

Vera Institute of Justice

Criminal Justice Issues and Prisoners' Rights

<https://www.vera.org/blog/when-a-mental-health-guidebook-becomes-a-rulebook-society-loses>

Public Facing Advocacy Writing

I was finishing this blog post last Friday when I learned about the Sandy Hook shooting. Like many others, I spent the weekend trying to process this atrocity, the constellation of events that got us there, and the range of reactions that followed calls for reforming our nations gun laws, demands that we reexamine our mental health care system, and reminders that this is one manifestation of an epidemic of violence that plays out on street corners and in peoples homes every day. We will likely never know what could have prevented Fridays events: talk of Adam Lanzas possible mental illness or developmental disorder is speculative; [the link between mental illness and violence is extremely complex](#); and it is impossible to know what kind of regulations might have kept guns out of his hands.

There is no one right answer. But these moments compel us to think creatively and holistically about what can be done to minimize the likelihood of such horrific acts of violence in the future. As we continue these conversations in the weeks and months to come, it is essential that we remember that prevention requires that we confront these difficult questions daily, not just in the wake of tragedy.

Given my line of work, I have been particularly affected by the discussions of our countrys failure to adequately address mental illness, and our overreliance on the criminal justice system as a source of psychiatric care. While this blog by no means provides an answer to the dilemmas we are facing in the aftermath of Sandy Hook, it highlights one way that we might make mental health care more accessible to all who need it.

After years of debate, the American Psychiatric Association (APA) board of trustees approved a final set of revisions to [the latest edition of its diagnostic manual](#) (the Diagnostic and Statistical Manual of Mental Disorders, or the DSM) earlier this month. While a clinical manual may seem like a mundane subject for argument, the DSMs role as the bible of psychiatry means that any changes to its contents will affect many of the [tens of millions of people in the United States who are diagnosed with mental disorders](#) in a given year. Some of the most [controversial revisions](#) to be included in the fifth edition of the manual (the DSM-5) are eliminating Aspergers syndrome from the definition of autistic spectrum disorders and broadening the definition of depression to include bereavement symptoms of depression associated with the loss of a loved one. In the first instance, opponents of the revision fear that the change will cause those previously diagnosed with Aspergers to lose opportunities for services; in the latter example, opponents are concerned that the new definition inappropriately pathologizes a natural grieving process.

At times, however, these micro-level arguments can distract from a more fundamental debate about the relationship between DSM diagnoses and treatment. Since the first edition was published in 1952, the DSM has been a cornerstone of the mental health field, shaping the way that we conceptualize mental illness and guiding who has access to treatment. Today, Medicaid, Medicare, and most private insurance companies generally require that people receive a DSM diagnosis from a trained clinician in order to be eligible for coverage of psychiatric services, including medication. This system is not unique to the mental health care system, but is representative of our countrys diagnosis-driven approach to health care.

Yet making DSM diagnoses a prerequisite for coverage of mental health care is a distortion of the intended purpose of the manual; the last edition begins with a Cautionary Statement, which explains that the diagnostic criteria are guidelines and the DSM-IV Classification of mental disorders reflect a consensus of current formulations of evolving knowledge in our field. They do not encompass, however, all the conditions for which people may be treated.

Failing to heed this warning can yield unintended consequences for mental health practice, with the rigid link between DSM diagnoses and access to treatment placing service providers in an uncomfortable position: when a client does not fit neatly into one of the manuals diagnoses, do you assign an inaccurate diagnosis in order for the client to receive services, or do you turn the client away? These dilemmas are heightened in settings where clients are unlikely to have the means to pay out-of-pocket for mental health care and declining to provide a diagnosis may mean that the person receives no mental health support whatsoever. On the other hand, inaccurate diagnoses may lead to inflated estimates of mental health need and, for low-income communities that are already marginalized in a variety of ways related stigmatization.

These matters are further complicated by the current reality in the United States: the criminal justice system has become the nations largest defacto mental health care provider. [Recent research](#) shows that three times as many people with serious mental illness are in jails and prisons than in hospitals. For many of these people, their first and sometimes only treatment contacts take place in jails, prisons, and courtrooms. [Veras study](#) of mental health needs of arrestees in Washington, DC, found that 62 percent of cohort members with mental health needs were first identified as having such a need by a criminal justice agency. Furthermore, two-thirds of those who were first identified by a justice agency were not subsequently identified as requiring treatment services by the citys community mental health agency.

Our studys finding is a call for action to improve community mental health services for marginalized populations. In the absence of readily available community services, however, the criminal justice system provides an essential opportunity to identify peoples mental disorders and link them with treatment services that they might otherwise not receive. Yet, this opportunity could be lost if the DSM is used too rigidly as an arbiter of who should have access to services both in criminal justice settings and when they return to the

community.

Given the low rates of this populations contact with community services, it is important that the mental health field increase flexibility and remove barriers to engagement whenever possible. Reconsidering the link between DSM diagnosis and treatment eligibility is an important first step that could help reduce stigma associated with seeking psychiatric care or create opportunities for more preventive approaches to mental health care, ultimately helping people receive support before becoming entrenched within the justice system.

As we look toward the full implementation of the Affordable Care Act in January 2014, it is important to ensure that the legislations intent is realized: to increase access to healthcare for millions of vulnerable, uninsured Americans. Part of this process will be to remove barriers to treatment for those who need help, even if they do not fit into the categories defined by the APA. Increasing access to treatment for people with mental health problems has the potential to shift the locus of treatment away from the criminal justice systems and toward the community where it belongs.

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