

More than 11 million individuals were estimated to be living in the United States in 2018 with a diagnosable mental illness serious enough to impair their personal, social and economic functioning. Of these persons, several million entered the civil or criminal legal systems through a variety of pathways: civil commitment proceedings associated with court-ordered inpatient or outpatient treatment; petitions for involuntary medication (“medication over objection”); guardianship proceedings; criminal and juvenile proceedings resulting from arrest/incarceration; child welfare issues and others.

In any of these circumstances, a presiding judge may be required to weigh a tangle of clinical, legal and community factors in order to make an individual adjudication or other disposition. These factors are likely to include the respondent’s or defendant’s clinical history and current condition, including potential of harm to self or others; treatment proposals, including general or specific medication recommendations; governing state statutes and prevailing local practices; and available outpatient and inpatient services to fulfill any court orders. The prognosis and trajectory of the respondent or defendant may be significantly influenced by the resulting disposition.

Because the capability of any community mental health network to serve justice-involved individuals is central to the court’s disposition of adults with serious mental illness and children/juveniles with serious emotional disturbance, this Facts in Brief describes the range of psychiatric services that may be relevant and the specific populations they serve.

BRIEF HISTORY

For roughly a century beginning in the mid-1850s, mental illness treatment in the United States was delivered primarily in state-operated mental hospitals, also called “asylums.” This trend peaked in the 1950s, when the convergence of clinical, social, political and other forces led to a widespread closure of state-operated psychiatric beds, a movement known as “deinstitutionalization.”

By the second decade of the 21st century, fewer than 2% of all public mental health care clients were being treated in state hospital beds. The development of effective psychiatric medications and community-based treatments had made it possible by then for the vast majority of individuals once treated in state hospitals to live successfully in the community. Additionally, many populations once housed in state hospitals no longer were being hospitalized at all (e.g., people with epilepsy or intellectual disabilities).

Reflecting as they do local conditions such as population density, workforce adequacy, funding priorities and public support, community mental health systems today differ significantly from one location to another. Some are robust, others may be incomplete or fragmented and, in some locations, they may barely exist. Individuals with mental illness who are criminal- or juvenile justice-involved are likely to be served in settings reserved for them.

COMMUNITY POLICIES AND PRACTICES

Just like for medical conditions, the ideal community mental health network includes a complete and integrated continuum of care that includes both outpatient and inpatient services.

Outpatient

- **Primary care providers** to identify signs and symptoms of mental health conditions and prescribe/monitor psychiatric medications in their patients, whose symptoms are most likely to first be seen in a general medical care setting.
- **Outpatient mental health clinics** staffed by mental health professionals to provide ongoing psychiatric treatment. These may be supplemented by dedicated clinics or programs for populations with special needs (e.g., young adults experiencing first episodes of psychosis).
- **Case management** to coordinate all aspects of treatment and support (e.g., case workers to set up appointments, arrange transportation, etc.).
- **Home-based services** to deploy trained staff for monitoring of psychiatric status, medication support and to otherwise serve patients in their homes (e.g., Assertive Community Treatment [ACT] and Forensic Assertive Community Treatment [FACT] teams).

- **Mobile crisis teams** to provide on-site emergency response to psychiatric emergencies.
- **Day treatment** to deliver psychiatric treatment and non-clinical support (e.g., education, job training) non-residential settings.
- **Family services** to equip and support parents and other caregivers.
- **Peer services** to link patients with individuals who have similar mental health challenges and have been trained to provide support.

Inpatient/Residential

For a much smaller number of adults and youths, intensive care or supervision may be required in an overnight setting with more intensive clinical and psychiatric staffing. Generically known as “psychiatric beds,” these inpatient and community settings differ in the intensity and duration of the 24/7 services they provide and the populations they serve. This array includes:

- **Crisis stabilization beds** providing psychiatric monitoring and support outside a hospital unit for individuals experiencing a mental health emergency. Stays typically are very brief (several hours to a few days). In some communities, crisis stabilization beds may be utilized by law enforcement as an alternative to jail booking for non-violent offenders.
- **Community-based hospital beds** providing psychiatric treatment in a free-standing psychiatric facility or dedicated psychiatric unit within a general hospital for individuals with a wide range of mental health diagnoses. Stays typically are brief (overnight to a few weeks).
- **State hospital beds** providing intensive specialized treatment to individuals who typically meet state criteria for inpatient commitment. These are individuals with a serious mental illness diagnosis (e.g., schizophrenia, bipolar disorder) and often include those who are criminal justice-involved (“forensic”). Stays average longer than those in community-based hospitals and may last months or even years if an individual continues to meet criteria for court-ordered hospitalization and there is no alternative setting for appropriate care.
- **Transitional or respite beds** in residential or other settings for 24-hour non-medical monitoring and support for patients discharged from or at risk for inpatient hospitalization because of severe mental health symptoms. Stays typically are relatively brief and limited (e.g., two weeks to 30 days).
- **Long-term beds** in staffed residential environments serving populations with chronic psychiatric conditions who are not ready or able to live independently in the community.

Supported housing is often left out of the discussion of “psychiatric beds.” However, in these housing units, individuals who live independently may receive some level of mental health support and daily living assistance where they live, which functionally adds such beds to the community-based mental health service options.

SUPPORTING EVIDENCE

Characteristics and outcomes associated with outpatient psychiatric care models have been extensively studied and reported by governments, mental health providers, academic researchers and mainstream media, both in the United States and internationally. Findings may differ by location, population and other variables, but the overwhelming consensus of this body of research is that mental health clients who receive effective community-based services experience lower rates of hospitalization,

criminal justice involvement, violence and/or other negative experiences than those who do not. Every patient does not need to receive every service for the individual and community to benefit; even partial support may produce results for those who qualify.

Because research by demographic data such as age, gender, diagnosis and other critical variables is not well-developed, population outcomes may not be relevant to an individual case before the court.

With regard to inpatient treatment, definitive outcome research by model of care, diagnosis treated, duration of stay and other key variables is not well-developed. For example, there is no consensus or validation for a specific number of 24/7 psychiatric beds per capita nor an evidence-based understanding of the association between hospitalization and suicide after release. That said, data are emerging in some communities that show crisis stabilization beds may help reduce hospitalization and justice involvement associated with serious mental illness and serious emotional disturbance.



CONSIDERATIONS

In adjudicating civil or criminal cases where mental health matters are at issue, the following questions may be pertinent to case disposition:

What is the individual's psychiatric history, current condition and prognosis under current circumstances?

Which available mental health services are the best fit for this subject's needs?

Where are local services located, and will the subject be able to access them?

Are there other obstacles to the subject accessing treatment that need to be addressed if he/she is to be served and, if so, how can they be overcome?

Who will be responsible for linkages between the subject and the various systems in which he/she is engaged?



SUMMARY

Judges are routinely called upon to rule in cases where the respondent's or defendant's mental health is a central issue. Familiarity with the elements of the psychiatric service continuum that may be available for addressing these issues can be useful in the disposition of such cases.

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