

# *The Atlantic*

POLITICS

## **America's Largest Mental Hospital Is a Jail**

At Cook County, where a third of those incarcerated suffer from psychological disorders, officials are looking for ways to treat inmates less like prisoners and more like patients.



Charles Rex Arbogast / AP

**MATT FORD** | JUN 8, 2015

It was 9 o'clock in the morning at Cook County Jail, but in the subterranean holding cells where dozens await their turn before a judge, you wouldn't be able to tell. Pre-bail processing here takes place entirely underground. A labyrinth of tunnels connects the jail's buildings to one another and to the Cook County Criminal Court. Signs and directions are intentionally left off the smooth concrete corridors to hinder escape attempts. Even those who run the jail get lost down here from time to time, they told me.

No natural light reaches the tunnels. Human voices echoed off the featureless walls, creating an omnipresent din. On this Monday, when those arrested over the weekend in Chicago and its suburbs filled the fenced cages, that din became a roar. Many inmates were standing, sitting, or milling around. But some—perhaps two or three per holding pen—were lying on the floor, asleep.

If you can sleep through this, you're fighting far greater demons than the commotion outside. And the doctors here want to know what they are.

At Cook County Jail, an estimated one in three inmates has some form of mental illness. At least 400,000 inmates currently behind bars in the United States suffer from some type of mental illness—a population larger than the cities of Cleveland, New Orleans, or St. Louis—according to the National Alliance on Mental Illness. NAMI estimates that between 25 and 40 percent of all mentally ill Americans will be jailed or incarcerated at some point in their lives.

“This is typically what I see everyday,” said Elli Petacque-Montgomery, a psychologist and the deputy director of mental health policy for the sheriff's department. She showed me a medical intake form filled with blue pen scribbles. Small boxes listed possible illnesses: bipolar disorder, ADHD, schizophrenia, and so on. The forms are

designed to help jail officials identify which inmates have mental illnesses as early as possible. Details from four new inmates could fit on a single sheet. She showed me a completed one. “Of those four,” she said, pointing to the descriptors, “I have three mentally ill people.”

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On a nearby counter, a nurse took down notes for a Hispanic inmate with an injured eye. A white inmate with dreadlocks wearing a Chicago Bears jersey—they had defeated the San Francisco 49ers the night before—stood next to them, translating his fellow inmate’s Spanish for the nurse.

What sort of crimes had these people been arrested for? One kid on the list had a tendency toward aggression, but officials emphasized that the overwhelming majority were “crimes of survival” such as retail theft (to find food or supplies) or breaking and entering (to find a place to sleep). For those with mental illness, charges of drug possession can often indicate attempts at self-medication. “Even the drugs of choice will connect to what the mental illness is,” Petacque-Montgomery told me. People with severe depression might use cocaine “to lift their mood.” Those who hear voices and have schizophrenia or bipolar disorder often turn to heroin to regulate their

sleep. Marijuana use “is just constant for kids with ADD and depression,” she notes. “I’ll ask, ‘Can you eat or sleep without this?’ and they’ll say no.”

Chicagoans with mental illness end up in jail through a chain of small decisions by different local officials. Police officers can choose to take a mentally ill person home, to the hospital, to a shelter—or to jail. Prosecutors can choose whether or not to bring charges. Judges can choose to set higher or lower bail amounts, thereby determining whether poorer defendants can avoid pre-trial detention and keep their jobs and housing. But once a person reaches the jail, the local sheriff can’t simply decline to take them into custody.

In Chicago, that responsibility falls to Tom Dart, the 52-year-old sheriff of Cook County. Dart supervises about 6,900 sworn officers in the Cook County Sheriff’s Department. His jurisdiction encompasses the roughly 5.3 million people living in and around Chicago. As sheriff, Dart is also responsible for Cook County Jail, the largest single-site jail in the United States. Because so many people with mental illness pass through his custody, Cook County Jail can also be considered the largest mental-health facility in the nation. The jail has been run accordingly since Dart’s election in 2006. All incoming staff, including the 300 to 400 new correctional officers hired annually, now receive 60 hours of advanced mental-illness treatment training. His officers can’t simply be guards anymore, Dart emphasizes. “You have to be a doctor. You have to be a nurse. You have to be a social worker. You have to be all of these things.”

Last month, Dart appointed Nneka Jones Tapia, a clinical psychologist who previously oversaw mental health care at Cook County Jail, as executive director of the facility. Jones Tapia is currently the only mental health professional in charge of a major jail in the United States. Her appointment underscores how much of the jail’s work is devoted to treating people with significant mental illnesses.

In most jurisdictions, the recently arrested are brought to local holding cells for fingerprinting and charges, then taken to the county jail for processing and a bond hearing. Cook County is no different—except for its mental-health screening. “What I did is, I put this new layer in between, so when they get dropped off before they go to the bond hearing, we interview them and we try to find some sort of alternatives for them to suggest to the judge,” Dart explained.

How did the judiciary respond, I asked? He shrugged. “They haven’t.” Dart has spent most of his career as part of the criminal justice system in some way. He previously worked in the state attorney’s office as a prosecutor until 1991, when he spent 11 years in the Illinois state legislature. “I’m not invited to a lot of their parties, let’s put it that way,” he said about the judges, cracking a grin.





All new detainees at the Cook County Jail go through mental health evaluations before their bond hearings. (Jim Young / Reuters)

Here it's worth noting that a jail is not a prison. Every inmate I spoke with had been arrested or charged with a crime, but not necessarily tried and convicted for it. In the law's eyes, they were still innocent until proven guilty. Jail officials told me that some of their cases would be likely dropped before reaching trial. The Cook County public defender's office advised the inmates not to give me their last names or discuss details of their alleged crimes with me. Few of them listened. Because of the sensitive nature of these conversations—and because mental illness can carry a lifelong stigma, even if the person is not a threat to himself or others—I've omitted the inmates' surnames throughout this story.

**D**emetrio's battle with mental illness began at an early age. "My mother was murdered and I watched it when I was young, so that's how it started," he told me. Doctors diagnosed him with post-traumatic stress disorder and bipolar disorder as an adolescent. He served time for drug-related offenses in 1987 and 1993, then kept out of trouble for the next 18 years. He drifted in and out of Chicago-area hospitals during that period, checking himself in when he felt suicidal.

While on parole for a 2009 burglary charge, he went off his medication and stopped reporting to his parole officer. That landed him back in state prison to serve the remainder of his sentence. There, Demetrio received medication and treatment, but it ended the moment he became a free man last year.

Prison doctors tried to set him up with an appointment in one of the city's remaining community mental-health

clinics. “They said the earliest I could see a doctor was June [2014],” he told the sheriff and me.

“When were you released?” asked Dart.

Nine months earlier in October 2013, Demetrio replied. He knew that surviving until the following June wouldn't be easy. “I was trying to stretch my medicine out by not taking it regularly like I should have every day,” he told me. “It didn't work.” This spring, he was arrested on aggravated battery charges—for getting in a fight with a man selling drugs to his family, he told me—and landed back in Cook County Jail on a \$250,000 bond. He said he wasn't medicated when the fight erupted and was eager to get back out.

“I've been in Chicago my whole life. I have a 14-year-old son. His mother's all messed up right now, she's on drugs, that's why I'm trying to get out of here,” he told me. Demetrio spoke lucidly and without difficulty during our conversation. He credited the hydroxyzine, Klonopin, and Prozac he was receiving at the jail. “I've been lucky so far,” he told me. “If I wasn't on my medication, I'd be a whole different person.”

Cook County Jail does house its share of serious violent offenders. Some of them are mentally ill. Many aren't. But the overwhelming majority of Cook County Jail's mentally ill population is booked for minor offenses, Dart told me. “When people do not receive the care they need, they become symptomatic,” Jones Tapia explained. “When people become symptomatic with acute mental illness, a lot of times those behaviors look criminal. And we have done an excellent job of criminalizing people with mental illness in our state.”

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When the criminal-justice system is your only hope, perverse incentives are also inevitable. In 1976, the Supreme Court ruled in *Estelle v. Gamble* that prisons are constitutionally required to provide adequate medical care to inmates in their custody. As a result, prisoners are the only group of Americans with a constitutional right to health care. Multiple city and county officials told me they had encountered mentally ill people who committed crimes simply to receive treatment.

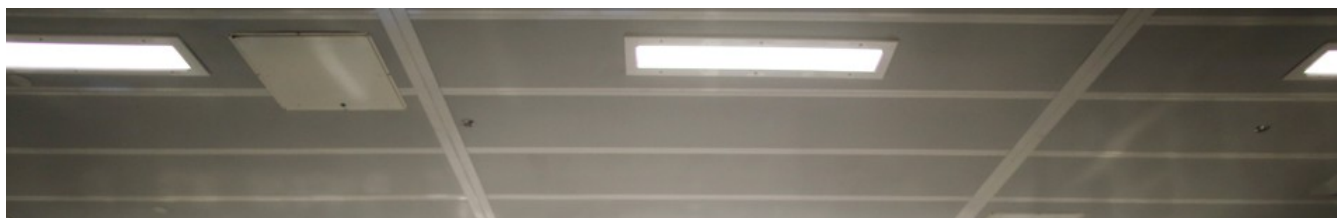
**T**he United States does not have a national mental-health system, nor has it ever had one. Caring for the severely mentally ill has long been the responsibility of the states, starting with the first asylums and mental-health hospitals established in the mid-19th century. In 1854, the social reformer Dorothea Dix pressured Congress to set aside 10 million acres of public lands for mental-health facilities. President Franklin Pierce, who viewed it as an overreach of federal power, vetoed the final bill. It would be another nine decades before Congress would enact the first mental-health law. As the scarred veterans of European and Pacific battlefields returned home from World War II, the National Mental Health Act of 1946 established the National Institutes for Mental Health and provided research funding to states.

The postwar era saw other changes in the way states addressed mental health. Foremost among these was the birth of psychopharmacology and the development of new drug treatments for mental illnesses. Chlorpromazine, best known in the U.S. under the brand name Thorazine, became the first widely adopted antipsychotic drug in 1955. Others soon followed, and they had an immediate impact on the therapeutic landscape. Although the

effects varied from person to person, many patients with serious mental illnesses could now be reliably treated beyond the asylum and hospital walls for the first time.

Against this backdrop, Congress passed the Mental Health Study Act in 1955. The law established a joint commission on mental health to evaluate the nation's mental-health policy and propose reforms. Greer Williams, a prominent psychiatrist and writer, became the editor of the joint commission's [final report](#), which was published in December 1960. In its July 1961 issue, when *The Atlantic* included a special supplement titled "Psychiatry in American Life," Williams contributed an article that detailed the commission's findings. "One of the most revealing disclosures" of the report, he wrote, "is that comparatively few of 277 state hospitals — probably no more than 20 per cent — have actively participated in the modern therapeutic trend toward humane, healing hospitals and clinics of easy access and easy exit, instead of locked, barred, prisonlike depositories of alienated and rejected human beings." The typical state hospital, he explained, "does a good job of keeping patients physically alive and mentally sick."

The solution, many activists and experts thought, would be to shift away from state-run mental hospitals altogether into a new model of mental-health treatment. Shaping this zeitgeist was a steady stream of depictions of the horrors of the asylum system by journalists and popular culture. Books like 1962's *One Flew Over the Cuckoo's Nest*, with its graphic depictions of electroconvulsive therapy and unsympathetic portrayals of mental-health workers, reflected popular views of psychiatric care.





New inmates are processed at the Cook County Jail. (Jim Young / Reuters)

These efforts found a receptive audience in President John F. Kennedy. His sister Rosemary, who suffered from intellectual disabilities, received a prefrontal lobotomy in 1941 and lived in private mental hospitals for the rest of her life. Kennedy highlighted the need for reform in a February 1963 [special message](#) to Congress.

There are now about 800,000 such patients in this nation's institutions—600,000 for mental illness and over 200,000 for mental retardation. Every year nearly 1,500,000 people receive treatment in institutions for the mentally ill and mentally retarded. Most of them are confined and compressed within an antiquated, vastly overcrowded, chain of custodial state institutions. The average amount expended on their care is only \$4 a day—too little to do much good for the individual, but too much if

measured in terms of efficient use of our mental health dollars. In some States the average is less than \$2 a day.

Kennedy's plan was to decentralize American mental health care. "We must move from the outmoded use of distant custodial institutions to the concept of community-centered agencies," he told legislators. To replace the asylums, the president envisioned a national network of community-based mental health centers, equipped to provide "a coordinated range of timely diagnostic, health, educational, training, rehabilitation, employment, welfare, and legal protection services."

The Senate responded accordingly by passing the Community Mental Health Act, but Kennedy's legislation met with resistance when it reached the House committee on interstate commerce. House Republicans and the American Medical Association opposed including funds for personnel in the bill. Committee members reduced the building construction provision to \$238 million and eliminated all \$427 million set aside for staffing in the final House version. The House and Senate later compromised on \$329 million overall, but with no funds for personnel. "For bricks and mortar, maybe, but for the care of human beings, nothing," Williams later complained in *The Atlantic*. The Community Mental Health Act was the last legislation Kennedy signed into law before his murder in Dallas.

The act accelerated a process called "deinstitutionalization"—a national shift in mental-health treatment from state hospitals to community-based facilities. Between 1955 and 1998, the populations in state and county mental hospitals dropped from approximately 558,000 to fewer than 60,000. "The decline was even more dramatic if general population growth is taken into account," wrote scholars Howard Goldman and Gerald Grob in

their history of federal mental-health policy. “Had the proportion remained stable and the mix constant, mental hospitals would have had about 950,000 patients in 2000.”

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Other legislation contributed to the process. When Congress created Medicaid in 1965, it barred payments for people in “institutions of mental diseases” but allowed payments for community mental health centers. In the last year of his presidency, Jimmy Carter signed the Mental Health Systems Act of 1980, which provided grants directly to community mental health centers. The boost in funding was short-lived. In one of the first speeches of his presidency, Ronald Reagan complained that, through federal mandates, “a federal helping hand is quickly turning into a federal mailed fist.” His administration repealed the Mental Health Systems Act within its first year, converted direct funding into block grants for the states, and cut federal mental-health spending by one-third. No one picked up the slack.

By the mid-1980s, it was apparent that something had gone wrong. “The policy that led to the release of most of the nation’s mentally ill patients from the hospital to the community is now widely regarded as a major failure,”

declared *The New York Times* in 1984. “States proved more enthusiastic about emptying the old facilities than about providing new ones,” the *Chicago Tribune* noted in 1989. “Many patients went from straitjackets to steam grates.”

Even then, it was arguably better than today. “We still had a semblance of a mental-health system in the 1980s and 1990s,” Dart told me. A study in 1990 found that 1 in 15 prisoners at Cook County Jail had some form of mental illness. Today, a conservative estimate is 1 in 3.

Deinstitutionalization’s aftershocks are still being explored by academics, but most concede its successes were mixed at best. “Cutbacks in mental health funds, together with cuts in federal money for public housing and other services, led to streams of apparently deranged people living on the streets,” wrote political scientist Marie Gottschalk. Their visibility “overshadowed the fact that many mentally ill people made successful transitions to community life.” But those who didn’t ended up in the mental institution of last resort: America’s jails and prisons.

**O**n the Cook County sheriff’s webpage, a graph shows the percentage of people who self-reported a mental illness or substance abuse disorder at intake that day. Not all of them ultimately go into the jail; some of them bond out or have their cases dropped. But the number gives a glimpse of how many mentally ill people are arrested each day in the Chicago area. “Even if they don’t end up in the jail, they were picked up by the police and oftentimes for things that were petty and/or simply the fact that they were experiencing symptoms on the street,” said Moshe Brownstein, a manager at NAMI Chicago, “which is the criminalization of mental illness.”

Cook County Jail itself is a sprawling complex covering some 96 acres in the South Lawndale neighborhood. Inmate populations fluctuate with the seasons, but between 9,000 and 11,000 people are housed in 11 separate divisions on average. Dart also supervises roughly 2,000 people who are released on electronic monitoring. In

addition to the jail itself, the complex also connects to the county's criminal courts. The facility processes about 100,000 people through it each year.

“If you have someone diagnosed with a mental illness, can you think of a worse place to put them than a jail?” Dart asked me. “The living units we put them in change some of that dynamic—these wide-open dormitory settings—but traditionally around the county, you find they’ll be tossed in four-by-eight [foot] jail cells. I mean, can you think, if you were mentally ill, how that must feel? In addition to whatever else you’re having problems with, being locked in that cement four-by-eight room with a stranger, usually who has some other illness that has nothing to do with yours?”





A detainee lies in his bunk at Division 2, in a minimum security dorm that houses inmates with mental health issues. About a third of the jail's inmates suffers from mental illness. (Jim Young / Reuters)

Division 2 was not built to be a mental ward, but it has become one. I met Dart in a dormitory there as he spoke with a crowd of beige-garbed inmates. At one end, next to the entrance, a small television played soap operas, with steel tables and benches surrounding it. A list of rules on the wall near the showers reminded inmates that Chicago Bears games take priority over other TV shows. Between 40 and 50 people live in each dormitory, sleeping on rows of bunk beds in the middle of a large room.

When Dart arrived, the inmates gathered around and started telling him their problems one by one. A few described quality-of-life issues at the jail. Most of them asked him for help with their respective cases. Some asked for help arranging earlier hearing dates. Others complained about their public defenders. One inmate showed me a 50-page petition for a writ of certiorari that he wished to file with the Supreme Court. Dart patiently heard their grievances for about 90 minutes while jotting down names, case numbers, and other relevant details on blank printer paper. As we left the dormitory, he told me that he could only do something about perhaps 25 percent of the problems they raised. The rest were simply beyond his control.

The Great Recession accelerated the nation's downward trend in mental-health spending. Between 2009 and 2012, America's 50 state legislatures **cut a total of nearly \$4.5 billion** in services for the mentally ill, even as patient intakes increased by nearly 10 percent during the height of the economic crisis. Until a few years ago, Chicago had 12 mental health clinics. In 2011, Mayor Rahm Emanuel's first budget proposed closing six of them. The closures—city officials referred to them as “consolidations”—would save the city an estimated \$3 million as it struggled to balance its budget.



As mental-health advocates rallied, Dart publicly warned in editorials and interviews that many patients who lost their clinics would end up at his jail. But it didn't work. The Chicago City Council [passed](#) Emanuel's budget that November without dissent, 50 to 0. "People are still angry about it," said Alexa James, the executive director of NAMI Greater Chicago. "There really wasn't a hearing, [the clinics] just kind of closed, and people are very, very angry."

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**“If I don’t get out of here by September 30,” Pierre repeatedly told me, “I’m going to lose my apartment.” His next court date was scheduled for October 1.**

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I asked Dart about his relationship with Emanuel. The sheriff's office [told \*Esquire\*](#) last year that Dart hadn't spoken with the mayor since Emanuel took office and that the mayor "might as well be Vladimir Putin or David Cameron" to him. But Dart demurred and instead told me that he had been in contact with some city aldermen and state legislators about the mental-health crisis. Around the same time the city closed half of its clinics, state budget cuts also shuttered three of the state's nine mental health hospitals. One of them, Tinley Park Mental Health Center, treated nearly 1,900 patients each year in Chicago. Its closure caused a "world of disruption," said John Jay Shannon, the CEO of the Cook County Health and Hospitals System. Many of the inmates I spoke with said they

had received treatment there at least once.

**P**ost-bail processing at Cook County Jail takes place in the afternoon. Inmates are brought to Building 7, one of the newer structures at the jail, where they line up in an orderly queue to be scanned, x-rayed, and thoroughly searched before entry. (The process resembled TSA screening lines at airports.) ID numbers are assigned. Fingerprints are taken. Khaki prison uniforms with “D.O.C.” stenciled on the back in large black letters are issued. Street garb is surrendered and vacuum-sealed. Jail officials then ask a series of pre-classification questions to determine where inmates should be housed. Those who give answers about significant mental illnesses, sexual-assault trauma, or other important classifications are often given protective custody.

What comes next is unusual, and possibly unique. After the normal post-bail intake procedure is complete, inmates file through a series of concrete cubicles staffed by a battalion of employees from the Cook County Health and Hospitals System. About 600 of the county hospital system’s 6,000 employees work at Cook County Jail. If the inmate is eligible, county officials can sign up him or her for CountyCare, a health insurance program for low-income Cook County residents created through the Affordable Care Act’s expansion of Medicaid. The assembly-line layout allows the county to process about 200 applications a day. Over 10,000 inmates have signed up so far.

For inmates with mental illness, who might struggle to afford prescription drugs or pay for mental health care, the program has the potential to significantly improve their quality of life. But it also has its limits. “I get really nervous when people start talking about it like it’s a panacea,” said Marlena Jentz, the deputy director of public policy at the jail. “I think there’s a lot of really positive change around this, but there are a lot of next steps too,” she told me, citing needs like health literacy and access to housing in the community.

A pervasive misconception is that violence and mental illness are closely linked. Dart and other jail officials

repeatedly emphasized to me that the men I met were nonviolent, as were the vast majority of those they encountered overall. One of them, Pierre, had been charged with retail theft. Though he had no history of violence, the judge remanded him to the county's custody on a \$100,000 bond. "I can't make a \$100,000 bond," Pierre told us pleadingly. "I couldn't either," Dart replied.

Pierre told me he'd been living in an apartment provided with the help of Thresholds, a local nonprofit, while surviving on disability checks. He feared that if he were cut off from Social Security while jailed, he would be unable to keep his housing.\* "If I don't get out of here by September 30," Pierre repeatedly told me, "I'm going to lose my apartment. They're going to put everything I own in the world out in the alley. I'll only have what I walk out of here with." His next court date was scheduled for October 1.





Cook County Sheriff Thomas Dart (right) speaks to a Division 2 resident. More than 5,000 inmates at Cook County Jail have signed up for Medicaid under a program that lets them apply while incarcerated. (Jim Young / Reuters)

Pierre was diagnosed with schizophrenia and bipolar disorder when he was 13 years old. His regular clinic, Woodlawn, was one of the six public mental-health centers closed by budget cuts in 2012. “That’s where I went to see my doctor,” said Pierre, a Division 2 resident. “When they closed it down, I wasn’t able to continue my medication or anything.” For patients like him who relied on the clinics, the impact was immediate: “One day they was open, next it was closed.”

For people with bipolar disorder, schizophrenia, or other serious mental illnesses, losing access to treatment can lead to a loss of employment, housing, and freedom. “Closing six clinics was huge because people were comfortable there, it was in their community, they had clinical teams that spoke the language—literally and figuratively—that they understood,” said James. She added that when patients have to “hop on a few buses or trains” to get treatment in another neighborhood, “it’s a cultural change, it’s an added stressor, and it created a little more non-compliance. We saw hospitalization rates go up and we also saw incarceration rates go up. We’ve really just reallocated the money into a different type of spending that’s actually more expensive.”

Pierre hoped that the sheriff would be able to help him leave the jail and keep his housing. Dart told him he’d look into getting him equipped with an electronic-monitoring device; the county tracks roughly 2,000 inmates this way. “I don’t have no violence, I promise,” Pierre reassured us. “I’m not a bad guy.”

“It’s a system that makes absolutely no sense,” Dart told me later in the tunnels. “At the heart of it, you’ve got somebody who’s been picked up and removed from the street with some type of mental illness. Instead of treating them and then following their case for the next few years to make sure they’re stable in their communities, you basically just churn them into the criminal justice system—which was never set up for these people—and you turn them in here.”

**T**he centerpiece of Dart’s reform efforts sits a few blocks away from the main jail campus, in a structure built on the site of a former boot camp. The Mental Health Transition Center, which opened last August, is designed to help inmates cope with mental illness and prepare to rejoin life on the outside. Phase one of the pilot program includes six weeks of daily group therapy sessions. The program’s goal is to reduce recidivism among mentally ill inmates who cycle in and out of the system.

“Many of them have come in and out of jail multiple times,” said Jones Tapia. “We have someone who’s been incarcerated 21 times.” At the time of my visit, 54 inmates had already completed the six-week program, and another 50 of them were set to begin it.

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**“Just think about how financially and fiscally dumb it is, too,” the sheriff said. “I mean, it’s inevitable they’re just coming back in.”**

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I met some of the program's participants during one of their regular group therapy sessions. The counselor had the inmates seated on plastic chairs around a whiteboard filled with bullet points. The room felt more like a classroom than a jail. Though the day was overcast, light poured in through large windows. The youngest inmate in the group was 18 years old; the oldest was 64. All of them were black men.

Today's theme was apologizing. The inmates listened intently, jotting down notes as their counselor spoke. She paced through the middle of the circle, asking each man in turn if there was something he should apologize for but hadn't yet.

"There's a lot..." mused one of the officers seated in the circle along with them.

"Join the club," joked one of the inmates. Everyone laughed. After the reverberating chaos of the tunnels and the dormitories, it was a surreal sound.

Dart entered the room midway through the session and took a chair near the back. At the end, he asked the group how they were doing. "You've got about a thousand guys who want to come over here," one inmate with thick glasses told the sheriff.

Dart nodded. "I'm trying." Some of the participants, he later told me, used what they'd learned in the sessions to lead their own self-help groups with other inmates back at the dormitories.





Inmates gather in one of the communal areas of Division 2. (Jim Young / Reuters)

The second phase of the pilot program adds in classroom education, GED study sessions, and job-readiness training. The classroom resembles something you'd find in an elementary school, with posters suitable for young children hanging on the walls. Counselors told me that kind of stimulation is necessary for some of the inmates who've cycled in and out of the criminal justice system for decades. Some of these habitual visitors have simply forgotten or never learned basic skills that many people take for granted, Jones Tapia told me. Persistent incarceration wears you down.

“And not just inside a correctional facility,” Jones Tapia said. “We’re re-teaching them things they learned in their family unit because a lot of these individuals come from dysfunctional families, unfortunately. What you see in correctional institutions are, more often than not, [symptoms] of a larger problem. And then you go into the communities and it’s single-parent homes, no-parent homes—it’s tough to teach your children when you’re not

there. So we're going back and teaching them those skills."

Through the windows, a patchwork of gardens could be seen. Dart told me the inmates maintained the gardens themselves and then ventured to a local farmers' market—accompanied by the sheriff and a few prison guards—to sell the fruits and vegetables. The staff had warned him against it, Dart says, but the gardening initiative had turned out to be "wildly successful." Dart is also working on programs that will help inmates find jobs at local restaurants, learn interview and resume skills, find out how to apply for classes, track down local mental-health service organizations, and take part in a job fair with companies that have a track record of hiring ex-offenders.

It's too early to measure the Transition Center's success rate, but preliminary numbers are promising. As of April, 22 inmates had been successfully discharged back into the community and all of them are continuing to receive mental-health and substance-abuse treatment, jail officials told me. Some of them have found jobs or enrolled in schools. Eight of the participants were tried and convicted of the original charges against them; they are now serving state prison sentences.

For Dart, the shift from inaction to action is significant in itself. "Prior to our discharge plan, [inmate release] was an exercise in pumping people out into the street at all hours of the night," he told me during our conversation in the tunnels. "Just cycle them out into the front here, and they wander around and they just fade away."

The cyclical nature draws most of his ire. "Just think about how financially and fiscally dumb it is, too. I mean, it's inevitable they're just coming back in," Dart told me in the tunnels. When I began to ask about the human-rights aspect, he scoffed. "Oh please," he said. "I've almost given up trying to talk to people on that level because they don't care."



In some larger American jails, abuse of mentally ill inmates is routine. Since the 1980s, virtually every correctional facility of a certain size has been under a federal consent decree to improve conditions. Last December, Los Angeles County [entered into a new federal agreement](#) after settling an ACLU-led class-action lawsuit on behalf of abused inmates with mental illnesses. ACLU lawyers claimed that excessive use of force in L.A. County jails was endemic, and federal prosecutors [brought charges](#) against almost 20 current and former sheriff's deputies.

In New York City, a months-long investigation last year by *The New York Times* last year [found rampant abuse of mentally ill inmates](#) at Rikers Island, the third-largest jail in the United States and, by default, one of the largest mental-health facilities in the country. Mayor Bill de Blasio announced in December that his administration would [take radical steps](#) to reform how the city's justice system tackled mental-health issues. Many of the proposals in his plan, for which city officials earmarked \$130 million, resemble Dart's efforts in Cook County: strengthening pre-trial diversion programs, expanding reentry programs to prevent recidivism, and shifting from punishment to treatment.

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**“Instead of sitting in bed all day, I get to come over here and talk to guys that's just tired of this life.”**

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Cook County Jail isn't without its own problems. In 2008, shortly after Dart began his first term as sheriff, the

Department of Justice's Civil Rights Division **accused the jail** of systematically violating inmates' constitutional rights. Some inmates had been badly beaten; others had been denied drugs for mental illness. One had to undergo an amputation because no one had treated an infected wound underneath his cast.

Cara Smith, who was the executive director of Cook County Jail when I visited, told me the sheriff's office had brought the facility into compliance with almost all of the consent decree's provisions and that federal monitors had recently described the jail as a "national model." Both the U.S. attorney's office in Chicago and the federal monitor tasked with overseeing Cook County Jail's compliance declined to comment for this article, citing ongoing legal processes. Their June 2014 monitoring report, provided to *The Atlantic* by the U.S. attorney's office, described "substantial improvements" in mental-health care since the consent decree's implementation. Staff vacancies and inadequate programming space were cited as the two remaining areas where improvement was needed.





A Division 2 detainee talks to a guard. (Jim Young / Reuters)

Still, Cook County Jail is clearly on the better end of a grim spectrum when it comes to mental-health services in jails. After their group therapy session ended at the treatment center, I spoke with five of the inmates about what they thought of the new re-entry program. All of them were soft-spoken, and deferential. We sat in a small circle at the center of the space. The guards left the room and a representative from the public defender's office stood off to the side near the door.

Had any of them come across any therapy regimens or educational courses similar to this one before, I asked?

“No, I haven't,” replied Marcus in a ponderous, gravelly voice. “I've been using drugs and coming in and out of the system for the last 30 years and I never received a break from no judge. I've always been sent right back to the penitentiary and I ain't learned nothing.”

All of them were enthusiastic about the therapy regimen. “Oh man, there's just so many words I've got to say about this program,” said Jermaine, sighing and leaning back in his chair before bolting back up and focusing intently on me. “Instead of sitting in bed all day, I get to come over here and talk to guys that's just tired of this life. Being chosen, y'know, kind of hand-picked for this, it's something that each individual should be beyond happy for.” They even seemed comfortable having guards participate in the therapy sessions. “[The guards] all feel that this is not a wasted opportunity or a waste of taxpayers' money,” said Marcus.

As the officers came back and motioned that it was time to return to the jail, I asked each of the inmates what they want to do after their release. William wanted to go to trucking school and travel the country. “I just lost my wife in November and I’ve been locked up since July,” said Marcus, “so I’m looking forward to moving to another state and starting over fresh.” Roscoe, the oldest of the group, said he simply wanted to spend time with his children and grandchildren.

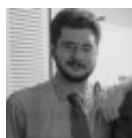
The other two said they hoped to help their communities. Jermaine told me he planned to get back on his feet as a public speaker and help the kids in his neighborhood. William had similar aspirations. “I’m going to take what I’ve learned,” he told me, “and show others it doesn’t have to be this way.”

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*\* This article originally stated that Thresholds' rules require eviction if a tenant is incarcerated. In fact, the decision to hold an apartment while a tenant is incarcerated is made by the landlord, not by Thresholds. We regret the error.*

#### ABOUT THE AUTHOR

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