

Prevalence of Untreated Severe Mental Illness in U.S. Communities Places Unmanageable Burden on First Responders and Law Enforcement



PROBLEM/ISSUE

Our nation’s public mental health system is not adequately resourced to meet the treatment needs of individuals with severe mental illness (SMI). Individuals living with inadequately treated SMI often also struggle with addictions making it essential that appropriate addiction recovery services is incorporated in all treatment plans for those with SMI. More than 11 million Americans live with a serious mental illness. Yet millions go without needed treatment and care (“New legislation”, 2015). Without treatment, many who could be living safe and productive lives instead fall into tragic circumstances of various kinds. Some withdraw from the world, harmless to others but at high risk of self-harm or suicide and vulnerable to abuse and exploitation. Others cause public disturbances, act out violently, or put others at risk of unintended physical harm. The burden of addressing inadequately treated mental illness and addictions in the community has largely fallen to first responders—law enforcement (including local sheriffs charged with jail operations), fire, medical, and emergency departments.

BACKGROUND

In a number of notorious rampage killings in recent years—Tucson, Aurora, Sandy Hook, and Isla Vista among them—first responders were called upon to put an end to the carnage. These tragic events have brought to public attention the severe stresses first responders are exposed to in the workplace due to inadequately treated mental illness. But far less understood by the public are the impacts of inadequately treated SMI to the day-to-day work of nearly every emergency department, emergency medical services agency, law enforcement agency, and fire department in the United States. Research findings make clear how great the challenges have become:

- Nationally, there are 10 times more individuals with SMI in jails and prisons than in state psychiatric hospitals (Torrey et al., 2010).
- In comparable Western countries, mental illness has been identified as a factor in 50% of all justifiable homicides committed by police (Kesic, 2013). The Treatment Advocacy Center estimated the same prevalence rate for the United States based on analysis of government statistics and anecdotal information for the years 1980–2008 (Torrey et al., 2013).
- Police agencies report spending more time responding to public disturbances involving mental illness than investigating common crimes such as burglaries or aggravated assaults (Biasotti, 2011).

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- Transportation and hospital security demands associated with SMI-related incidents consume substantial law enforcement resources, consuming more officer time than routine larceny, traffic accident reports, and domestic disputes (Biasotti, 2011).
- Across the United States, “high-volume utilizers” (i.e., members of the public who call 911 frequently) increasingly burden police officers, firefighters, and emergency medical personnel. A national literature review found psychiatric illness consistently identified as a major contributing factor to this problem (Clark, 2014).
- Opportunities to interrupt this cycle early at an early stage are often missed, resulting in costs to first responders, communities, individuals and their families.

Diverting resources and attention to address these demands has an incalculable impact on the capacity of law enforcement fire, rescue, and emergency medical services (EMS) agencies to perform the functions for which they exist, including preparing for and responding to large-scale public emergencies.

Moreover, a common outcome is the criminalization of individuals with inadequately treated mental illness and addiction. Criminalization is devastating to an individual’s prospects for recovery and avoiding recidivism. By their very nature, jails and prisons are environments antithetical to good mental health treatment. After release, a criminal record typically limits a person’s access to employment, housing, and public assistance.

DISCUSSION

Recognizing the need to divert individuals with mental illness and addiction whenever possible from the criminal justice system into the mental health system, many agencies have embraced laudable policies such as [Crisis Intervention Training \(“CIT”\)](#) (University of Memphis, n.d.), which helps equip first responders to find alternatives to arrest and incarceration for those who pose minimal threat to public safety and are clearly in need of treatment. Law enforcement has also been active across the nation in helping support [mental health courts](#) (National Center for State Courts, n.d.), which offer non-violent mentally ill criminal defendants treatment in the community in lieu of prosecution.

However, there are practical limits to what can be accomplished through diversion. Law enforcement interaction as a prerequisite for treatment reduces the potential for effective early intervention and increases risk of tragic outcomes to mentally ill individuals, their families, and the public. Even when individuals are taken safely into custody, symptomatic behavior may result in felony charges that ultimately disqualify the defendant from available diversion programs.

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For these reasons, it is essential that first-response agencies advocate strongly—in their own communities and on the state and national levels—for a *comprehensive, functional, proactive mental health treatment and addiction recovery systems*. In broad terms, the answer lies in expanding timely access to treatment so that individuals desiring treatment for their addictions and mental illness are provided that treatment within the community so that they pose no more risk of violence or criminal conduct than the general public (Rueve & Welton, 2008). The only way out of the current predicament is for the public mental health system to be provided the resources and tools to perform its intended function, so that first responders and the criminal justice system may be permitted to perform theirs.

In large part, this will require the commitment of greater public resources into community-based mental health and addiction recovery care. At minimum, such resources must include supportive housing, access to medication and medical services, intensive case management, employment assistance, and substance abuse treatment.

Many people with SMI suffer at various times from lack of insight—known clinically as “anosognosia” (National Alliance on Mental Illness, 2015)—leaving them unaware of their own illness and need for treatment, however painfully obvious it may be to observers. For these individuals, it is not enough to make treatment available; it will often be necessary to provide treatment on an involuntary basis, with the hope that, in time, insight can be restored and allow a transition to voluntary care.

Current research indicates that early community-based provision of comprehensive evidence-based mental health treatment and addiction recovery services effectively reduces burdens on the criminal justice system, first responders, and emergency departments and dramatically reduces the trauma that individuals with mental illness and addictions and their families experience (Menear et al., 2014; Patel et al., 2015). Without these services, individuals with SMI will continue to suffer needlessly with reduced prospects for recovery, unaware of their own need for treatment.

RECOMMENDATIONS

Highlighted below are several policies and practices proven to help the most challenging individuals with SMI receive the care they need to avoid further psychiatric deterioration, criminality, and/or self-harm.

Implement Assisted Outpatient Treatment (AOT)

Assisted outpatient treatment (AOT), also known as “outpatient commitment” or “court-ordered outpatient treatment,” is a civil legal procedure that allows a judge to approve an outpatient

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treatment plan for an individual with SMI and a history of treatment non-adherence and to place the individual under court order to follow the plan in the community. Assisted outpatient treatment is ordered under strict legal criteria, which in most states are targeted to mentally ill individuals whose history demonstrates difficulty adhering to prescribed treatment on a voluntary basis, with resulting hospitalizations and/or arrests.

While most people with SMI would not meet the criteria for AOT, those who do consume a grossly disproportionate share of mental health and criminal justice resources. These are the patients caught in the “revolving door,” shuttling endlessly between hospitals, correctional facilities, and the streets.

Assisted outpatient treatment is a widely recognized, evidence-based best practice to improve outcomes for many of these individuals. Multiple studies have confirmed its effectiveness in significantly reducing a number of negative outcomes among appropriate individuals served through **comprehensive** AOT that includes psychosocial, pharmacologic, housing, criminal justice, employment, and addiction services for those with SMI, resulting in reduced hospitalization, incarceration, suicide, violence, and crime (Stettin, 2014). Accordingly, AOT has been recognized by the following three organizations:

- The National Institute of Justice, Office of Justice Programs, regards AOT as an effective evidence-based practice to reduce arrests of and violent behavior by people with SMI (National Institute of Justice, n.d.).
- The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) includes AOT in the National Registry of Evidence-Based Programs and Practices (NREPP) based on studies showing reductions in hospitalization and suicide risk and improvements in patients’ perceived quality of life (SAMHSA NREPP, 2015).
- The Agency for Healthcare Research and Quality (AHRQ) identifies AOT as an evidence-based means to reduce re-admissions and length of hospital stay for mentally ill adults with multiple prior hospitalizations (Research Triangle Institute – University of North Carolina Evidence-based Practice Center, 2015).

Forty-five states and the District of Columbia have statutes permitting some form of AOT. Numerous local mental health systems across the nation are employing these laws to great effect, saving both lives and money. These systems include Bexar County, Texas; Seminole County, Florida; Butler County, Ohio; Clark County, Nevada; and New York City. But AOT is far from being the ubiquitous, standard intervention tool it needs to become. For this to happen, awareness and understanding of AOT must be raised among mental health policymakers and judges; funding and other support for AOT program start-ups and expansions must flow from local, state, and federal governments; and in the five states where no AOT programs currently exist, emergency services in those states should advocate for the adoption of such programs.

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Utilize Evidence-based Emerging Practices to Treat SMI

Other emerging early intervention for populations at risk for SMI, such as the National Institute of Mental Health (NIMH) RAISE program (NIMH, 2015) for Comprehensive Versus Usual Community Care for First-Episode Psychosis, have been shown to improve outcomes several years later (Kane et al.2011). Such programs should be part of a comprehensive continuum of care approach to reduce the burden of SMI and secondary impacts on first responder and hospital systems.

Improve Consistency of Evidence-based Inpatient Civil Commitment Standards

When an individual falls into psychiatric crisis, appropriate treatment may require a period of intensive intervention, which is normally provided in a hospital. People in this situation are often unable to recognize their own illness and need for care, and therefore it is often necessary to utilize the state’s civil commitment laws to hospitalize the person involuntarily.

At the heart of each state’s civil commitment process is a statute providing the criteria for commitment. These criteria address the question: What must be proven about a person’s condition to allow a judge to find that the constitutional right to freedom of movement is outweighed by the need for hospital care?

While there is a common belief across the United States that commitment hinges on a simple finding of “danger to self or others,” in fact the criteria vary considerably from state to state. While it is true that all states allow commitment based on a finding of “danger” or “likelihood to cause serious harm,” there are crucial differences in:

- How “danger” or “likelihood to cause serious harm” is defined
- How immediate or imminent the risk must be
- Whether there are other, alternative grounds for civil commitment available
- Whether the person’s history may be considered to provide context for evaluating his or her current condition

The most effective state commitment standards:

- Include language to explicitly cover individuals whose untreated mental illness renders them unable to meet basic survival needs. (This is sometimes known as a “gravely disabled” standard.)
- Include language to explicitly cover individuals whose untreated mental illness renders them unable to recognize their own illness and who are in need of treatment to prevent psychiatric deterioration. (This is sometimes known as a “need-for-treatment” standard.)

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- Permit a judge to commit on the basis of a substantial risk of harm in the foreseeable future, even if the imminence of such harm is unclear.
- Permit the court to consider the person’s history in assessing the likelihood of future harm, rather than basing a decision purely on the person’s apparent condition at the time of assessment.

Most states fall short of these standards in one or more respects. For example, a recent survey of civil commitment laws found that only 18 states explicitly provide a “need-for-treatment” standard for inpatient commitment (Stettin et al., 2014). Improving consistency of these laws across the nation is key to ensuring that individuals in psychiatric crisis receive adequate care.

Increase Community Continuum of Care Availability Including Sufficient Inpatient Psychiatric Beds

Even in states with adequate legal criteria for civil commitment, people with SMI often do not receive crucial stabilizing care due to an inadequate psychiatric bed capacity in most communities. A primary reason is the decades-long decline of psychiatric hospital beds.

The lack of inpatient beds forces mental health systems to allocate the beds they have to those considered the most imminently dangerous, regardless of what the law may permit. The continuous emptying of state psychiatric hospitals for the past half century, coupled with an increasing criminalization of mental illness filling the remaining state hospital beds with forensic patients who cannot be turned away, has decimated the number of psychiatric beds available for the involuntary and/or voluntary patients.

A 2012 study (Torrey et al.) underscores the depth of this troubling trend:

- Thirteen states closed 25% or more of their total state hospital beds from 2005 to 2010. New Mexico and Minnesota closed more than 50% of their beds in that period; Michigan and North Carolina closed just less than 50%.
- Closures reduced the number of inpatient beds available nationally in 2010 to 14.1 per 100,000 in population—a level not seen since 1850. A consensus target for providing minimally adequate treatment is 50 beds per 100,000. (By way of comparison, the ratio in England in 2008 was 63.2 per 100,000.)

In the absence of needed treatment and care, individuals in acute or chronic psychiatric crisis increasingly find their only access to psychiatric care to be hospital emergency departments and jails and prisons, often after engaging fire, rescue, EMS, and law enforcement services that are not the most appropriately resourced or trained to care for these community members with mental illness and addiction. This situation will continue until we resolve, as a nation, to restore the psychiatric hospital beds lost in recent decades and treat the complex psychiatric problems these patients have in a manner equal to treatment of all other medical conditions.

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Provide Adequate Funding for Mental Illness and Addiction Recovery Services

Adequate public funding should be made available for comprehensive mental illness treatment and addiction recovery services for individuals not best served through AOT yet causing similar burdens to our law enforcement, fire, EMS, emergency departments, and criminal justice systems.

Adequate funding dedicated for services that provide for the unique needs of children and adolescents at risk for SMI should be made available.

Public and private health insurance must be held accountable to be in compliance with the Mental Health Parity and Addiction Equity Act of 2008.

The scope of mental health treatment and addiction recovery services financed by Medicaid should be expanded.

Medicaid should eliminate the 190-day lifetime treatment limit. (National Academies of Sciences, Engineering, and Medicine, 2015; Menear & Briand, 2014; Patel et al., 2015).

Please contact the InterAgency Board at info@interagencyboard.us with any comments, feedback, and questions. Additional information on the InterAgency Board is available at www.interagencyboard.org.

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