

When family caregivers, neighbors, employers and others in the community engage with individuals experiencing acute psychiatric symptoms, they often call 911 on the assumption that law enforcement involvement will result in treatment for the crisis. This pattern has set the stage in recent decades for law enforcement to emerge as the nation's mental health responders of first resort. Although alternative crisis services are currently expanding, an estimated 2 million individuals with mental illness are arrested in the United States in a typical year, most of them for non-violent offenses. Correctional facilities today house more people with mental health disorders than any other institutional setting in America. Inevitably, this has rendered the courts a required stop on the route from the community to incarceration for a compromised population.

This *Mental Health Facts in Brief* provides an orientation to circumstances that have led jails to be used as therapeutic settings for individuals with mental illness who become criminal justice-involved; the distinctions between true therapeutic settings and the realities of jail mental health care; and clinical outcomes related to their use. Alternatives to correctional settings for individuals who enter the criminal justice system as a result of unaddressed mental health conditions are identified.

BRIEF HISTORY

In colonial America, individuals considered to be “mad” or “lunatic” but not violent were typically housed at home with their families or sent to “almshouses” for the poor. Those considered violent were sent to prisons and jails. By 1694, the Massachusetts Bay Colony passed legislation authorizing incarceration for any person “lunatic and so furiously mad as to render it dangerous to the peace or the safety of the good people for such lunatic person to go at large.”

Over the next century, the model of incarcerating individuals with mental illness increasingly came to be regarded as inhumane, and a shift began to house the population in therapeutic settings where peace, care and protection were the purpose. In 1752, the first dedicated hospital psychiatric ward was opened, followed about 20 years later by the first psychiatric hospital dedicated exclusively to individuals deemed to be “insane.” By the middle of the 1800s, the widespread construction of “asylums” for individuals

COMMUNITY POLICIES AND PRACTICES

In the 2011 landmark case of *Brown v. Plata*, the US Supreme Court upheld lower court rulings that prison overcrowding in California violated the Eighth Amendment of the Constitution by depriving inmates of needed and sufficient medical and mental health care. This ruling, along with similar Fourteenth Amendment guarantees for pretrial inmates, has intensified pressures on correctional systems to provide more therapeutic approaches to individuals with mental illness and other behavioral health disorders who enter the criminal justice system.

However, therapeutic and correctional settings exist to serve fundamentally different purposes, a distinction that is often lost in the panic and sense of helplessness that leads to a 911 call and the absence of easily accessed alternatives in the community. Therapeutic settings focus on policies, practices and an environment that prioritize care and treatment in the best interest of the individual. Jails are required to provide community-level mental health screenings, assessments and care, but their overarching focus is to provide custody and security in the interest of public safety. Practices such as individual psychotherapy that might be common and desirable in the community may not be feasible in a jail setting.

A number of organizations have developed standards, training programs and other resources designed to improve inmate conditions and outcomes in correctional settings. The National Commission on Correctional Health Care (NCCHC), for example,

with psychiatric conditions led to a separation of populations, with criminal inmates going into correctional settings and people with mental illness going to hospitals. The 1880 federal census found only 397 “insane persons” in prisons and jails, less than one percent of the entire US jail and prison population.

Prevalence rates of mental illness in jails and prisons remained in low single digits for decades. By the mid-20th century, however, state psychiatric hospitals were themselves coming under criticism for their conditions and practices. At the same time, medications were being introduced that allowed individuals with severe psychiatric disease to live safely in the community. States began reducing their psychiatric hospital beds, a policy known as “deinstitutionalization.”

In the decades since, the population of mentally ill inmates in jails and prisons has risen dramatically. Though the causal relationship between deinstitutionalization and the growth of this population is a subject of ongoing controversy and debate, surveys indicate as many as 40% of males and a staggering 68% of females arrive in jail with a previously diagnosed mental health condition. Similar overrepresentation is seen in the juvenile justice system. Such data have led in recent years to characterizations that mental illness is being criminalized and to renewed calls for the affected population to be returned to more therapeutic settings.

has established measurable standards under which correctional facilities may earn accreditation for the quality of their health care in general and mental health and substance use treatment in particular. The NCCHC, American Correctional Association, National Institute of Corrections and other federal and state-level organizations provide educational programs and technical assistance to inform and improve therapeutic quality, and the Federal Bureau of Prisons has published guidelines for classifying and responding to inmate medical and mental health conditions and needs in federal facilities.

The purpose of such guidance is generally to promote screenings for conditions that require clinical attention (e.g., suicide risk) and to promote therapeutic practices in carceral settings to address them. Relevant practices include crisis response, medication therapy and the engagement of mental health professionals to support individuals in need. Guidelines also encourage inmate release planning and referrals to community-based mental health and substance use services, including medication therapy.

Ultimately, however, even with the best of treatments within them, jails are not therapeutic settings. Even when budgetary or mental health resources are robust, correctional officials are challenged to maintain course on therapeutic and correctional tracks at the same time. Efforts to change this dynamic often rely on pre-arrest diversion strategies to reduce the number of individuals in mental health crisis who reach the jails to begin with and mitigation strategies to reduce the impacts of incarceration on those who do end up behind bars. Diversion tactics include de-escalation training to better equip law enforcement to handle mental health crisis calls, mobile response teams that may include mental health professionals with law enforcement, and crisis intervention centers where detainees in crisis can be taken instead of to jail. Mitigation strategies include reforms to bail practices and to practices surrounding competency-to-stand-trial systems, both of which aim reduce the amount of time disordered individuals spend in jail before coming to trial.

Realistically, communities often are not equipped to effectively divert persons with mental illness away from jail or to mitigate the impact of incarceration on them, a gap that is likely to perpetuate current trends. While it does, this population will continue to experience longer and more restrictive incarcerations than unaffected inmates.

SUPPORTING EVIDENCE

Studies, surveys of clinical and correctional professionals and anecdotal evidence overwhelmingly find that individuals with untreated mental illness fare poorly during incarceration. If untreated or undertreated, they often create behavioral management problems for the institutions housing them, disturbances to other inmates and staff and significant taxpayer costs. Rendered vulnerable by their symptoms, they may be unable to advocate for themselves and are easily victimized. They are less likely to obtain bail and more likely to break rules, leaving them at risk for longer incarceration than unaffected inmates and contributing to jail/prison overcrowding. They are more likely than other inmates to be held in isolation and, if symptoms worsen without therapeutic supports, at heightened risk to injure or kill themselves. Once released from jail or prison, they are often sicker than when they arrived. Back in the community, they are at high rates for re-arrest, re-incarceration and even death. All the while, abundant evidence exists to confirm that effective treatment for psychiatric disease or substance use disorders improves outcomes.

State and local governments and correctional officials are keenly aware of these challenges and have funded, trialed and implemented a wide variety of clinical, operational, even architectural measures in efforts to improve the therapeutic qualities of jails and prisons. In a 2016 survey, more than half the sheriffs' departments that responded had implemented housing or staffing changes to accommodate seriously mentally ill inmates. Most recently, large numbers of non-violent inmates were released into their communities to reduce coronavirus infection rates, an action with therapeutic intent. However, it remains to be reported whether mentally ill inmates were released in proportion to their numbers and how they fared when released to communities where outpatient supports had been curtailed by the pandemic.

JUDICIAL CONSIDERATIONS

People with mental health disorders introduce unique and complex issues to the judges they appear before. Adjudicating their cases should involve consideration of the following questions, among others:

- *Are alternatives to incarceration available that would address public safety needs and at the same time support therapeutic goals? Alternatives might include transfer to a medical or psychiatric crisis facility, release to home with support from community services while awaiting trial, competency assessment and/or restoration in the community and others.*
- *Are there local or state standards that set minimum criteria for access to treatment during the incarceration of this defendant?*
- *Is the jail staffed and equipped to meet these standards and inmate treatment needs? If not, what alternatives exist to improve conditions for inmates with serious mental illness?*
- *Is the community resourced to support re-entry after incarceration and reduce the risk of re-arrest?*
- *Is the individual currently in treatment, including medication treatment? What can be done to maintain that treatment during incarceration and upon release?*
- *If the individual is not in treatment or medicated, what are the protocols for assuring they receive medication in jail, address medication refusals and alert the jail staff to signs of suicide risk?*

SUMMARY

Jails and prisons today house more individuals with mental illness than any other institutional settings in America. These individuals have a constitutional right to health care while incarcerated, but correctional settings are not designed to be therapeutic. Judges are in a unique position to facilitate treatment as part of case disposition. Given the superior outcomes for individuals who receive appropriate treatment for mental health disorders, embracing this opportunity is likely to produce better results for affected inmates, the system and the community in general.

RESOURCES

- Grob GN. *Mental institutions in America*. New York: Free Press (1973).
- Torrey EF et al. *The treatment of persons with mental illness in prisons and jails: A state survey*. Arlington, VA: Treatment Advocacy Center (2014). Retrieved from <https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf>
- Massoglia M & Pridemore WA. "Incarceration and health." *Annual Review of Sociology* (vol. 41, 2015, pp 291-310). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6124689/> Accessed 1 Oct 2021.
- AbuDagga A et al. *Individuals with serious mental illnesses in county jails: A survey of jail staff's perspectives*. Washington, DC: Public Citizen's Health Research Group and the Treatment Advocacy Center (2016). Retrieved from <https://www.treatmentadvocacycenter.org/storage/documents/jail-survey-report-2016.pdf>.
- National Commission on Correctional Health Care. https://www.ncchc.org/search-results?search_term=mental+health&go= Accessed 1 Oct 2021.
- American Psychiatric Association. *Psychiatric services in correctional facilities* (3rd edition). Washington, DC: American Psychiatric Press (2015).

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