of states have restrictions on how long it may be used.
- 5. *Community forensic treatment teams:*** Communities across the country are experimenting and succeeding with a host of promising reentry and transition approaches, the discussion of which exceeds the scope of this study. However, in many communities, coordination between corrections and community mental health treatment systems remains lacking. In addition, for many of these treatment systems, providing services for individuals with serious mental illness who have been released from jail or prisons remains a low priority. For this reason, community forensic treatment teams are the preferred method of treatment. As described in Chapter 2, FACT teams have proven to be remarkably effective. FACT teams are currently in use in Arizona, Georgia, Iowa, Illinois, Kentucky, Massachusetts, Missouri, New York, North Carolina, Ohio, Pennsylvania, Texas, Virginia, Washington and Wisconsin. Cuddeback and colleagues calculated the number of FACT teams needed per population; they determined that large urban areas should develop enough FACT teams to serve 44% of their population of individuals with serious mental illness, or 0.5% of their adult population.⁴ FACT teams are especially useful in that they focus on housing and rehabilitation needs, as well as on medication needs.⁵ Other states have developed community forensic treatment teams that function, at least in part, like FACT teams. Examples are the specialized forensic mental health clinicians in California, the forensic communities coordinator in Georgia, the forensic coordinator in Hawaii, the forensic community-based services teams in Colorado, the forensic aftercare clinic in Louisiana and the new forensic multidisciplinary teams in Florida. Other examples of community forensic treatment teams used by specific states are listed in Table 6.2.
- 6. *Adequate psychiatric treatment:*** As this report shows, many individuals with serious mental illness who have committed major crimes are among the most seriously ill patients in the state system. It is therefore essential to offer them state-of-the-art psychopharmacological treatment. For treatment-resistant psychosis, clozapine is considered the medication of choice, yet it is seriously underused in the United States compared to most other countries. The states that are the best users of clozapine are South Dakota, Connecticut, Colorado, Washington, Vermont and Maine.⁶
- 7. *Risk assessment and civil commitment:*** Individuals with serious mental illness who are incarcerated should be treated for their illness and, if they have committed a major crime, should be screened for potential dangerousness prior to being released from jail or prison. Many risk assessment screening tools have been developed with varying levels of predictive validity.^{7,8} For those individuals released from jail or prison who are clearly considered to be potentially dangerous due to their mental illness,

state laws should allow for civil commitment, either as an inpatient or outpatient, for additional treatment. AOT is especially useful in this regard, because it allows the person to live in the community while being treated.

- 8. Adequate laws and educated judges:** State laws should facilitate efforts to maintain treatment by enabling evidence-based programs. Where laws are inadequate or create barriers to treatment, amendment by the legislature may be necessary. An example of this is shaping conditional release laws based on models that have been shown to be effective for individuals with serious mental illness who have committed major crimes. New laws may require education and outreach to state judges so that laws are enforced and implemented according to best practices. Similarly, it is important to educate judges more generally regarding the nature of serious mental illness and the relative effectiveness of different programs.
- 9. Interdepartmental collaborations:** In this survey, we identified departments of corrections in several states that are making commendable efforts to identify inmates with serious mental illness being released from prisons and jails and coordinating follow-up care in the community. Individuals with severe mental illness who have committed major crimes exist within both the mental health system and the corrections system in all states, yet not all states make a point of ensuring that the systems work together to encourage better outcomes. New York is regarded as a model for cooperation between the Office of Mental Health and the Department of Corrections. Connecticut's Department of Corrections reentry training program has reduced reoffending by half. Connecticut also uses specially trained parole officers who have caseloads of 25–30 released inmates with serious mental illness. In Kansas, although the Behavioral Health Services Commission is doing almost nothing to reduce reoffending rates among inmates with serious mental illness, the Department of Corrections is making commendable efforts, including a program at the Wichita County Jail that was recognized as a model program by the Council of State Governments Justice Center. In Louisiana, a cooperative agreement between mental health and corrections departments has standardized the medication formulary so that released prisoners can be continued on their same medications. In both Louisiana and Arizona, if a prisoner with serious mental illness is not stable at the time of release, Department of Corrections officials can take the prisoner to a psychiatric facility for evaluation for further court-ordered treatment. In Rhode Island, a prison release planner can request a specific time for the release of a prisoner with serious mental illness so he or she can be taken directly to the initial CMHC appointment after being released. A close relationship between the mental health and corrections departments will lead to more consistent success, regardless of where an individual is in the system when reentry to the community occurs.
- 10. Interstate cooperation:** Movement across state lines adds another hurdle to ensuring consistent treatment for individuals with serious mental illness who have committed major crimes. When an individual who has serious mental illness and has committed a major crime moves across state lines, the jurisdiction control from the state providing treatment services is lost. This can lead to individuals being lost in the system or left untreated; psychiatric symptoms may decompensate and, in some cases, result in the individual reoffending. For example, Richard Mutchler, diagnosed with bipolar disorder, killed a man in Colorado and, 17 years later, killed a man and a woman in Iowa.⁹ Similarly, Rodney Woidtke, diagnosed with paranoid schizophrenia, killed a man in Missouri and, 13 years later, having stopped his antipsychotic medication, killed a man in California.¹⁰ Jeannette Harper, described in

the Appendix and diagnosed with schizophrenia, killed a man in West Virginia and, seven years later, killed a woman in Virginia. When an individual with serious mental illness who has committed a major crime moves to another state, there should be a formal mechanism for either returning the individual to the original jurisdiction (if the move was a violation of the treatment plan) or transferring services and supervision to the new location to ensure that he or she can remain safe within the community.

Limitations

There are some limitations to the *Treat or Repeat* state survey. The survey collected the structure and systems developed and implemented by a state to decrease or prevent reoffending. However, the survey cannot determine the accuracy in implementation and how these systems are used without analyzing outcome data, which is collected by very few states. For example, the number of individuals on conditional release and the number of FACT teams available were collected, but the authors were unable to measure the quality of care for individuals on conditional release or to measure a FACT team's effectiveness. Therefore, it is possible that a state received a grade of C on this survey based on the number of structures in place but may actually be doing a better job than a state graded B, which may have more structures in place but is not using them as well.

Another limitation is that some recommended elements of a model system may be available in only a few counties within a state, leaving citizens in other counties with inadequate programming. Therefore, although we can identify whether each element is authorized under law and policy, we cannot fully assess whether these elements are available or implemented throughout the state. For larger states in particular, this can prove problematic. It should not be assumed that a state offering most recommended elements of a model system serves all parts of its territory well, only that the laws would enable it to do so.

It is also important to note that the state grade refers specifically to the forensic program for individuals with serious mental illness who have committed major crimes. Other mental health services in that state may be graded higher or lower than this grade.

CHAPTER 7

Conclusions and Recommendations: Treat the 2%

In 1751, Benjamin Franklin petitioned the Pennsylvania Provincial Assembly to open a hospital for persons “disordered in their Senses.” Such persons, said Franklin, “hath greatly increased in this Province,” and “some of them going at large are a Terror to their Neighbors who are daily apprehensive of the Violence they may commit.”¹ A century later, Dr. John P. Gray, who would become president of the APA, again described the problem:

*A disposition to violence is a common characteristic of mental disease. It is exhibited in every conceivable manner, from harsh words to suicide and the most cruel and brutal murders, and is found in every form of insanity. If, then, among the unhappy phenomena or symptoms developed, under the influence of the delusions and hallucinations peculiar to the disease, we meet with a tendency so universal, so destructive of happiness, and so dangerous to society, how important is its careful study, with reference to the welfare both of the patient and the public!*²

Now, more than 150 years later, we have the ability to effectively treat such people. Isn't it time to do so?

Conclusions

Based on our calculations, we estimate that approximately 200,000 people with serious mental illness who have committed a major crime are living in US communities. These individuals, representing approximately 2% of all people with severe psychiatric disorders, have been either discharged from a hospital or released from a corrections setting and often are receiving no treatment or other follow-up care. Without such treatment, the risk of these individuals reentering the criminal justice system increases. In fact, the rate of re-arrest is two times higher for individuals with serious mental illness than for other released inmates,³ and it is more than twice as high in the United States compared to nine other countries.⁴

The number of state hospital beds in the United States has plummeted by almost 97% from its historic peak in 1955 of 337 beds per 100,000 adults to 11.7 beds per 100,000 adults in 2016, with limited community services to take the place of inpatient treatment.

Several treatment strategies and practices have been found effective in reducing the re-arrest rate for this population. When properly implemented, these methods reduce psychiatric symptoms, enhance public safety and reduce the risk of re-arrest for individuals involved. Common sense would suggest that such treatments should be widely used. Yet, as our state survey for *Treat or Repeat* has shown, these programs are far from being systematically implemented nationwide.

Many factors explain why individuals with serious mental illness who have committed major crimes are not treated more aggressively. Beginning in the late 1950s, psychiatric state hospitals began closing their doors in a movement referred to as *deinstitutionalization*. The expectation was that these hospitals would be replaced with adequate community services; however, for various reasons, this did not happen. As a result, the number of state hospital beds in the United States has plummeted by almost 97% from its historic peak in 1955 of 337 beds per 100,000 adults to 11.7 beds per 100,000 adults in 2016, with limited community services to take the

place of inpatient treatment. Without sufficient access to inpatient hospital care, acutely ill individuals deteriorate and may find themselves picked up by police and entering the revolving door of the criminal justice system. The grades of the states in this report solely reflect each state's forensic systems. Even states that score highly in this study may not provide adequate services for all individuals with serious mental illness. In fact, *Treat or Repeat* found that states with the most robust forensic services practices were severely lacking in civil, noncriminal treatment standards and resources.

In their 2017 article, "Understanding and Treating Offenders with Serious Mental Illness in Public Sector Mental Health," Lamb and Weinberger presented the argument that any effort to decarcerate through diversion practices and the expanded use of mental health courts will only work if community-based treatments are adequate to help criminal justice-involved individuals with serious mental illness succeed.⁵ This, they argue, must include close monitoring of treatment adherence, a staff capable of and willing to work with these clients, and adequate funding to do so. Shifting the burden of providing care for criminal justice-involved populations with severe mental illness will also require changes to and restructuring of the mental health system, which will now be expected to provide care for those individuals previously receiving care through corrections systems. The authors concluded, as we do in this report, that the need for collaboration between treatment staff and their counterparts in the criminal justice system will be increasingly important as criminal justice-involved individuals are diverted or released back to the community in greater numbers.

Recommendations

Based on these findings, the Treatment Advocacy Center recommends the following steps:

- ◆ **Federal, state and local governments must create policies to stop the criminalization of individuals with serious mental illness.**

Failing to treat mental illness in a timely fashion can give rise to conduct that entangles individuals with serious mental illness in the criminal justice system. *Treat or Repeat* found that all states with good grades on their forensic treatment systems displayed weaknesses or gaps in their civil systems. As admirable and necessary as a strong forensic system may be, to reverse trends of criminalization, policymakers need to eliminate treatment barriers for individuals with serious mental illness before they enter the criminal justice system. A system that requires violence or criminal conduct before the initiation of treatment fails both the individual and the public, at high cost to both. The 21st Century Cures Act, passed by Congress and signed into law by President Barack Obama in December 2016, is a first step in this process.

- ◆ **Federal, state and local governments must prioritize treatment for individuals with serious mental illness who are involved in the criminal justice system.**

Government agencies, including the federal SAMHSA and the DOJ, should work together to create programs that function across budgets and across the public mental health and criminal justice systems to help prioritize the provision of treatment for individuals with serious mental illness who have committed major crimes. Prioritization and treatment for these individuals, who make up only 2% of individuals with serious mental illness, is necessary to reduce reoffending, a concern for the safety of the public and of the individuals and their families.

- ◆ **State and local governments must implement evidence-based treatment programs for individuals with serious mental illness who have committed major crimes.**

Programs such as FACT teams, PSRBs and evidence-based corrections programs, as well as civil programs such as AOT, have been shown to reduce the risk of reoffending among individuals with serious mental illness. State and local governments should implement programs such as these to treat individuals living in the community who are at risk for reoffending and to provide every opportunity for success.

- ◆ **Researchers and government agencies must conduct research and evaluate programs to inform best practices for individuals with serious mental illness who have committed major crimes.**

Research and analysis of data are necessary to inform decisions on which programs to expand and which to eliminate. It is also necessary to expand the evidence base on effective programs for individuals with serious mental illness to inform these policy decisions. The federal government, through the DOJ and SAMHSA, should conduct research and fund projects to systematically collect data to analyze and share best practices that are effective in reducing the criminalization of individuals with serious mental illness, including individuals with severe psychiatric disorders who have committed major crimes.

- ◆ **Data collection, treatment and supervision must be individualized and based on outcomes.**

State-collected data do not currently track the sequence of events and outcomes for individuals as they move through the corrections and forensic mental health systems. Instead, data are disconnected from the individual and are collected at each point of interaction with the system: at entry into the criminal justice system, receipt of forensic services or corrections, and reentry into the community. The resulting data cannot be compared across systems to measure the effectiveness of or outcomes associated with different practices along the entire continuum. For example, the data do not show how many individuals initially found IST continue through the system and are ultimately found NGRI or how many are instead convicted of crimes and incarcerated. Evaluation of efforts to prevent reoffending requires the ability to assess an individual's journey through the system and the resulting outcomes. A best practice is to follow the individual through the criminal justice and mental health care systems into the community following release. Such data could be used to determine longitudinal outcomes and patterns, including competency restoration, criminal behaviors, treatment and recidivism in order to assess the effectiveness of different interventions and to identify individuals cycling in and out of systems. Understanding how individuals interact with the systems would enable services to be individualized, care to be better coordinated across civil and criminal systems, and success in the community to be promoted.

- ◆ **State and local governments should incorporate mandatory, detailed population-level data collection and reporting for programs serving individuals with serious mental illness who are involved in the criminal justice system.**

Many questions remain on the efficacy of programs adopted by states; this is largely due to lack of data upon which to evaluate them. Statutes and policies can and should include requirements for data collection and analysis. Such data should include specifics on outcomes, such as reductions in psychiatric symptoms, re-arrest rates, rehospitalization rates and costs throughout the system. This would allow for evaluations of these programs and would help determine state-specific solutions. What works best in Rhode Island may be quite different from what works best in Texas or Wyoming.

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APPENDIX

Case Study: How a Graduate of Duke University Killed, Was Treated and Then Killed Again

Duke University's class of 1978 included several individuals who have achieved significant public recognition. They include an ambassador, a leader in fashion merchandising, a nationally syndicated columnist, an editor of *The Wall Street Journal* and a woman who murdered two people over a seven-year period. The last has not been featured in the alumni association's *Duke Magazine*, despite its intent to "address the issues of the day." This is an unfortunate omission, because the failure to treat individuals who have serious mental illness is an issue of the current day. Moreover, Jeanette Harper illustrates the complexity of this issue.

Jeanette was the second of four children, born in 1956 to parents who were high school math and science teachers in Beckley, West Virginia. Her father also sold Christmas trees for the holidays. Jeanette liked ballet and swimming, was a cheerleader and student council president, and excelled in school. In later years, she was remembered by schoolmates as having been "beautiful, quiet but nice, a bookworm type." Jeanette recalled periods of depression during high school, and her mother said that she had been somewhat of "a loner with few close friends."

"You'd better give me the electric chair or I'm going to do it again."

—Jeanette Harper

In the fall of 1974, Jeanette entered Duke University. She initially majored in biomedical engineering but found the mathematics difficult and switched to social psychology. She achieved average grades and had a few close friends. Her problems began during her final semester at college. During a dinner in a restaurant, her father recalled that Jeanette complained that a woman several tables away was talking about her. Her father also recalled that at graduation "she didn't look right to me." His concern proved justified when, two months later, she was referred for psychiatric evaluation, and her father brought her back to Beckley.

The following eight years were chaotic for both Jeanette and her family. She was initially treated in an outpatient setting but, at age 22, was admitted for the first of what would ultimately be 16 psychiatric hospital admissions. She was variously diagnosed as having paranoid schizophrenia, bipolar disorder with psychotic features or, most often, schizoaffective disorder. The latter diagnosis is simply a mixture of symptoms of the first two. Dr. Riaz U. Riaz, her principal treating psychiatrist, remembers her well: "She was bright but difficult to treat because she thought nothing was wrong with her and therefore refused to take her medicine." Dr. Riaz also remembered her because he had diagnosed one of her brothers with schizophrenia and was treating both siblings. One of Jeanette's hospitalizations was precipitated by running naked down the street "to get away." Between hospitalizations, she worked at various jobs for short periods, obtained a teaching certificate, and traveled to South Carolina and Florida where she found jobs and quickly lost them.

Set amid the rolling hills in southern West Virginia, Beckley is a friendly town in which many of its 17,600 citizens know one another. The town was founded in 1838 by US Army General Alfred Beckley, the son of the first Librarian of Congress. The town's best-known offspring is country music singer Little Jimmy Dickens. Its population, three-quarters white and one-quarter black, has generally gotten along without serious problems. Beckley's racial relations were challenged by Jeannette on October 18, 1986. Although she was not regarded as being prejudiced in high school, Jeannette had become increasingly obsessed with ideas that black

men were harassing her and planning to kill her. As she later described in a court document, "I began to develop a paranoia of being raped and left to die in a wooded area by a group of black men." She was not taking her antipsychotic medication and had purchased a .22 caliber handgun to protect herself.

Joseph Pundzak, a white contractor, lived in the Harpers' neighborhood and employed a 28-year-old black man, Ronson Jay Booker, to help him. On that Saturday afternoon, the men had stopped at Pundzak's house to get some water. Jeanette was walking in the neighborhood when she spotted Booker, whom she did not know. She returned to her house, picked up her gun and put on a maroon ski mask to disguise herself. She returned to Pundzak's house and, according to an account in a local newspaper, "walked through a garden area to where the two men were standing." She then "casually pulled out the pistol and shot Booker." Booker immediately started running away, but "she chased him, continuing to fire." Shot multiple times, Booker died a week later from his wounds.

Jeanette was arrested and, following Booker's death, charged with murder. The complaint filed with the local magistrate described it as a hate crime: "Every time the defendant would see a black person, she would outburst, calling them niggers, saying they were gross and didn't deserve to live. She made a verbal statement that the reason she shot this black man [was] because she don't like niggers." Once charged, Jeanette was sent to Huntington State Hospital in Charleston and then to Weston State Hospital for psychiatric examination.

Jeanette was found competent to stand trial. Her first trial took place in July 1987, with both sides agreeing to the facts of the murder. Testimony regarding her sanity and responsibility for her actions at the time of the murder were vigorously debated by opposing mental health specialists, and the jury was unable to reach a verdict. A second trial took place in June 1988. Harper answered questions posed by Michael Froble, her public defender, and stated that she did not believe Booker was really dead. On cross-examination, however, she sat silently, "with a slight smile," refusing to answer all questions from the prosecutor. According to Froble, Jeanette studied a Spanish dictionary during much of the court proceedings. When asked by the judge why she was doing this, she said that she had heard there were many Hispanics in state prison, so she was trying to learn Spanish. At one point, she accused the prosecutor of "trying to convict an innocent person": "I will tell you this. I believe I'm not getting a fair trial, and your actions are causing that." To the prosecutor and the judge she added, "I know what you're doing." Despite a repeat performance of dueling mental health professionals, the jury of nine men and three women found her not guilty by reason of insanity. Following the verdict, Booker's mother expressed her frustration that her son was dead because of the defendant's racial animus.

Following her trial, Jeanette was sent to Weston State Hospital to regain her sanity. Construction of the hospital had been funded in 1858 by the Virginia State Legislature as the Trans-Allegheny Lunatic Asylum. It had still been under construction in 1861 when the Civil War began. Soon after the start of the war, 50 counties in western Virginia voted to secede and join the Union as West Virginia. The new asylum was the only government building that came with the new state. Weston continued to operate as a state psychiatric hospital until it was replaced by a new hospital in 1994.

At the time Jeanette was there, Weston held approximately 400 patients. It is a dark, foreboding structure and the largest hand-cut stone masonry building in the nation, second largest in the world next to the Kremlin. Surrounded by portentous hills, the hospital looks like it belongs with Count Dracula's castle in the Carpathian Mountains of Transylvania. This

impression is reinforced by the fact that public “ghost tours” are currently being offered through the abandoned buildings. “Apparition sightings, unexplainable voices and sounds, and other paranormal activity” can be experienced on tours lasting from 9 pm to 5 am for \$100 per person.

The medical director of Weston State Hospital was Dr. Calvin Sumner, a well-trained and dedicated public-sector psychiatrist. He was the only fully licensed physician at the hospital at that time. Most US-trained psychiatrists had left state hospitals in favor of private practice; as such, state hospitals often relied on foreign-trained physicians, who were encouraged to come to the United States under special immigration policies for staffing. Many of these physicians could not pass state medical licensing requirements but were allowed to practice in state mental hospitals under a special permit. At the time Jeanette was at Weston State Hospital, 90% of the physicians practicing in the two state hospitals were unlicensed, including four physicians at Weston. Some of them had had no psychiatric training; indeed, the physician in charge of Jeannette’s ward, which included all patients with criminal charges, is remembered as having been trained as an ophthalmologist in his home country.

Dr. Sumner remembers having been under great pressure to discharge patients from the hospital. This was the era of deinstitutionalization of patients from state mental hospitals throughout the United States; the two hospitals in West Virginia had decreased their patients from 5,619 to 550 over the previous 30 years. Each time a state hospital closed a bed, it saved state money by effectively shifting the cost from state to federal programs, such as Medicaid and Supplemental Security Income. In addition, in 1981, the West Virginia courts had ruled that psychiatric patients should be treated in the “least restrictive environment,” which meant in the community, whenever possible.

The effect of the antipsychotic medication was immediate. Within one month, according to her hospital record, “the patient’s behavior, attitude, and general disposition changed significantly toward complete cooperation, willingness, and trust of her care takers.”

For the first eight months at Weston, Jeanette made no progress in the restoration of her sanity. In the hospital records, she was described as being “very uncooperative,” experiencing auditory hallucinations and being “suspicious of others.” She refused to take antipsychotic medication: “Respondent believes she can get better without medication,” and “she denies being mentally ill or needing any medication.” The hospital record also noted several occasions when

Jeanette explicitly stated she would not take medication once she was out of the hospital: “She said ‘I am okay’ and would stop taking her medication when she is out of the hospital.” Thus, it was clear that she had an impaired ability to recognize her own illness and need for treatment. This occurs in about half of all individuals affected with serious mental illness and is caused by the effects of the disease on the parts of the brain we use to think about ourselves. In neurological terms, it is called *anosognosia*.

In March 1989, after having been hospitalized for more than eight months, Harper did an abrupt about-face and agreed to take Prolixin®, an antipsychotic medication. In retrospect, she said she did so because she was told it was the only way she would be able to get out of the hospital. The effect of the antipsychotic medication was immediate. Within one month, according to her hospital record, “the patient’s behavior, attitude, and general disposition changed significantly toward complete cooperation, willingness, and trust of her care takers.” Two weeks later, her treatment team began discharge planning, proposing that she initially be given a three-day pass to stay with her family in Beckley. At this point, Jeanette had been seriously mentally ill for 10 years and had responded to medication for only one month.

The plan to discharge Jeanette to Beckley, where she had murdered a man, caused local alarm. According to a newspaper account, "Community leaders in Raleigh County have urged court officials to bar Harper from returning to her ... home, fearing another outbreak of violence." The prosecuting attorney therefore petitioned the court to block the discharge plan.

At this point, Protection and Advocacy (P&A) lawyers tasked with representing consumers stepped in. Such advocates are an outgrowth of the 1986 federal Protection and Advocacy for Individuals With Mental Illness Act, widely referred to as PAMI. The program's original intent was to investigate the abuse of mentally ill and mentally disabled individuals in hospitals, but it has also been widely used to get patients discharged from hospitals. The West Virginia P&A program, which continues to exist, currently receives \$406,700 in federal funds each year, the state's share of the total \$35 million federal P&A appropriation.

The 15-page amicus brief filed by the West Virginia advocates in the West Virginia Supreme Court of Appeals was instrumental in helping to get Jeanette discharged from Weston State Hospital. It claimed that attempts to block her from returning to Beckley were "outrageous," adding that "there was absolutely no evidence produced by the prosecuting attorney that Ms. Harper is a danger to herself or others." The brief further detailed studies showing that "predictions of dangerousness are fraught with error. ... Psychiatrists who make such judgments tend to over predict dangerousness." It also argued that "the insanity defense is event specific" and thus should have no bearing on Harper's present mental state: "An acquittal by reason of insanity indicates very little about the individual's present mental state because mental illness is by its nature a fluid concept." Finally, the amicus brief reminded the court that "West Virginia law mandates appropriate treatment in the least restrictive placement." Since Jeanette was no longer overtly psychotic, the least restrictive placement meant out of the hospital.

On June 9, 1989, a court hearing was held at the hospital to decide the matter. After listening to both sides, the judge ruled that Jeanette could not be returned to her home in Beckley but could go elsewhere in the state. Since she had an aunt living in Charleston who was willing to take her, that became the plan. Froble, who had been Jeanette's public defender at the trial, represented her. In a recent interview, Froble recalled that at the hearing, "we were all afraid that when she was released she would stop taking her medicine. She never wanted to take medicine."

Thus, on July 25, 1989, 33-year-old Jeanette Harper was discharged from Weston State Hospital with orders to continue her medication at the Shawnee Hills Community Mental Health Center in Charleston. Her discharge plan predicted that "prognosis is good for her provided she maintain medication follow-up."

For the first year following hospital discharge, things went well for Jeanette. She lived with her aunt and held a clerical job at Shawnee Hills, where she received her monthly Prolixin injections. It was her understanding that she was legally required to take medication for a year, but that at the end of that time, she would be free to do whatever she wanted. She later described it as having spent "a year as a required outpatient at a drug clinic required to take shots of drugs they prescribed before I could get away from all that." There is no indication that she believed she was psychiatrically ill or needed the Prolixin injections. Her writings indicate that she believed her killing of Booker had been the consequence of continued harassment by black men, which had caused extreme stress and "paranoia," resulting in the killing.

In July 1990, one year after having been discharged from the state hospital, Jeanette requested and was granted a discharge from Shawnee Hills. She had been stable on Prolixin for more than a year and had caused no problems. In addition, she had developed a close relationship with a young man who was also a patient at the CMHC, and the two had plans to move to northern Virginia. As a general rule, CMHCs did not regard patients with psychoses who had been discharged from state mental hospitals as a priority, because they were not considered to be good candidates for psychotherapy, the preferred activity of the psychologists and social workers who largely staffed such centers.

In August 1990, Jeanette and her boyfriend moved to Falls Church, Virginia, to stay with Ada Sanderson, the boyfriend's aunt. Sanderson was a retired secretary who had worked for the Department of Defense. She was divorced, with a son living in California, so she was glad to have some company. Since Jeanette was psychiatrically stable from having been on Prolixin for over a year, she got a job as a telephone marketer and was able to pay Sanderson for their room. However, her boyfriend started using drugs and was soon sent back to Charles-ton by his aunt. Jeanette opted to stay with Sanderson.

The period of psychiatric stability was not to last. Without continuing medication, the effects of the Prolixin wore off, and Jeanette entered a 2.5-year period of psychotic perturbation. First, she lost her job. Then she was arrested for trespassing at the home of one of her boyfriend's other girlfriends. She returned briefly to Beckley and then went back to Falls Church, where she was hospitalized for two weeks. In November 1991, she wrote a love letter to Hugh Caperton, a man she had known in Beckley, claiming they had had a child together and were going to be married. Since he was the nephew of the then-governor of West Virginia, a restraining order was issued, and the police in northern Virginia were alerted regarding her criminal history.

By January 1992, Jeanette was living out of her car. In an apparent attempted suicide, she rammed her car into a tractor-trailer on the Washington beltway. Not seriously injured, she then fled across eight lanes of traffic until being stopped by the police. She was taken to a hospital, where she was described as catatonic and then transferred to the Northern Virginia Mental Health Institute, a state hospital, where she remained for more than three months. Following her discharge, she went to Florida for five months, where she was again hospitalized. She next returned to Falls Church, made a visit to West Virginia and then returned to Falls Church in February 1993, having received no psychiatric treatment for more than six months.

On February 24, 1993, Jeanette applied for a voluntary psychiatric admission to a hospital in Falls Church because, she said, she was again homeless. Her hospital chart described her as blatantly psychotic, but, as usual, she refused medication. She was transferred back to the Northern Virginia Mental Health Institute, where she remained for another three months. By this time, she had perfected a strategy of using hospitals as places to stay without participating in treatment. The treating psychiatrists at this hospital, and at the other hospitals in northern Virginia where she was treated, were fully aware that she had previously killed a man when psychotic, and it was so noted in her hospital records.

In retrospect, questions were raised regarding why she had not been treated during her lengthy hospital stays. The answer, quite simply, is that the laws of Virginia, and of most other states, did not (and still do not) permit individuals with mental illness to be treated

against their wishes. That was not always the case; prior to the 1970s, state laws did permit such treatment based on a patient's psychiatric needs. But, in the 1970s, civil rights lawyers instituted lawsuits designed to protect patients. In Wisconsin, for example, the influential court decision in *Lessard v. Schmidt* restricted involuntary hospitalization to situations in which the individual with mental illness could be proven to be an immediate danger to self or others and had so demonstrated by a *recent* act. Virginia law adopted similar language, stating that people can only be medicated against their wishes if "by clear and convincing evidence" there can be proven to be "a substantial likelihood" that they will, "in the near future, cause serious physical harm to himself or others as evidenced by recent behavior."

The protection of individuals with serious mental illness in Virginia is detailed in 49 pages of "Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services." Except in a psychiatric emergency, under which a patient may be involuntarily treated for only 24 hours, involuntary treatment involves a psychiatric examination to establish that the person lacks the capacity to consent, the appointment of a substitute decision maker, and a decision by a local human rights committee. This committee must have five or more members, of which at least two must be consumers, one a "healthcare provider," and the others being "persons with interest, knowledge or training in mental health, mental retardation, or substance abuse field." There is no requirement to include a psychiatrist or psychologist on the committee, and they usually are not included. For any treatment recommendation with which a patient disagrees, there is an extensive appeals process, which may go up to the state human rights committee and which can take several weeks.

To assist patients who are being evaluated for involuntary medication, the Virginia Office of P&A provides a lawyer. Like the P&A programs in all states, the Virginia program is funded by the federal government; the present annual allocation to Virginia is \$630,150. The stated goal of the Virginia P&A program is to "protect and advocate for the rights of people with mental illness," including their right to not take medication if a patient does not want to. Thus, Jeanette had federally funded lawyers available to assist her in getting discharged from the state hospital in West Virginia and in avoiding involuntary treatment in Virginia.

"We all knew she was potentially dangerous and needed to be treated. But, if she didn't agree there was nothing we could do. Our hands were tied."

It would have been apparent to any P&A lawyer, as it was apparent to Jeanette's treating psychiatrists, that she did not meet Virginia's criteria for involuntary treatment. When hospitalized, she was quiet and cooperative, except for not taking antipsychotic medication. Her homicide qualified as "serious physical harm," but it had occurred more than six years previously, so it did not qualify as "recent."

The fact that she did not qualify for involuntary treatment was reflected in her hospital records. For example, in the admission summary for her February 1993 hospitalization, she was noted to have "a long history of ... paranoia ideation with violent impulsive acts," including killing a man, and also to be noncompliant with medication because "she feels that she does not need medication." Despite this picture, the admitting psychiatrist noted, "Unless her behavior becomes out of control and dangerous and assaultive [while in the hospital], I do not think we can give medication IM [involuntarily]." The psychiatrist later added, "We all knew she was potentially dangerous and needed to be treated. But, if she didn't agree there was nothing we could do. Our hands were tied." It was like watching two trains speeding toward each other on the same track.

On June 10, 1993, Jeanette, still psychotic, signed herself out of the Northern Virginia Mental Health Institute after a stay of more than three months. She returned to Sanderson's house and resumed her relationship with her boyfriend. On the July 4 holiday, Jeanette's boyfriend ignored her and did so again on July 7, her birthday. When he finally showed up on July 8, she was furious. Later that day, she got into an argument and a physical fight with Sanderson. The police were called, and, aware of Jeanette's homicidal history, they took her to the Woodburn Center for Community Mental Health for evaluation. Since she was well known to be uncooperative with treatment, they simply released her two hours later.

While walking back to Sanderson's house, Jeanette stopped at a People's drug store, where she shoplifted a nine-inch butcher's knife. She later said that she did so to protect herself. When she entered the house, she and Sanderson again began arguing and then fought. As Jeanette later described it: "I stabbed her as many times as I could until she stopped moving." At the autopsy, 27 stab wounds were noted, including some on the hands, arms, chest, back, face and scalp. Several of the wounds on the back exited through the chest, apparently delivered as Sanderson lay on the floor. The neighbors called the police, and Jeanette was arrested. She immediately confessed and added, "You'd better give me the electric chair or I'm going to do it again."

Harper's four-day trial in February 1994 held little suspense. She was charged with "willful, deliberate, and premeditated" first-degree murder. Jeanette's father testified about her illness, and Sanderson's son attended the trial. Three psychiatrists and two psychologists established the facts of her mental illness, but this was overridden by Jeanette's own statements suggesting premeditation. Her previous homicide was not allowed to be presented as evidence but may have been known to at least some members of the jury. Since she had previously been inadequately treated and released by mental health professionals, this jury of six men and six women would not make the same mistake. After only two hours of deliberation, she was sentenced to life in prison.

Since 1994, Jeanette has been in the Virginia state prisons, most recently at the Fluvanna Correctional Center in central Virginia. She is held with 1,200 other women in a set of two-story buildings surrounded by fields and woods. She has taken antipsychotic medication intermittently while in prison but is not certain that she needs it. In her requests for parole, she has expressed a belief that the real cause of the homicides was her harassment by black men and by Sanderson. The parole board has denied all such requests by her. The cost to Virginia taxpayers for her stay in prison is approximately \$28,000 per year, or \$644,000 to date. The cost of the Prolixin, which kept her well in the community as long as she took it, was approximately \$500 per year. She is just one of many.

Jeanette Harper's story was compiled from the following:

- ◆ News articles in the *Charleston Gazette*, *Beckley Register-Herald* and *Washington Post*
- ◆ Psychiatric records from Weston State Hospital in Weston, West Virginia, and Dominion Hospital in Fairfax, Virginia
- ◆ Trial records from Fairfax Court in Fairfax, Virginia
- ◆ Correspondence between Jeanette Harper and Dr. E. Fuller Torrey
- ◆ Interview of Jeanette Harper by Dr. Torrey, August 1, 2014
- ◆ *Lessard v. Schmidt*, 413 F. Supp. 1318 (E.D. Wis. 1976).

Glossary of Terms

TERM	ABBREVIATION	DEFINITION
Assertive community treatment	ACT	Multidisciplinary, mobile-outreach team service-delivery model that provides individualized treatment services directly to consumers 24 hours a day, seven days a week, to improve functioning and enhance quality of life.
Assisted outpatient treatment	AOT	Form of civil commitment involving court-supervised treatment in a community setting. To be a candidate for AOT, a person must meet specific criteria, such as having a prior history of repeated hospitalizations or arrest.
Civil commitment		Legal mechanism for court-ordered treatment for mental illness or substance abuse based on statutory criteria; can be inpatient or outpatient as defined by state law.
Community mental health center	CMHC	Psychiatric facility providing mental health services in a community setting.
Conditional release		Revocable discharge from a hospital subject to the patient's adherence to a specified treatment plan. Can be used for civil or forensic patients; references in this report are exclusively to forensic programs.
Criminalization		The effect created by public policies and practices that result in the transfer of individuals with mental illness from the mental health system to the criminal justice system, regardless of intent.
Forensic assertive community treatment	FACT	One example of a forensic community treatment team; provides ACT services to forensic clients.
Forensic community treatment teams		Service delivery structure of mental health professionals focused only on forensic populations in outpatient settings.
Guilty but mentally ill or guilty except insane	GBMI or GEI	Statutory class used by some states to acknowledge an underlying mental illness while holding an offender legally culpable for a crime.
Incompetent to proceed	ITP	Legal term for an individual who is unable to proceed with a criminal case due to mental illness.
Incompetent to stand trial	IST	Legal term for an individual who is unable to understand the character and consequences of court proceedings due to mental illness.

Glossary of Terms

TERM	ABBREVIATION	DEFINITION
Major crimes		Defined in this report as felony and misdemeanor crimes posing a potential threat to individual or public safety; nonviolent felonies and drug crimes are excluded.
Mentally disordered offender		Statutory term used in California for a criminal inmate with serious mental illness.
National Association of State Mental Health Program Directors	NASMHPD	National organization working with state agencies, the federal government and other entities to define, collect and analyze data on public behavioral health systems.
Not guilty by reason of insanity	NGRI or NGMI	Statutory class for individuals the court deems not legally culpable due to mental illness; based on the defendant not having the requisite mens rea (guilty state of mind) for criminal responsibility.
Psychiatric security review board	PSRB	State body vested with central authority to oversee treatment and placement decisions for individuals found NGRI; degree of authority varies by state.
Reoffending		Defined in this report as committing a crime after release from jail, prison or forensic hospitalization that results in either re-arrest or rehospitalization for forensic services.
Severe mental illness or serious mental illness		Defined in this report as schizophrenia, schizoaffective disorder, bipolar disorder or major depression with psychotic features.
Substance Abuse and Mental Health Services Administration	SAMHSA	Federal agency under the US Department of Health and Human Services charged with improving the quality and availability of prevention, treatment and rehabilitative services in order to reduce the impact of substance abuse and mental illness on US communities.

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The Treatment Advocacy Center is a national nonprofit organization dedicated exclusively to eliminating barriers to the timely and effective treatment of severe mental illness. The organization promotes laws, policies and practices for the delivery of psychiatric care and supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder.