# 10. Forensic Issues

**ISSUES AND BACKGROUND:**
As state hospitals are being downsized or closed, the conventional wisdom is that jails and prisons have taken their place. It is clear that people with mental illness are over-represented there. According to the National GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System <www.prainc.com>, the rates of mental health disorders are four times higher among prisoners than in the general population.

Some believe that people who commit crimes as a result of their mental illnesses should be in hospitals, not prisons — while others say prisons, not hospitals.

It is vital to consider the demographics of those who are brought into the criminal justice system and who is most likely to be convicted. For example, people who live in poverty are more likely to be in jail than those who have sufficient financial resources, and mental illness often causes poverty. Poverty also results from racism: clearly, African-American males constitute a disproportionate share of the prison population.

There are a number of issues that consumer/survivor groups seem to be examining. One is that, because a lot of people end up in jail (whether or not they have a mental illness) as a result of issues of poverty, homelessness, and unemployment, these concrete issues should be addressed instead of labeling people mentally ill. At the same time, those who strongly oppose all forms of involuntary treatment must ask themselves what to do if someone who has refused treatment ends up in jail because of behaviors directly related to his untreated mental illness.

There needs to be an effective system for assessing mental health issues for incarcerated individuals, and if mental health needs exist, non-coercive treatment models need to exist. Forcing medication on incarcerated individuals without addressing both basic resource needs and basic mental health needs is not a solution. There are also strong currents in the movement to support the concept that medication and

other psychiatric treatments should be readily available and fully financed within all correctional facilities, so that individuals who want and feel they need psychotropic medications to help them control behaviors that otherwise would get them in trouble would have those options available.

Another issue affecting people with mental illnesses in jails and prisons is that many state managed care systems automatically "disenroll" forensic consumers upon their incarceration, and have no provisions for re-enrollment upon their release.

Many people who have mental illnesses may choose a simple guilty plea over pleading Not Guilty by Reason of Insanity (NGRI) since the latter plea may result in their spending more time locked up in a hospital than they would have spent in prison by pleading guilty. (Across the country, the NGRI plea is used less than 1 percent of the time, and is successful in only 25 percent of those cases.) In addition, many people prefer not to plead Guilty But Mentally Ill (GBMI) because, while members of the general prison population are often paroled long before their sentences have expired, it is likely that people convicted as GBMI will serve their full terms, since parole boards look askance at these individuals' chances for success in the community. In addition, many feel that there are more opportunities — including education, vocational skills training and work opportunities — available in prison than in mental hospitals. (Someone taking a GBMI plea would first be sent to a hospital; then, if their illness improved, they would have to serve the rest of their sentence in prison. With an NGRI plea, they could be released. But it's difficult to get out even if someone is deemed ready for discharge, due to the lack of placements in the community.)

• • •

**FACILITATOR:**
Miriam Gershow is the resource and communication coordinator of the Office of Consumer Technical Assistance (OCTA) of Oregon, a statewide consumer-run education and outreach organization that works to increase the consumer/survivor voice throughout Oregon's mental health system. Miriam has worked with survivors of sexual abuse, homeless and runaway adolescents and youth, and homeless adults with mental illnesses. She recently presented at the White

House Conference on Mental Health, via satellite, about a partnership between the consumer movement in Portland and the police department, which has changed the way police there respond to people in crisis.

**CO-FACILITATOR:**
Mary Jadwisiak has been involved in mental health advocacy for more than 10 years. She is currently employed as the mental health ombudsman in Clark County, Washington, where she presents regular trainings on the mental health system, advocacy issues and consumer rights. As the ombudsman, she is an advocate for people accessing publicly funded mental health care. Mary served for three years as the president of the local CHADD (Children and Adults with Attention Deficit Disorder), and was on the Bridge Builders Project board. She is the owner of Voice Lessons Consulting, a company dedicated to enhancing the consumer voice within the mental health system. She is working with United Behavioral Health to design and write a consumer handbook and to provide ongoing trainings in psychiatric advance directives.