



## Mental Health Policies Are Cause for Alarm in the Corrections Community

By *Mary Zdanowicz, J.D., Executive Director, Treatment Advocacy Center*

### Why Should Corrections Executives Care about a Mental Health Policy?

*Because America's jails and prisons have become the nation's de facto psychiatric hospitals.*

How times have changed. In the 18th Century, an advocate named Dorothea Dix discovered with horror that many in the country's jails and prisons had mental illnesses. She began a crusade that eventually led to the creation of the state psychiatric hospital system. It was successful. By 1880, less than 1 percent of the population in jails and prisons was mentally ill.

If we had the same conditions today, there would be fewer than 22,000 incarcerated severely mentally ill. Instead today's estimates range from 175,000 (8 percent) to 350,000 (16 percent) of the total jail and prison populations.

### Present Day Crusaders Are Ignoring Needed Reforms of the Mental Health System

Unlike Dorothea Dix, modern mental health advocates overwhelmingly refuse to own this crisis and stem the tide.

In fact, they do exactly the opposite – they tend to focus very little on what the mental health system should be do-

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*The corrections and law enforcement community must advocate reform of the mental illness treatment system.*

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ing to abate this tragedy and instead shift the burden to law enforcement and corrections officials.

The criminal justice system is called upon to divert the mentally ill from the criminal justice system through specialized police programs, mental health courts, and jail-based treatment. Mental health advocates push law enforcement to improve crisis intervention training, ignoring the fact that it is their role to stop crises before they get to that point. They want more mental health courts, seemingly forgetting that those useful tools still require someone with a severe mental illness to be arrested before that "diversion" tool can be implemented.

### Mental Health Policies Directly Impact Jail and Prison Operations

The magnitude of the crisis and the lack of leadership by the mental health community for reversing it mean that corrections executives and law enforcement have no choice but to understand

– and get involved in reforming – mental health policy.

It is important for corrections executives to recognize that federal, state, and local mental health laws and policies have a direct impact on the size of their mentally ill inmate populations.

### The Impact of the Policy of Exclusively Self-Directed Mental Health Care

The current new trend in mental health policy is driven more by what “feels good” than what is “proven good.” The federal government is funding the “transformation” of state mental health systems to care only for psychiatric patients who are on the road to recovery and are able to direct their own care. Self-directed care is the cornerstone of this new system – refusing medication and all of the consequences of non-treatment are a “choice” that patients make.

That means when the mentally ill are diverted from jails and prisons, they will still be free to refuse treatment. Non-adherence with treatment leads to relapsing symptoms in a mental health system that encourages choice until the person becomes dangerous. Then police are called and the cycle continues.

### The Impact of the Policy of Reducing Hospital Beds

While mental health experts wax dreamily about a perfect mental health system where trusting relationships rather than medication are the road to recovery, law enforcement executives lament the reality. **Gabe Morgan**, Sheriff of Newport News, Virginia describes how changes in mental health care have impacted criminal justice: “Acute care for the mentally ill was once provided by the staff of psychiatric hospitals – but now many who are severely ill are instead living in our communities, where the burden of managing symptomatic and psychotic behaviors often falls on law enforcement. Because the mentally ill can refuse treatment until they are dangerous, officers often have no alternative but to take them to jail. Jails were never intended to be treatment facilities, but now it seems they are replacing psychiatric hospitals.”

The proportion of state psychiatric hospital beds that are committed to

forensic use is evidence that the criminal justice system is dependent on psychiatric hospitals, not only as a means of preventing criminalization, but for evaluating and restoring defendants’ competency to stand trial and caring for the growing number of those found not guilty by reason of insanity.

But the state psychiatric hospital system that Dorothea Dix championed is nearly defunct. Since 1970, 90 percent of public psychiatric hospital beds have closed.

In an article published this year, Fred Markowitz at Northern Illinois University reported the results of a very sophisticated study to determine how psychiatric hospital capacity impacts crime and arrest rates. He studied data from 81 cities around the country and,



not surprisingly, found that public psychiatric hospital capacity is inversely related to crime and arrest rates. That is, communities with greater access to public psychiatric beds have lower rates of arrests and crime. The same relationship exists when violent crimes are analyzed separately.

Markowitz found that the same can’t be said for psychiatric beds in general hospitals. With the closure over the years of public psychiatric hospitals (which do not qualify for Medicaid reimbursement under the federal “IMD exclusion”), state and local governments have come to rely on psychiatric beds in general hospitals (which are eligible for Medicaid) to address the needs of psychiatric patients who need inpatient hospitalization.

While these community beds can be just as expensive on a per diem basis, they lack the clinical capacity for treating the most severely ill patients. This is evidenced by recent data from Virginia where the average length of stay in the state hospital (55.3 days) was 9 times

that of the contracted community beds (6.1 days). Perhaps the more rapid discharge of patients from the local hospitals explains why access to psychiatric beds in general hospitals did not have the same effect as access to beds in public hospitals in reducing crime and arrests.

What Dr. Markowitz’s research demonstrates is that the corrections community will lose out if it sits idly by and lets the mental health community determine hospital capacity issues. Under pressure from mental health advocates, to move the money from hospitals to community treatment, public psychiatric hospitals closed in the 1990s at a rate three times greater than in the years 1970 – 1990. In 2004, when asked if they were experiencing a shortage of psychiatric beds, more than half of responding states said yes.

Between 1981 and 2001, the great proportion of funding flipped from state psychiatric hospitals (63% to 32%) to community mental health (33% to 66%). Yet, things don’t seem much better. In fact, Dr. Markowitz evaluated whether the total amount of city mental health expenditures made a difference in reducing crime and arrests – it did not. He acknowledges that the amount of expenditures is not necessarily an indication of effectiveness. An important factor may also be whether assisted outpatient treatment, which has been shown to reduce arrests, incarceration, and homelessness, is used.

It is not surprising that **Stan G. Barry**, Sheriff of Fairfax County, Virginia, observed “When I first started it was very, very rare that someone who was clearly mentally ill ended up in jail. Over the years, I’ve watched that change drastically.”

This research demonstrates that public psychiatric hospitals play a very important role in reducing crime and arrests and thus, the burden on the criminal justice system.

### The Flawed Policy of Choice

The most common reason for hospitalization is medication non-adherence. The most common reason for non-treatment is the belief that treatment is not needed – usually because these patients don’t even realize they are ill. For example, they think the CIA is causing the voices in their head.

## Corrections and Law Enforcement: A Vital Role as Mental Health Advocates

There is no incentive for mental health directors to keep the mentally ill out of the criminal justice system.

So it falls in large degree to the law enforcement and corrections communities to take the reins to ensure that mental health laws and policies work to divert people away from prisons and jails, help people before they deteriorate to crisis, and keep the responsibility for people with severe psychiatric diseases where it belongs – with the mental health system.

### To Begin

#### Ask questions

The mental health community has no trouble querying sheriffs and jail administrators about their policies and practices in regard to mentally ill inmates. Officials can turn the tables and ask whether the mental health system is prepared to keep its clients engaged in treatment once they have been diverted? And what is the mental health system doing to prevent its most vulnerable clients from having encounters with law enforcement at all?

#### Go to the source

Make sure that *everyone* knows what the state civil commitment laws allow. 42 states allow for assisted outpatient treatment. At least half allow for inpatient treatment for reasons other than “dangerousness” such as “grave disability.” This means the mental health system *can* intervene before a person is dangerous and law enforcement and jail don’t have to be the first responders.

#### Become an advocate

If not actually advocating for new hospitals, corrections officials must be engaged in the dialogue about the feasibility of closing more hospital beds. In Florida, the Florida Sheriffs’ Association actually led the charge to reform their state’s mental illness treatment law. In states like Maine and New Jersey and California, corrections and law enforcement personnel have testified in front of legislative committees about the burden of caring for people with mental illnesses in prisons and the costs – both fiscal and in personnel – to do so. Officer advocates have written letters to the editor, talked to reporters, spoken to advocates, attended task force meetings – all with the goal of turning the responsibility of care back to the mental health community.

In the 21st century, the corrections and law enforcement community must play the role of Dorothea Dix to advocate reform of the mental illness treatment system.

As states and communities begin “transforming” their mental health systems, corrections officials need a seat at the table to remind everyone what will happen to the patients who do not choose treatment – and that law enforcement and corrections officers, no matter how well trained, are not mental health professionals.

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They take medication in the hospital because they know it is the only way they can get released. Once in the community, “choice” is the mantra, and many choose not to take medication, often because they think they don’t need it. Without medication, symptoms return. For these patients, it doesn’t matter how much money is invested in the community mental health system – if community services are voluntary they can “choose” not to participate.

If there is ever to be any real hope of breaking the cycle of criminalizing the mentally ill, the community mental health system must play an active role in taking responsibility for the most severely ill patients. Researchers have found that the use of formal and informal means of leveraged treatment is quite common in the mental health system. The MacArthur Network on Mandated Community Treatment identified several forms of leverage used to facilitate people’s acceptance of outpatient mental health treatment.

- **Money as leverage.** Government disability benefits for people with a serious mental disorder are in some cases received and distributed by a family member or other appointed payee. Payees frequently use these payments as leverage to coerce treatment.
- **Housing as leverage.** People who depend on disability benefits often can’t afford market-rate housing, so government-subsidized housing is used both formally and informally as leverage to ensure adherence to treatment.
- **Avoidance of jail as leverage.** For people who commit a criminal offense, adherence to treatment may be made a condition of probation. This long-accepted judicial practice has become more explicit with the recent development of specialized mental health courts.
- **Avoidance of hospital as leverage.** Under some statutes, judges can order patients to comply with

prescribed community treatment, even if the patient doesn’t meet the legal standards for in-hospital commitment. Failure to comply can result in hospitalization.

- **Advance directives.** In some states, a patient can attempt to gain some control over treatment in the event of later deterioration by specifying treatment preferences or a proxy decision maker.

Interviews with outpatients from five sites in five states around the country revealed that 44 percent to 59 percent of patients had experienced at least one form of leverage.

Leveraged treatment is necessary because some patients, particularly those with schizophrenia, lack the capacity to make informed decisions about treatment. Mental health systems that adopt the federal government’s “transformation” initiative based on patient self-direction and choice will only be serving those patients capable of directing

their own choice – those who are not just willing to consent, but able to do so. That means an entire segment of the mentally ill population– the ones who are the sickest, the ones who are most likely to land in jail – are not included in this flawed policy.

In fact, according to the “transformation” initiative, neither informal nor formal means of leveraged treatment can be condoned in a system built on choice. This should cause great alarm in the criminal justice community.

### Assisted Outpatient Treatment: A Proven Policy Option

When someone refuses treatment despite all efforts to cajole them, despite what is offered, where do we turn? Civil commitment laws are the answer – laws that govern when and how to treat people over objection.

Data show a clear connection between civil commitment laws and criminalization. In the 1970’s, civil commitment laws were weakened dramatically to require dangerousness or imminent

danger before a person could be hospitalized. Jails and prisons were affected almost immediately.

In 1976, a few months after Pennsylvania weakened its laws, one prison documented a sharp increase in the number of severely mentally ill inmates. In 1971, a California prison psychiatrist lamented

*We are literally drowning in patients, running around trying to put our fingers in the bursting dikes, while hundreds of men continue to deteriorate psychiatrically before our eyes into serious psychoses. . . . The crisis stems from the recent changes in the mental health laws allowing more mentally sick patients to be shifted away from the mental health department into the department of corrections. . . . Many more men are being sent to prison who have serious mental problems.*

Since the 1970s, many states have improved their laws to allow for more timely treatment intervention. There has been a recent trend to reform laws to allow for court-ordered community treatment, known as assisted outpatient

treatment, for individuals who have a history of repeated hospitalization or arrests or who may become violent without treatment. Assisted outpatient treatment (AOT) allows someone to be court-ordered into a treatment plan while still in the community – BEFORE they are arrested, and before they deteriorate too significantly. Of patients in New York’s AOT program, known as Kendra’s Law, 83 percent fewer experienced arrest and 87 percent fewer experienced incarceration. It also dramatically reduced homelessness and the need for inpatient psychiatric hospitalization.

AOT laws require the mental health system to take responsibility for these patients before they enter the criminal justice system. ☘

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