



# Prisons & Jails are North Carolina's New Mental Hospitals

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*We have regressed to the late 1800s...*

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In less than 200 years, we have taken mentally ill individuals who were in jails and prisons and transferred them to mental hospitals. Then, mental hospitals downsized, forcing the mentally ill individuals back to jails and prisons. Just since 2001, State hospitals have cut resident beds by 60%. At that time, there were 1904 beds. In 2009, the number was reduced to 770. In 2006, NC Prisons had a resident population of 5,513 severely mentally ill inmates with a reported growth trend of 400 mentally ill inmates per year. Assuming the trend has continued until 2009, the population has grown to 6,183. If you are severely mentally ill in NC, odds are 8 to 1 that you will be in a prison bed instead of a state psychiatric hospital bed. Note that many more people with mental illness are incarcerated in County jails across the state. It is inhumane to deny treatment to helplessly ill individuals causing them to become incarcerated.

## **Executive Summary**

North Carolina was behind most other states in “transforming” the public mental health system. The system provided long term residential care for almost 2,000 people, including court-order, forensic patients. In 2001, the Mental Health Reform Act was passed and the state began to quickly move long term residential patients into the community, citing the Olmstead Act as impetus for the move. By 2009, the state had reduced the resident population in state hospitals to 770, a reduction of more than 60%. Although lessons learned in other states as reported by Swartz and Morrissey in 2003 indicated that most had failed to fund care in the community (1), NC continued to move forward rapidly before community services were in place. During the same period 500 community psychiatric hospital beds also closed. The impact of these psychiatric bed closures followed patterns in other states—the population of inmates with mental illnesses began to climb. The NC Department of Corrections reported that during the years 2002 – 2006 there has been a steady increase in the number of inmates diagnosed with mental disorders. “On average, the Department has had approximately 400 more inmates per year in prison at years end with a mental health issue than would be expected by growth of the population alone.” Just comparing the category of severely mentally ill (SMI) inmates as opposed to inmates with a mental health concern, The DOC study found that there were 5,513 with an SMI diagnosis. Given the growth trends, it is clear that many more people with mental illness are being incarcerated in prisons than are being treated and rehabilitated in state mental hospitals.

### **INSTITUTIONALIZING THE MENTALLY ILL Part I. Mental Institutions**

In the early years of our county, the mentally ill were placed into jails and prisons, out of sight of the common citizen. While there, they were often mistreated and lived in filth. Louis Dwight, a Congregationalist minister in Massachusetts, was shocked by what he saw, and began to advocate for them to receive better treatment. In response to Dwight’s advocacy, in 1827 the Massachusetts state legislature enacted recommendations that confinement in jails of mentally ill persons be made illegal and that those in jails be transferred to hospitals. Shortly thereafter the legislature approved the erection of the State Lunatic Asylum at Worcester for 120 patients (2).

The most famous and successful advocate for the mentally ill was Dorothea Dix. Her personal outcry to the state legislatures resulted in many new state mental hospitals, including the one we are honored to have here in the state of North Carolina. These institutions provided safe asylums for those who deeply troubled and disturbed over the years, through the Civil War, the Great Depression of the 1930s, World War I, World War II, Korea Conflict, Viet Nam War, and other major economic and social jolts to our citizenry. The public and the political leaders saw the need to protect and treat the residents with dignity and respect and funding was always provided to serve their needs.

In 1850, largely as a result of efforts by Ms. Dix, there was one public psychiatric bed for every 5000 people in the population(3). Those with mental illness were mostly kept out of the prisons and jails for over one hundred years, even though. These individuals were treated as patients, not as criminals, and were sent to mental hospitals, although the hospitals had little treatment to offer them at that time.

In 1950 there was approximately 1 public psychiatric hospital bed available for every 300 people in the population (4). Deinstitutionalization (closing of the mental hospitals) began in the mid-1950s starting in California, as a way to conserve public funds. It is now extremely difficult to find a bed for a seriously mentally ill person who needs to be hospitalized. In 2004 there were slightly over 100,000 psychiatric beds available in public and private psychiatric hospitals and in the psychiatric units of general hospitals. This equates to one psychiatric bed for every 3,000 Americans (5). An individual with a serious mental illness was 10 times more likely to find a psychiatric bed for treatment in 1955 than in 2004.

Currently there is less than one bed available for every 3,000 people, including the beds in private psychiatric hospitals and on the psychiatric units of general hospitals. In fact, many beds in these latter units are not really available to individuals with serious mental illnesses, because most such individuals do not have insurance to cover the costs. Therefore, the situation faced by individuals with serious mental illnesses today is remarkably similar to individuals with serious mental illnesses in the 1840s—a shortage of psychiatric beds and an abundance of jail and prison cells.

The situation in North Carolina has paralleled the national trend. However, since reform began, North Carolina has reduced the number of public psychiatric beds over 50 percent. Prior to reform taking place, North Carolina lost approximately 500 general hospital psychiatry bed under private sector managed care. (1) Since reform began, there has been an additional reduction of over 300 community psychiatric beds. The reduction in number of available psychiatric beds has had a dramatic effect on the number of persons served. For example, in FY2001, the state served 17160 persons. In FY2009, the state served only 9643. Adjusted for population, at the beginning of the 21<sup>st</sup> Century, North Carolina was providing a service rate of 205 persons/100,000 population. Today, that service rate has dropped by about 50% to 103 persons/100,000 population.

Closing the public psychiatric hospital beds has been argued as being the right thing to do (free the individual to live in the community), and not just a cost-saving policy. It was thought that by closing the public psychiatric hospital beds, the funding could be used to build community support programs. However, as questioned by Drs. Swartz and Morrissey in 2003, “The most fragile piece of the financing plan is bridge funding. System reform is a promise: closure of state hospital beds will be used to fund new comprehensive community services. Stakeholders must accept this promise as they anxiously watch the closure of safety-net hospital beds. In far too many states, this promise has collided with state fiscal shortfalls—beds are closed but new community treatment capacity has not been realized.” (1) Add North Carolina to the list of states that tried to

make this fiscal equation work only to realize that balancing the fiscal budget trumps mental health services to their residents. Stakeholders were naïve to assume that this would be a promise kept.

The lack of resources for developing an adequate system of community support for those with mental illness has a major ramification for the Federal Olmstead Decision which requires states to place individuals with mental disabilities in community settings, rather than in institutions provided that the following three conditions are satisfied: 1) whenever treatment professionals determine that such placement is appropriate; 2) the affected person does not oppose such placement; and 3) the state can reasonable accommodate the placement, taking into account the resources available to the state and the needs of others with disabilities. From an advocate's position, the state is responsible for the individual, and if that means institutionalizing the individual when community supports are not in place, then the person should not be released into the community. Otherwise, the state would be liable if the individual should suffer some harm as a result.

## **Part II. Prisons and Jails**

It should be clear to all that the intent of the Olmstead Decision was not to trade off treatment in mental hospitals with incarceration, yet that is what has happened across the U.S. and in North Carolina. However, one tragic outcome of reducing the number of public and private psychiatric beds is that many of the affected individuals become re-institutionalized in our prisons and jails. This was first observed in California where deinstitutionalization began 20 years before the Olmstead Decision. Within 15 years it became evident that those with mental illness were flooding the jails and prisons in California, with one sheriff saying that there were at least 10 times more people with mental illness in his jail than what he had 10 years earlier.

The trend of increasing numbers of those with mental illness ending up in the criminal justice system has been documented across the United States. One study has documented that in less than 30 years, the percentage of seriously mentally ill prisoners has tripled. In 2000 the American Psychiatric Association estimated that about 20 percent of prisoners were seriously mentally ill, with 5 percent actively psychotic at any given time (6). Similar results were reported in 2002 by the National Commission on Correctional Health Care (7), in 2003 by the Human Rights Watch (8) and in a 2006 Department of Justice survey (9). In a report by the Treatment Advocacy Center, the authors concluded that in the United States there are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals (5). We have thus effectively

returned to conditions that last existed in the United States in the 1840s at the time of Dorothea Dix.

Jails and prisons are not created to be *de facto* mental hospitals. They are not structurally appropriate for severely mentally ill patients, and the staffs are not recruited as psychiatric caretakers. It costs more to take care of mentally ill inmates. For example, Texas has estimated the average cost to be about \$22,000/year, but mentally ill inmates costs from \$30,000 to \$50,000 a year. Medication costs are a significant portion of the increased costs. Another identified problem relates injuries associated with treatment by other prisoners or staff while in prison. (10) For example, consider the following report provided by Gary Hunter of the Charlotte News and Observer.

Timothy E. Helms remains paralyzed from the neck down following a confrontation with guards after he lit a fire in his cell at North Carolina's Alexander Correctional Institution in Taylorsville. The next day, on August 4, 2008, Helms arrived at Catawba Valley Medical Center in the back of a squad car, suffering from what Dr. Jon Giometti described as extreme blunt force injuries.

"The patient has [welt] markings consistent with [being] struck by a Billy club across his upper extremities. Across his trunk, he has contusions on the chest wall as also on the back consistent with multiple blows from a Billy club," Dr. Giometti wrote.

A CT scan revealed hemorrhaging in Helms' brain stem and bleeding in both temporal lobes, as well as a broken nose and fractured skull. Helms said in an interview that guards had beat him and slammed his head into a wall while he was handcuffed and shackled. He also said he was restrained with a collar and leash, like a dog. Staff at the Alexander facility had been ordered to discontinue the use of nylon leashes to control prisoners in 2006.

Helms, who has an IQ of 79, is accused of setting fire to his cell and becoming combative when guards tried to extract him and extinguish the blaze. During his 14 years in prison he had amassed 125 disciplinary cases and cut himself repeatedly.

Now largely paralyzed, Helms is incontinent and unable to walk or feed himself. Helms remains in prison, serving three life sentences for a 1994 DUI accident that left three people dead. He has regained some use of his limbs through physical therapy, and faces criminal charges for setting the fire in his cell.

A question comes to mind about how likely is it for a seriously mentally ill person to receive treatment in a psychiatric hospital versus being admitted into the criminal justice system under some legal infraction? The Treatment Advocacy Center looked at this question using data for FY2004 and came up with the odds for all 50 states was 3.2 to 1 that they would be in a jail or prison versus a psychiatric hospital. In North Carolina, the odds were 3.5 to 1. Obviously these odds would be much higher today after the major reduction of community and state psychiatric beds (5).

The Division of Prisons in North Carolina has also looked into the growing impact of the mentally ill population (11). They examined prison records from 2002 – 2006, shown in Table 1, and observed that "the growth in the numbers of inmates with a mental health condition has outpaced growth in the overall prison population." Average growth of the population with mental illness was calculated to be about 5% per year. Diagnoses of severe mental illness (SMI) were made for 5513 inmates in 2006, or 14.6% of the prison population. This percentage is up from 12.7% in 2001(11).

By extrapolating the population of inmates by 3 percent per year (the latest reported average inmate population growth), it can be estimated that the total number of prison inmates in 2009 is 41222. Using an estimate of 15% of the prison population with SMI, there were approximately 6200 inmates with SMI. This means that there is an odds ratio of 8 to 1 that you will be in a prison bed instead of a state psychiatric hospital bed. if you have SMI.

Table 1. Mental Health Status of Inmates in Prison at Year End: 2002-2006

Year	Mental Health Concern		No Mental Health Concern		Total Number	Percent with MH
	Female	Male	Female	Male		
2002	1249	9035	948	21866	33098	31.1
2003	1314	9469	983	22143	33909	31.8
2004	1474	9949	992	23338	35753	31.9
2005	1539	10166	1091	23814	36610	32.0
2006	1580	10553	1141	24450	37724	32.6
<b>Change</b>	<b>331</b>	<b>1518</b>	<b>193</b>	<b>2584</b>	<b>4626</b>	
<b>% Change</b>	<b>26.5</b>	<b>16.8</b>	<b>20.4</b>	<b>11.8</b>	<b>14.0</b>	

NC Department of Corrections also analyzed FY 2005/06 correctional program evaluation data and found that there was a higher percentage of prisoners with mental health problems who had infractions while incarcerated (54.4%) when compared to prisoners with no mental health problems (41.7%). As shown in Table 2, they also found that prisoners who had mental health problems had a greater number of infractions when compared to prisoners with no mental health problems (11).

Table 2. Average Number of Infractions During Incarceration by Mental Health Status (For Prisoners with Infractions)

Time Served	0-4 Months	5-8 Months	9-24 Months	25 or more Months	Overall
Prisoners with Mental Health Problems	2.1	2.7	4.5	11.8	6.5
Prisoners without Mental Health Problems	1.7	2.2	3.3	6.8	3.4

## Discussion

A brief review of the two public institutions providing “treatment” for North Carolina’s mentally ill population demonstrates that our public policy of caring for the mentally ill has shifted from that of an asylum where people were treated with care, dignity and respect back to incarcerating them, locked up from the rest of humanity. In today’s technological world with all its advances, we as a society

have chosen to step backwards in time with respect to those with this horrible illness and lock them up with murders and rapists, instead of listening to their cries for help and providing them a bed and hope for recovery. Representative Verla C. Insko said in an article about the new mental health reform in 2003:

“Most advocates and providers alike worry that legislators will peel off savings to support other programs or to provide tax cuts rather than build community capacity. All those who care about these populations must work to prevent any one of these scenarios.” (12)

About the same time, then Lt. Governor Beverley Perdue at a NC Institute of Medicine annual meeting said the following:

“The biggest problem facing mental health in North Carolina is that no one in the General Assembly has been carrying water for mental health.” (1)

Mental health reform in North Carolina, as in other states, has not worked. Stakeholders have tried and have failed to provide input into the change process, but they had no influence. Legislators did not carry water for those with mental illness. While we are all blaming each other for this failure, a tornado is sweeping across the state resulting in loss of lives, loss of hope for recovery, and added pain and burdens for those who do not want this illness as they wait days, weeks, and even months for an available psychiatric hospital bed. Meanwhile those that can wait no longer and give up waiting for treatment are being incarcerated where they have no freedom and are victims to what befalls them while there.

We always find money for building new prisons and jails and add staff to watch over them. Maybe when the last person is transferred out of Dix, a spokesperson from the NC Department of Corrections will announce something like the following, which actually happened in New York (only substituting “Dix” for “Marcy”).

Marcy State Psychiatric Hospital was shut down many years ago and turned over to the State Department of Corrections to become the Marcy Correctional Facility. Then, in December 2009, it was announced that the Marcy Correctional Facility would open a 100-bed Residential Mental Health Unit for inmates with serious mental illness. Thus, seriously mentally ill individuals who were once treated in the psychiatric hospital may end up being treated in exactly the same building, except that now it is called a prison(6). Office of Mental Health Commissioner Michael Hogan lauded the special unit as “a collaborative and innovative approach that to our knowledge is the first of its kind anywhere.” And Governor David Paterson said: “This cutting-edge program represents government at its best.”(13)

In less than 200 years, we have taken mentally ill individuals who were in jails and prisons; transferred them to mental hospitals; then we closed down the mental hospitals, thereby forcing the mentally ill individuals back to jails and prisons. There are those who would say that “this represents government at its best.”

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