



Will Anything

# BREAK

## the Jail to Hospital Logjam?

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Within American jails and prisons the prevalence of serious mental illnesses such as schizophrenia, bipolar disorder, major depressive disorders, and other psychotic disorders has been estimated to be as high as 14% (Prins, 2014). While inmates with serious mental illness are not likely to be violent, they do have higher rates of institutional infractions and are at risk for being victimized by peers (Bureau of Justice Statistics, 2006). They are less likely to be granted parole and they serve longer sentences than non-mentally ill offenders. When serious mental illness is unrecognized and untreated, there is a substantial risk of death by suicide. In addition, treatment costs for mental healthcare comprise a significant percentage of the correctional healthcare budget.

National accreditation standards require correctional facilities to screen for mental disorders and to provide treatment by qualified mental health professionals. However, jails face many challenges related to the provision of mental healthcare to detainees. Many small facilities have no psychiatric infirmary and a limited number of crisis observation cells. Psychiatrists or other mental health staff are not available continuously even when staffing levels are sufficient. Institutional policies or State law may limit a psychiatrist's ability to involuntarily medicate a detained patient. Finally, attempts to medicate a pretrial detainee may be opposed by the defendant's counsel out of concern that the medication side effects might affect the defendant's ability to participate in a trial.

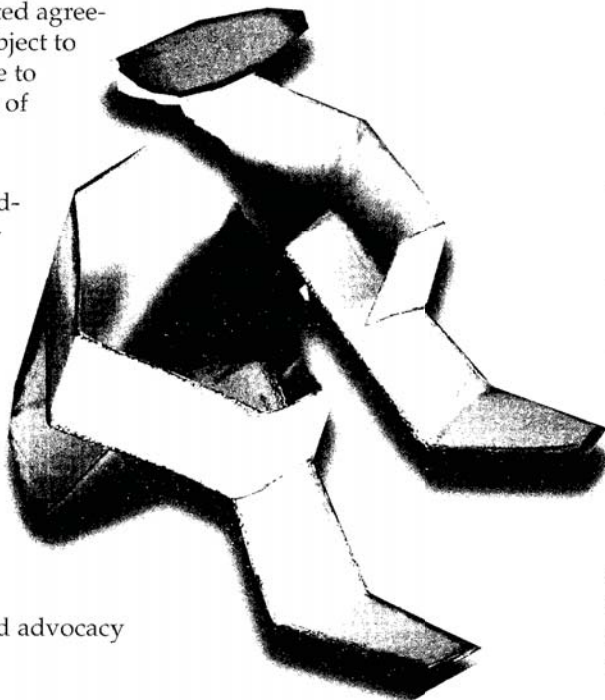
In spite of all these barriers, facilities face significant consequences for failure to provide care. In 2015, the Civil Rights Division of the Department of Justice investigated 150 facilities in 27 States, the District of Columbia, the Commonwealth of Puerto Rico, and the Territories of Guam and the Virgin Islands (Department of Justice, 2016a). Many of these cases involved allegations of poor medical or mental healthcare. While most cases are resolved through negotiated agreements, facilities can be subject to large daily fines for failure to improve care and the cost of litigation is burdensome.

Considering this, jail administrators understandably attribute criminalization of the mentally ill to the community's failure to provide care and to psychiatric hospitals' unwillingness to accept prompt patient transfers from correctional facilities. The purpose of this article is to provide an overview of national trends and State efforts to fix this problem by health departments and advocacy organizations.

### Virtual Logjam

Without question, the loss of inpatient beds has strained the public mental health system to a breaking point. According to the Treatment Advocacy Center (2017), a 2015 survey of 40 State hospital officials revealed that the majority of facilities had admission waiting lists. For most States the wait for transfer was approximately 30 days. However, three States reported delays of six months to one year. While forensic patients currently compose most of the State hospital system, jail transfers are only one of many sources of hospital admissions. Emergency departments and psychiatric units within community or private general hospitals also hold civil patients who need State hospital care. Limited inpatient beds and increasing referrals for admission have created a virtual logjam in the public mental health system.

Several States have created ad hoc work groups or legislatively mandated task forces to study this problem. These States include New York, South Dakota, Missouri, Michigan, and Texas. In Minnesota, a governor's task force was convened to reform access to public mental health services and to address gaps



in access to care. The task force identified several barriers to inpatient mental healthcare such as:

- An increasing number of emergency room visits due to psychiatric and substance abuse problems.
- A shortage of trained mental health professionals.
- State and Federal funding cuts.
- Financial disincentives for community hospitals to provide psychiatric care.

In addition, discharges are delayed and patients are left lingering in the hospital unnecessarily due to lack of community outpatient resources and insufficient supported housing (Governor's Task Force on Mental Health, 2016).

Earlier this year, the Michigan Department of Health and Human Services (2017) issued a 143-page workgroup report that included 70 policy recommendations. Many of the workgroup recommendations were common to those made by other States:

- a need to integrate behavioral health, substance abuse, and medical services.
- expansion of supported housing options.
- improved sharing of information between agencies and systems.
- assertive community treatment and crisis intervention programs.
- expansion of mental health courts and pretrial diversion programs.
- crisis intervention training for law enforcement to prevent inappropriate arrests.
- improved financial incentives and parity enforcement.
- reformation of involuntary treatment laws to include assisted outpatient treatment.

Although controversial, assisted outpatient treatment (AOT)—also known as involuntary outpatient treatment (IOT)—is a process that allows a court to order adherence with community care either as an alternative to involuntary hospitalization or upon release

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from a civil commitment. In order to qualify for outpatient commitment, a patient must have prior admissions due to violence as a result of mental illness. A patient who violates an AOT order may be brought to a hospital for an emergency evaluation without any additional legal proceeding. The New York City outpatient commitment program has been shown to reduce hospitalization rates as well as the length of the admission, and to improve compliance with treatment. Presently 45 States have outpatient commitment laws; however, the laws are rarely used in reality because many communities don't have sufficient treatment resources to support committed patients. An effective outpatient commitment program requires a large upfront investment in supported housing, outpatient clinics, and substance abuse treatment in order to be beneficial. Outpatient commitment is opposed by some patient advocacy groups because it restricts the civil liberties of patients who are well enough to live safely in the community at the time of commitment (Miller & Hanson, 2016).

## New Legal Efforts

In addition to expanding community programs and services, State legislatures and advocacy organizations are using new statutes and lawsuits to facilitate psychiatric admissions. In a unanimous House and Senate vote, the Minnesota legislature modified its civil commitment procedures to require hospitals to prioritize transfers from a jail or correctional institution, as well

as transfers involving a criminal defendant found legally insane or incompetent to stand trial. The law also mandated that the transfer must take place within 48 hours of commitment. In the first 18 months after the law went into effect, 104 patients were transferred to State psychiatric facilities (Serres, 2014).

The new law improved jail transfers, but the waiting time for non-forensic, non-prioritized admissions doubled. State hospitals protested and pushed back, citing the lack of staff to manage these higher acuity, more violent jail transfers. One hospital was cited for safety violations for failing to prevent patient-on-patient violence (Serres, 2017) and the inflow of patients overwhelmed existing staffing levels to the extent that the Centers for Medicare and Medicaid Services threatened to withhold Medicare and Medicaid funding.

Similar issues arose in South Dakota and Vermont. Concerns about violence caused one general hospital in South Dakota to threaten to send psychiatric patients to jail to await a bed in that State's only psychiatric facility (Anderson, 2017), while the State of Vermont was fined \$14,000 by the Occupational Safety and Health Administration for failing to protect staff from patient assaults. Between January 2015 and June 2016, there were more than 200 incidents of spitting, biting, kicking, punching, scratching, and choking of staff by patients in the Vermont Psychiatric Care Hospital, many of whom were transferred from jail (Mansfield, 2017).

The problem of violence within State psychiatric hospitals was severe enough that the professional organization for these facilities, the National Association of State Mental Health Program Directors (NASMHPD), noted in a 2014 report:

"It appears that the criminal justice system is increasingly relying upon State psychiatric hospitals to admit and treat persons of this nature. Courts often insist that State psychiatric hospitals continue to house/detain persons with a violent and criminal nature even after their mental illness has been successfully treated. State psychiatric hospitals are struggling to maintain safety for all persons that they serve and staff while maintaining the previously discussed principles of recovery-based care, trauma-informed care, and reduction/elimination of seclusion and restraint in a hospital environment (as opposed to jail or prison) when a portion of the persons they serve have a violent criminal nature in addition to and independent of their mental illness." (National Association of State Mental Health Program Directors, 2014)

The association encouraged States to work with courts to respect hospital recommendations to discharge and transfer patients back to the correctional facility when the patient was determined not to have a mental illness.

### "Psychiatric Boarding"

Meanwhile, patients who were not charged with crimes dropped lower on the admission waiting list and were left lingering in general hospital emergency rooms. In the 2014 case *Detention of D.W. v. Department of Social and Health Services*, the Washington Supreme Court held that prolonged detention of psychiatric patients in a hospital emergency room was a violation of that State's civil commitment law. The lawsuit challenged a practice known as "psychiatric boarding," in which patients held temporarily under that State's Involuntary Treatment Act were actually being kept in the emergency department for several days, with no care for their mental illness, due to a lack of bed space in the State's psychiatric facilities. The court held that keeping patients in an emergency department could not be used "as a method to avoid overcrowding certified evaluation and treatment facilities." The implication of this case is that the State must release temporarily detained patients if no inpatient space is available, even if there are no community resources to release them to.

The Washington lawsuit was one of several stemming from a U.S. Supreme Court case, *Olmstead v. L.C.* (1999). In *Olmstead*, two mentally disabled women were held in a Georgia psychiatric facility even though they no longer required hospitalization and were willing to be treated voluntarily in the community. They could not be released due to lack of community services. The court found that the Americans with Disabilities Act required States to provide community-based treatment to people with mental disabilities if they did not require institutional care. This case has also been interpreted to mean that disabled people living in the community must be provided any treatment that is required to keep them from being institutionalized. According to the Civil Rights Division of the

Department of Justice, *Olmstead* litigation has been pursued in at least 25 States since 2009 (Department of Justice, 2016).

*Olmstead* litigation has substantially improved access to community care and decreased crowding in State hospitals. In Delaware, use of inpatient services decreased by half. Two statewide mobile crisis teams were created, which diverted 80% of the people they encountered away from the criminal justice system into treatment. Reforms were so successful that the Department of Justice was able to terminate the settlement agreement and end oversight of that State. Similar settlement agreements are in place in Georgia, Virginia, New Hampshire, New York, North Carolina, Oregon, Rhode Island, and the city of Providence (Department of Justice, 2016c).

### Reducing Incarceration

Professional organizations have also banded together to reduce the number of people with mental illness in the criminal justice system. The American Psychiatric Association Foundation (2015), together with the National Association of Counties and the Council of State Governments Justice Center, have formed the Stepping Up Initiative. This program encourages State and local criminal justice, public health, and legal professionals to design programs and policies to link people with mental illness to community resources upon release from a correctional facility or as an alternative to hospitalization.

Supported by the U.S. Department of Justice's Bureau of Justice Assistance (BJA) and National Alliance on Mental Illness (NAMI), summit meetings have been held in Washington, D.C. as well as in counties in Florida and California. During the two years this program has been in place, more than 365 counties have passed resolutions to join the initiative. More information about the Stepping Up Initiative, including educational resources, peer-to-peer support

services, and technical assistance can be found at [stepuptogether.org](http://stepuptogether.org), the program's website.

Any effort to reduce the incarceration of people with mental illness requires funding from States and the Federal government. In 2016 Congress passed the 21st Century Cures Act, which provides billions of dollars for research into the treatment of brain disorders like schizophrenia and Alzheimer's disease. The bill also strengthens parity laws, creates a mechanism to fund evidence-based interventions, and provides grants to increase training of psychiatrists and psychologists (DeBonis, 2016).

However, as this article was being written Congress was debating how to reform, repeal, or replace the Affordable Care Act. Some versions of these bills would substantially reduce payments to hospitals for psychiatric care and allow States to drop insurance coverage for pre-existing conditions like psychiatric disorders, or would also potentially allow States to place annual and lifetime caps on reimbursement for the treatment of mental illness. The American Medical Association and the American Psychiatric Association have rallied their forces to oppose this legislation, which could potentially reverse any gains made to this point.

### Conclusion

The number of people with serious mental illness in American jails and prisons will be determined by State and Federal policies and legislation. All stakeholders—patient advocacy groups, professional organizations, care providers, correctional officials, and the courts—have a responsibility to work cooperatively to ensure that each patient receives timely care regardless of the institutional setting. ■

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