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The Treatment of Persons with Mental Illness in Prisons and Jails:
A State Survey (abridged)

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The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey

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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.

EXECUTIVE SUMMARY

Prisons and jails have become America's "new asylums": The number of individuals with serious mental illness in prisons and jails now exceeds the number in state psychiatric hospitals tenfold. Most of the mentally ill individuals in prisons and jails would have been treated in the state psychiatric hospitals in the years before the deinstitutionalization movement led to the closing of the hospitals, a trend that continues even today. The treatment of mentally ill individuals in prisons and jails is critical, especially since such individuals are vulnerable and often abused while incarcerated. Untreated, their psychiatric illness often gets worse, and they leave prison or jail sicker than when they entered. Individuals in prison and jails have a right to receive medical care, and this right pertains to serious mental illness just as it pertains to tuberculosis, diabetes, or hypertension. This right to treatment has been affirmed by the U.S. Supreme Court.

The Treatment of Persons with Mental Illness in Prisons and Jails is the first national survey of such treatment practices. It focuses on the problem of the treatment of seriously mentally ill individuals who refuse treatment, usually because they lack awareness of their own illness and do not think they are sick. What are the treatment practices for these individuals in prisons and jails in each state? What are the consequences if such individuals are not treated?

To address these questions, an extensive survey of professionals in state and county corrections systems was undertaken. Sheriffs, jail administrators, and others who were interviewed for the survey expressed compassion for inmates with mental illness and frustration with the mental health system that is failing them. There were several other points of consensus among those interviewed:

- Not only are the numbers of mentally ill in prisons and jails continuing to climb, the severity of inmates' illnesses is on the rise as well.
- Many inmates with mental illness need intensive treatment, and officials in the prisons and jails feel compelled to provide the hospital-level care that these inmates need.
- The root cause of the problem is the continuing closure of state psychiatric hospitals and the failure of mental health officials to provide appropriate aftercare for the released patients.

Among the findings of the survey are the following:

- From 1770 to 1820 in the United States, mentally ill persons were routinely confined in prisons and jails. Because this practice was regarded as inhumane and problematic, until 1970, such persons were routinely confined in hospitals. Since 1970, we have returned to the earlier practice of routinely confining such persons in prisons and jails.
- In 2012, there were estimated to be 356,268 inmates with severe mental illness in prisons and jails. There were also approximately 35,000 patients with severe mental

illness in state psychiatric hospitals. Thus, the number of mentally ill persons in prisons and jails was 10 times the number remaining in state hospitals.

- In 44 of the 50 states and the District of Columbia, a prison or jail in that state holds more individuals with serious mental illness than the largest remaining state psychiatric hospital. For example, in Ohio, 10 ten state prisons and two county jails each hold more mentally ill inmates than does the largest remaining state hospital.

- Problems association with incarcerating mentally ill persons include:

    - Jail/prison overcrowding resulting from mentally ill prisoners remaining behind bars longer than other prisoners
    - Behavioral issues disturbing to other prisoners and correctional staff
    - Physical attacks on correctional staff and other prisoners
    - Victimization of prisoners with mental illness in disproportionate numbers
    - Deterioration in the psychiatric condition of inmates with mental illness as they go without treatment
    - Relegation in grossly disproportionate numbers to solitary confinement, which worsens symptoms of mental illness
    - Jail/prison suicides in disproportionate numbers
    - Increased taxpayer costs
    - Disproportionate rates of recidivism

- In state prisons, treatment over objection can be accomplished administratively in 31 states through the use of a treatment review committee. Such committees were originally authorized in the case of *Washington v. Harper* and upheld in 1990 by the U.S. Supreme Court. Even though this treatment mechanism is authorized in those states, it is often grossly underutilized.

- In state prisons in the other 18 states and the District of Columbia, treatment over objection requires a judicial review or transfer to a state psychiatric hospital, making such treatment much more difficult to carry out. Arkansas was the only state that refused to provide information for the survey.

- In county and city jails, the procedures for treating seriously mentally ill inmates over objection are much more varied and less clear. All counties in South Dakota and occasional counties in other states use a treatment review committee similar to that used in state prisons, and more jails could use this procedure if they wished to do so. Many jails require the inmate to be transferred to a state psychiatric hospital for treatment; since such hospitals are almost always full, such treatment does not take place in most cases.

- Prison and jail officials thus have few options. Although they are neither equipped nor trained to do so, they are required to house hundreds of thousands of seriously mentally ill inmates. In many cases, they are unable to provide them with psychiatric medications The use of other options, such as solitary confinement or restraining devices, is sometimes necessary and may produce a worsening of symptoms. Yet, when things go

wrong, as they inevitably do, the prison and jail officials are blamed. The present situation is unfair to both the inmates and the officials and is untenable.

- The ultimate solution to this problem is to maintain a functioning public mental health treatment system so that mentally ill persons do not end up in prisons and jails. To this end, public officials need to:
    - **Reform mental illness treatment laws and practices** in the community to eliminate barriers to treatment for individuals too ill to recognize they need care, so they receive help *before* they are so disordered they commit acts that result in their arrest.
    - **Reform jail and prison treatment laws** so inmates with mental illness can receive appropriate and necessary treatment just as inmates with medical conditions receive appropriate and necessary medical treatment.
    - **Implement and promote jail diversion programs** such as mental health courts.
    - **Use court-ordered outpatient treatment** (assisted outpatient treatment/AOT) to provide the support at-risk individuals need to live safely and successfully in the community.
    - **Encourage cost studies** to compare the true cost of housing individuals with serious mental illness in prisons and jails to the cost of appropriately treating them in the community.
    - **Establish careful intake screening** to identify medication needs, suicide danger, and other risks associated with mental illness.
    - **Institute mandatory release planning** to provide community support and foster recovery.
    - **Provide appropriate mental illness treatment** for inmates with serious psychiatric illness.
- A model law is proposed to authorize city and county jails to administer nonemergency involuntary medication for mentally ill inmates in need of treatment.

FINDINGS AND RECOMMENDATIONS

In 1972, Marc Abramson, a young psychiatrist in San Mateo County, California, sounded the initial alarm for what he viewed as the “criminalization of mentally disordered behavior.”[i] As California was emptying the state mental hospitals, Abramson was noting a rapid increase in the number of mentally ill inmates in the San Mateo County Jail. Reports from the California state prisons were describing a similar increase.

Forty-two years have elapsed since Abramson published his observations. The present study surveyed each state to ascertain what has happened to this trend during the intervening years.

FINDINGS

1. **How many individuals with a serious mental illness are now in America's prisons and jails?** In 2011, there were 1,382,418 inmates in state prisons.[ii] If 15 percent of them were seriously mentally ill, as discussed in chapter 3, that would make a total of approximately 207,000 state prison inmates with serious mental illness. In 2012, there were 744,524 inmates in county and city jails.[iii] If 20 percent of them were seriously mentally ill, as discussed in chapter 3, that would make a total of approximately 149,000 jail inmates with serious psychiatric disease. *Thus, the total number of prison and jail inmates who were seriously mentally ill in 2012 would total approximately 356,000 inmates*. This is equivalent to the population of cities such as Anchorage, Alaska; Montgomery, Alabama; Peoria, Illinois; or Trenton, New Jersey.

   State mental hospitals were originally built for the protection and treatment of individuals with serious mental illness. At their maximum census in 1955, the state mental hospitals held 558,922 patients. Today, they hold approximately 35,000 patients, and states are continuing to close beds to reduce that number. Since there are 356,000 inmates with serious mental illness in prisons and jails and only 35,000 individuals with serious mental illness remaining in the state mental hospitals, *there are now 10 times more individuals with serious mental illness in prisons and jails than there are in state mental hospitals*.

   However, this situation is actually worse than it appears. Because of crowded prison conditions, a few states, such as Alaska and Hawaii, send some prisoners out of state to private prisons; such individuals are not counted in this survey among their state prison populations. Likewise, prisoners from the District of Columbia who previously were housed in the Lorton Reformatory Prison were dispersed within the federal prison service when Lorton closed and also are not counted in this survey. The situation is also worse than it appears because the majority of beds remaining in the state mental hospitals are not available for all the individuals with serious mental illness who need to be hospitalized. The reason these beds are not available is because they are occupied by long-stay forensic patients and sex offenders who have been sent to the state hospital by court order. Thus, the 356,000 mentally ill inmates in prisons and jails are there by court order, and the majority of patients in state mental hospitals are there by court order. The trend toward the "criminalization of mentally disordered behavior," initially observed 42 years ago, is almost complete.

   This is a far grimmer picture than the one that emerged from the Treatment Advocacy Center's 2008 report on the criminalization of mental illness, "More Mentally Ill Persons Are in Jails and Hospitals Than Prisons."[iv] That study utilized 2004 and 2005 hospital bed data and included the psychiatric beds not only in the state mental hospitals but also in private psychiatric hospitals and on the psychiatric units of general hospitals. In practice, most beds in private psychiatric hospitals and on psychiatric units of general hospitals are not available for individuals with serious mental illness, such as schizophrenia and bipolar disorder and almost certainly not available to patients charged or convicted of committing crimes. Such patients tend to be much more difficult and expensive to provide care for, including requiring more staffing and security. They

also are less likely to have insurance coverage. The present study included only psychiatric beds in state mental hospitals, and thus the ratio of individuals with serious mental illness in prisons and jails compared to those in psychiatric hospitals is higher in the present study (10:1) than in the 2008 study (3:1).

In looking at the situation in individual states, this survey found that in 44 of the 50 states and the District of Columbia, at least one prison or jail in that state is holding more individuals with serious mental illness than is the largest remaining psychiatric hospital operated by the state. The only states for which this is not true are Kansas, New Jersey, North Dakota, South Dakota, Washington, and Wyoming. Indeed, the Polk County Jail in Iowa, the Cook County Jail in Illinois, and the Shelby County Jail in Tennessee each have more seriously mentally ill inmates than *all* the remaining state psychiatric hospitals in that state combined. In Ohio, 10 state prisons and two county jails each hold as many inmates with serious mental illness as does the largest remaining state hospital. In Michigan, nine state prisons each hold more inmates with serious mental illness than does the largest remaining state psychiatric hospital. Although the placement of mentally ill individuals into prisons is not the only cause, it is a significant contributing factor to the nationwide prison overcrowding problem. To illustrate, half a century ago in Michigan, there were 20,000 individuals in the state psychiatric hospitals and 10,000 individuals in the state prisons. Today, there are 1,000 in the state mental hospitals and 51,000 in the state prisons.[v]

2. **What is it like to be seriously mentally ill and in prison or jail?** Previous studies have reported many adverse aspects of incarceration for an individual with serious mental illness. Such individuals are often raped or otherwise victimized, disproportionately held in solitary confinement, and frequently attempt suicide. Because treatment of mental illness is often not available behind bars, symptoms often get worse, sometimes leading to self-mutilation.

   Prior to the introduction of effective medication in the 1950s, conditions for patients in state mental hospitals were often abysmal. Exposés of these conditions provided a major impetus for the deinstitutionalization of the patients and the closings of hospitals. However, by shifting the venue of these mentally ill individuals from the hospitals to prisons and jails, we have succeeded in replicating the abysmal conditions of the past but in a nonclinical setting whose fundamental purpose is not medical in nature. The present survey identified many examples of such conditions. In New York, a man with schizophrenia was in prison for 15 years, 13 years of which were spent in solitary confinement. In a Minnesota county jail, a man with schizophrenia blinded himself with a pencil while “standing naked in his cell, standing in his own feces, screaming gibberish.” In a Mississippi prison specially designed for mentally ill inmates, “rats climb over the prisoners’ beds, and some prisoners capture the rats, put them on makeshift leashes, and sell them as pets to other inmates.” President John Kennedy, as part of his proposal to close state psychiatric hospitals, promised that “the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability.” This unquestionably is not what he meant.

3. **How can prison and jail inmates be treated for their serious mental illness?** The availability of psychiatric treatment for inmates with serious mental illness varies widely from state to state and also among prisons and jails within a state. Despite many legal and other impediments to providing such treatment, this survey found that the administrators of many prisons and jails have undertaken impressive efforts to provide appropriate psychiatric treatment. Treating mentally ill inmates who are aware of their illness and will voluntarily accept treatment is comparatively easy. The real problems come from mentally ill inmates who refuse treatment because they believe they have no awareness of their illness and believe they are not sick (i.e., suffer co-occurring anosognosia).

Prison treatment. This study found that, in 31 states, a seriously mentally ill inmate can be involuntarily treated when the inmate's mental illness meets state-specific criteria and a small treatment review committee of prison officials, including a medical professional, is convened to review the case. This procedure is authorized by a legal case originating in Washington State (*Washington v. Harper*), as described in chapter 2 and upheld by the U.S. Supreme Court. The states in which a *Washington v. Harper* committee can authorize involuntary treatment are the following:

Alabama	Kentucky	Oklahoma
Alaska	Michigan	Oregon
Arizona	Mississippi	South Dakota
Colorado	Missouri	Tennessee
Connecticut	Montana	Texas
Delaware	Nebraska	Utah
Georgia	Nevada	Washington
Idaho	New Jersey	West Virginia
Illinois	North Carolina	Wyoming
Indiana	North Dakota	
Kansas	Ohio	

In addition to these 31 states, available public information suggests Arkansas may also use this committee procedure. Because Arkansas was the only state that refused to provide information to the survey, this could not be verified. It is important to add, however, that even though a state *authorizes* the use of a treatment review committee, state prisons may not actually *use* this procedure.

States that authorize the use of a treatment review committee provide at least a theoretically reasonable approach for the use of involuntary treatment for seriously mentally ill inmates who meet specific criteria. For the other 18 states and the District of Columbia that do not authorize the use of a treatment review committee, the involuntary treatment of mentally ill inmates in state prisons is more difficult. These include the following:

California	Maryland	Rhode Island
District of Columbia	Massachusetts	South Carolina
Florida	Minnesota	Vermont
Hawaii	New Hampshire	Virginia
Iowa	New Mexico	Wisconsin
Louisiana	New York	
Maine	Pennsylvania	

Of these, in five states and the District of Columbia, the involuntary treatment of mentally ill prisoners can take place only by court order, by the court appointment of a guardian, or by the transfer of the mentally ill inmate to a state mental hospital. The last is especially problematic because most state mental hospitals are continuously full, so no beds are available. Thus, such individuals languish in prison for weeks or months, untreated. Those states in which involuntary treatment of inmates is most difficult are the following:

District of Columbia	Maryland	Pennsylvania
Iowa	New York	South Carolina

County jails. Procedures vary widely by county and are often applied ad hoc without any formal policy or procedure. South Dakota is the only state that has authorized the use of a treatment *Washington v. Harper*-type review committee for the county jails in that state. One or more individual counties in Utah and Washington also authorize the use of treatment review committees. In the majority of states, there appears to be no legislation to prohibit the use of treatment review committees by jails, making this mechanism one that could be developed and utilized by counties. However, a majority of counties specify that seriously mentally ill jail inmates must be transferred to state mental hospitals before involuntary treatment can take place; this, of course, means that such treatment rarely occurs, and inmates continue to be seriously mentally ill in jail, often with worsening symptoms over time.

Given the many legal difficulties in providing adequate treatment for individuals with serious mental illness in prisons and jails, it is not surprising many of them, including those who are most severely ill receive no treatment whatsoever. This leaves corrections officers with few options for controlling the mentally ill inmates' psychotic, often violent behavior. One option is to use seclusion, which often makes the inmate's mental illness worse. Changes to restrict the use of seclusion for mentally ill prisoners was recently introduced in Colorado and New York State as well as in New York City.An alternative approach to controlling inmates experiencing psychiatric symptoms that make them violent is to use pepper spray on them. This tactic, too, has come under fire, and authorities in California in 2013 drafted new rules to limit its use. Some prisons and jails have resorted to restraining devices, but their use has been less common since a mentally ill inmate in the Utah State Prison died after being confined in a restraining chair for 16 hours.

In summary, we have placed more than 300,000 severely mentally ill individuals in prisons and jails that are neither equipped nor staffed to handle such problems. We subsequently have made it very difficult to treat the mentally ill inmates, put restriction on other options for controlling their behavior, and then blamed the prison and jail administrators when they fail. It is a situation that is grossly unfair to both the inmates and the corrections officials and should be the subject of public outrage and official action.

The survey thus demonstrates that the transinstitutionalization of seriously mentally ill individuals from state psychiatric hospitals to state prisons and county jails is almost complete. From the 1830s to the 1960s, we confined such individuals in hospitals, in large part because there were no effective treatments available. Now that we have effective treatments available, we continue to confine these individuals but in prisons and jails where the treatments are largely not available. We characterize seriously mentally ill individuals as having a thinking disorder, but surely it is no worse than our own.

RECOMMENDATIONS

All recommendations for improving the situation begin with the general premise that individuals with severe mental disorders who are in need of treatment belong in hospitals, not in prisons and jails. The present situation suggests that the public mental illness treatment system is broken. Thus, the ultimate solutions to the problems presented in this report include having an adequate number of public psychiatric beds for the stabilization of mentally ill individuals and involve a fundamental realignment of the public mental illness treatment system in which public mental health officials at the state and county level are held responsible for any failure of the treatment system. Until that is done, the following are some interim recommendations.

1. **Provide appropriate treatment for prison and jail inmates with serious mental illness:** Decisions by the U.S. Supreme Court have affirmed that prisons and jails have a duty to provide medical care to individuals in their custody. Just as inmates should be treated for tuberculosis, diabetes, and hypertension, so also should they be treated for schizophrenia, bipolar disorder, and major depression.

   The capacity to provide appropriate treatment will vary widely. Treatment issues for a state prison with several hundred long-term prisoners with schizophrenia are obviously very different from those for a small, rural county jail that is asked to hold an individual who is acutely psychotic while awaiting transportation to a state hospital.

   To lay the foundation for appropriate treatment existing state laws need to be amended, as necessary, to require provide for such treatment. Providing a centralized, comprehensive source of information about the state of existing laws for each state is a major goal of this report and its publication on the TACReports.org website. A model law (below) is also provided to inform changes to state laws as needed.

Another aspect of providing appropriate treatment is the administration of psychiatric medication. This can be done by a nurse or other healthcare professional, and the issues are thus similar as for the administration of medication for other diseases. Some states have provisions in their laws stating that involuntary medication can be given only in a hospital setting, but this is not necessary.

A major issue is the availability of specific psychiatric medications, many of which are expensive. In many cases for individuals who have just been incarcerated, the family of the mentally ill inmate will bring the medication he/she is on to the jail. Some jails refuse to accept such medication because of fears of legal liability. Laws should be written in such a way that corrections officials are legally protected under a "good faith" provision. The officials may reject the medications, however, if they are stimulants, benzodiazepines, or the antipsychotic quetiapine (Seroquel), all of which can be used as drugs of abuse, or if the officials suspect that the drugs being offered may be street drugs.

2. **Implement and promote jail diversion programs:** The use of mental health courts and crisis intervention team (CIT) policing has proven to be effective in diverting mentally ill persons from incarceration, but their use by the states varies widely. In states such as Utah, Arizona, New Mexico, and Connecticut, these programs are comparatively widespread, whereas in states such as Iowa, Mississippi, West Virginia, and Arkansas, they are virtually nonexistent. If we want to reduce the criminalization of mental illness, utilizing these proven diversion techniques is an obvious place to start. For an assessment of program availability in all the states, see "Prevalence of Mental Health Diversion Practices: A Survey of the states" published by the Treatment Advocacy Center in 2013.[vi]

3. **Promote the use of assisted outpatient treatment (AOT):** Assisted outpatient treatment (AOT) to assure treatment delivery to at risk individuals with mental illness while they continue living in the community is available in 45 states and the District of Columbia but is markedly underutilized. The Department of Justice has deemed AOT an effective and evidence-based practice for reducing crime and violence and where it has been actively implemented, AOT has proven to be very effective in reducing the time mentally ill individuals spend in jail. In North Carolina, a randomized study reported that patients "with a prior history of multiple hospitalizations combined with prior arrests and/or violent behavior" had a reduction in arrests from 45 percent to 12 percent in one year while participating in AOT.[vii] In New York, the percentage of mentally ill individuals arrested decreased from 30 percent prior to receiving AOT to five percent while in the state's "Kendra's Law" program, and the percentage of those incarcerated decreased from 23 percent to three percent while on AOT.[viii] In both studies, court-ordered outpatient treatment was also accompanied by a major reduction in alcohol and drug abuse. And in a small pilot study in Nevada County, California, the use of AOT reduced jail time for the seriously mentally ill persons in the program from 521 days to 17 days, a 97 percent reduction.[ix] In these contexts, AOT can be regarded as another type of jail diversion.

4. **Encourage cost studies:** One of the driving forces behind the closure of state mental hospitals and subsequent transinstitutionalization of mentally ill individuals from hospitals to prisons and jails has been a belief that it saves money. The daily cost of care for jail and prison inmates can appear to significantly less expensive than the daily cost of care in a state mental hospital. However, such comparisons omit many costs, including the higher costs of mentally ill inmates; the longer incarcerations of inmates with mental illness because of the time often required to restore their sanity sufficiently to try them in a court of law; the higher rate of recidivism among mentally ill inmates; and the high cost of settlements and awards resulting lawsuits following inmate suicides and self-mutilation. Cost assessments that identify the comprehensive expense of incarcerating mentally ill individuals would provide public officials with a more accurate basis for making mental illness treatment policy and unmask cost savings that are illusory.

   The least expensive option of all, of course, is to make sure seriously mentally ill individuals receive proper psychiatric care in the community so they do not end up in jails or prisons. For example, a study in Florida followed 4,056 individuals with schizophrenia or bipolar disorder for seven years following their discharge from psychiatric hospitalization. Those who remained on medication were significantly less likely to be arrested and cost the state 40 percent less in total care costs over the seven-year period.[x]

5. **Establish careful intake screening:** One of the most effective ways to minimize problems associated with mentally ill individuals in prisons and jails is to identify the potential problems at the time the individual enters prison or jail. A variety of screening techniques are available; all should include an assessment of suicide potential and the person's medication history. The American Psychiatric Association has established guidelines for serving mentally ill individuals in prisons and jails that describe some alternatives.[xi,xii]

6. **Mandate release planning:** For all mentally ill inmates being released from prison or jail, a written plan for psychiatric follow-up should be developed. Studies have suggested this presently happens in only a small percentage of cases.[xiii] One recent study reported that inmates with serious mental illness who were released from prison without follow-up treatment were almost four times more likely to commit another violent crime compared to mentally ill inmates who were given treatment after their release.[xiv] Included in the plan should be identification of the organization specifically responsible for the person's psychiatric care. This responsibility could be assigned, for example, to the mental health center or to the prison or jail system along with funding to discharge this responsibility. The important point is that some agency or organization must be specifically assigned responsibility for psychiatric follow-up and then held accountable.

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