A JOINT REPORT

The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey

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The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey

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The Treatment Advocacy Center is a national nonprofit organization dedicated exclusively to eliminating barriers to the timely and effective treatment of severe mental illness. The organization promotes laws, policies and practices for the delivery of psychiatric care and supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder.

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EXECUTIVE SUMMARY

Prisons and jails have become America's "new asylums": The number of individuals with serious mental illness in prisons and jails now exceeds the number in state psychiatric hospitals tenfold. Most of the mentally ill individuals in prisons and jails would have been treated in the state psychiatric hospitals in the years before the deinstitutionalization movement led to the closing of the hospitals, a trend that continues even today. The treatment of mentally ill individuals in prisons and jails is critical, especially since such individuals are vulnerable and often abused while incarcerated. Untreated, their psychiatric illness often gets worse, and they leave prison or jail sicker than when they entered. Individuals in prison and jails have a right to receive medical care, and this right pertains to serious mental illness just as it pertains to tuberculosis, diabetes, or hypertension. This right to treatment has been affirmed by the U.S. Supreme Court.

The Treatment of Persons with Mental Illness in Prisons and Jails is the first national survey of such treatment practices. It focuses on the problem of treating seriously mentally ill inmates who refuse treatment, usually because they lack awareness of their own illness and do not think they are sick. What are the treatment practices for these individuals in prisons and jails in each state? What are the consequences if such individuals are not treated?

To address these questions, an extensive survey of professionals in state and county corrections systems was undertaken. Sheriffs, jail administrators, and others who were interviewed for the survey expressed compassion for inmates with mental illness and frustration with the mental health system that is failing them. There were several other points of consensus among those interviewed:

- Not only are the numbers of mentally ill in prisons and jails continuing to climb, the severity of inmates' illnesses is on the rise as well.
- Many inmates with mental illness need intensive treatment, and officials in the prisons and jails feel compelled to provide the hospital-level care that these inmates need.
- The root cause of the problem is the continuing closure of state psychiatric hospitals and the failure of mental health officials to provide appropriate aftercare for the released patients.

Among the findings of the survey are the following:

- From 1770 to 1820 in the United States, mentally ill persons were routinely confined in prisons and jails. Because this practice was regarded as inhumane and problematic, until 1970, such persons were routinely confined in hospitals. Since 1970, we have returned to the earlier practice of routinely confining such persons in prisons and jails.
- In 2012, there were estimated to be 356,268 inmates with severe mental illness in prisons and jails. There were also approximately 35,000 patients with severe mental illness in state psychiatric hospitals. Thus, the number of mentally ill persons in prisons and jails was 10 times the number remaining in state hospitals.

- In 44 of the 50 states and the District of Columbia, a prison or jail in that state holds more individuals with serious mental illness than the largest remaining state psychiatric hospital. For example, in Ohio, 10 state prisons and two county jails each hold more mentally ill inmates than does the largest remaining state hospital.

- Problems association with incarcerating mentally ill persons include:

    - Jail/prison overcrowding resulting from mentally ill prisoners remaining behind bars longer than other prisoners

    - Behavioral issues disturbing to other prisoners and correctional staff

    - Physical attacks on correctional staff and other prisoners

    - Victimization of prisoners with mental illness in disproportionate numbers

    - Deterioration in the psychiatric condition of inmates with mental illness as they go without treatment

    - Relegation in grossly disproportionate numbers to solitary confinement, which worsens symptoms of mental illness

    - Jail/prison suicides in disproportionate numbers

    - Increased taxpayer costs

    - Disproportionate rates of recidivism

- In state prisons, treatment over objection can be accomplished administratively in 31 states through the use of a treatment review committee. Such committees were originally authorized in the case of *Washington v. Harper* and upheld in 1990 by the U.S. Supreme Court. Even though this treatment mechanism is authorized in those states, it is often grossly underutilized.

- In state prisons in the other 18 states and the District of Columbia, treatment over objection requires a judicial review or transfer to a state psychiatric hospital, making such treatment much more difficult to carry out. Arkansas was the only state that refused to provide information for the survey.

- In county and city jails, the procedures for treating seriously mentally ill inmates over objection are much more varied and less clear. All counties in South Dakota and occasional counties in other states use a treatment review committee similar to that used in state prisons, and more jails could use this procedure if they wished to do so. Many jails require the inmate to be transferred to a state psychiatric hospital for treatment; since such hospitals are almost always full, such treatment does not take place in most cases.

- Prison and jail officials thus have few options. Although they are neither equipped nor trained to do so, they are required to house hundreds of thousands of seriously mentally ill inmates. In many cases, they are unable to provide them with psychiatric medications The use of other options, such as solitary confinement or restraining devices, is sometimes necessary and may produce a worsening of symptoms. Yet, when things go wrong, as they inevitably do, the prison and jail officials are blamed. The present situation is unfair to both the inmates and the officials and is untenable.

- The ultimate solution to this problem is to maintain a functioning public mental health treatment system so that mentally ill persons do not end up in prisons and jails. To this end, public officials need to:

    - **Reform mental illness treatment laws and practices** in the community to eliminate barriers to treatment for individuals too ill to recognize they need care, so they receive help *before* they are so disordered they commit acts that result in their arrest.

    - **Reform jail and prison treatment laws** so inmates with mental illness can receive appropriate and necessary treatment just as inmates with medical conditions receive appropriate and necessary medical treatment.

    - **Implement and promote jail diversion programs** such as mental health courts.

    - **Use court-ordered outpatient treatment** (assisted outpatient treatment/AOT) to provide the support at-risk individuals need to live safely and successfully in the community.

    - **Encourage cost studies** to compare the true cost of housing individuals with serious mental illness in prisons and jails to the cost of appropriately treating them in the community.

    - **Establish careful intake screening** to identify medication needs, suicide danger, and other risks associated with mental illness.

    - **Institute mandatory release planning** to provide community support and foster recovery.

    - **Provide appropriate mental illness treatment** for inmates with serious psychiatric illness.

- A model law is proposed to authorize city and county jails to administer nonemergency involuntary medication for mentally ill inmates in need of treatment.

Chapter 1

History of the Problem:

Have We Learned Anything in 200 Years?

Prisons and jails were commonly used to house mentally disordered persons in colonial America. If a "lunatic" or "mad person" was not violent, he or she would usually be kept at home. But those that were assaultive or violent would be confined in jail. As early as 1694, legislation was passed in the Massachusetts Bay Colony authorizing confinement in jail 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."[i]

Jailers were usually paid a fee by the person's family or by the town for confining such persons. For example, in New York City, the town marshal was paid two shillings six pence each week by the churchwardens "for to subsist Robert Bullman, a Madman in prison."[ii]

However, from the earliest days, there were voices of protest in the colonies, claiming that confining mentally ill persons to prisons and jails was inhumane. Such sentiments were important in leading the Pennsylvania Hospital in Philadelphia in 1752 to admit its first "lunatics" to what was essentially the nation's first psychiatric ward. Then, in 1773, Virginia Governor Francis Fauquier authorized the building in Williamsburg of the nation's first psychiatric hospital exclusively for the insane. Fauquier acknowledged that, lacking any alternative, he had been "forced to authorize the confinement of lunatics in the Williamsburg jail, against both his conscience and the law."[iii]

From 1820 to 1970

In the early years of the newly created United States, there were many Americans who claimed that putting mentally ill people in prisons and jails was inhumane and uncivilized. Such sentiments became prominent in the 1820s, with the organization of the Boston Prison Discipline Society. Founded in 1825 by the Reverend Louis Dwight, a Yale graduate and Congregationalist minister who had been shocked by what he saw when he began taking Bibles to inmates in jails, the Society began publicly advocating for improved prison and jail conditions in general and for hospitals for mentally ill prisoners in particular. According to Gerald Grob's *Mental Institutions in America*, Dwight's "insistence that mentally ill persons belonged in hospitals aroused a responsive chord, especially since his investigations demonstrated that large numbers of such persons were confined in degrading circumstances."[iv]

Dwight's advocacy led to the appointment in 1827 of a committee by the Massachusetts legislature to investigate conditions in the state's jails. The committee reported shocking conditions for "lunatics" being so confined: "Less attention is paid to their cleanliness and comfort than to the wild beasts in their cages, which are kept for show."[v] The committee recommended that confinement of mentally ill persons in prisons and jails be made illegal.

Three years later, Massachusetts approved the building of a state psychiatric hospital for 120 patients at Worcester. When the hospital opened in 1833, more than half of the admissions during the first year were transfers from jails, prisons, and almshouses.

The pioneering reform efforts of Louis Dwight are today not well known compared to the efforts of his successor, Dorothea Dix. A 32-year-old school teacher, Dix began her crusade in 1841, when she agreed to teach a Sunday school class at the Cambridge jail in suburban Boston. She was horrified by the conditions of the mentally ill inmates and immediately began investigating conditions in other Massachusetts jails. Dix's interest was presumably also influenced by the fact that she had grown up with a father who was almost certainly mentally ill, described as "fanatically religious, with a penchant for writing theological tracts in fits of 'inspiration.'"[vi]

Over the following year, Dix visited every jail in Massachusetts, then moved on to New Jersey and other states. In each state, she publicized the horrid conditions for mentally ill persons in the jails, prisons, and almshouses, then urged the state legislatures to appropriate funds for the building of state psychiatric hospitals where such persons could be treated humanely. What is perhaps most remarkable about her public speeches is how relevant they are for conditions today:

> I come to present the strong claims of suffering humanity. I come to place before the Legislature of Massachusetts the condition of the miserable, the desolate, the outcast. I come as the advocate of helpless, forgotten, insane and idiotic men and women; of beings, sunk to a condition from which the most unconcerned would start with real horror; of beings wretched in our Prisons, and more wretched in our Alms-Houses. And I cannot suppose it needful to employ earnest persuasion, or stubborn argument, in order to arrest and fix attention upon a subject, only the more strongly pressing in its claims, because it is revolting and disgusting in its details.

Mentally ill individuals, said Dix, do not belong in prisons and jails:

> Prisons are not constructed in view of being converted into County Hospitals, and Alms-Houses are not founded as receptacles for the Insane. And yet, in the face of justice and common sense, Wardens are by law compelled to receive, and Masters of Alms-House not to refuse, Insane and Idiotic subjects in all stages of mental disease and privation.

Good treatment for mentally ill persons is not possible in prisons and jails, she said, and the people running prisons and jails are not trained to provide such treatment:

> Jails and Houses of Correction *cannot* be so managed as to render them suitable places of confinement for that unfortunate class of persons, who are the subjects of your inquiries, and who, never having violated the law, should not be ranked with felons, or confined within the same walls with them. Jailors and Overseers of Houses of Correction, whenever well qualified for the management of criminals,

do not usually possess those peculiar qualifications required in those to whom should be entrusted the care of lunatics.

Putting mentally ill persons in prisons and jails, she added, is also unfair to other prisoners who are not mentally ill:

Injustice is also done to the *convicts*; it is certainly very wrong that they should be doomed day after day, and night after night, to listen to the ravings of madmen and madwomen. This is a kind of punishment that is not recognized by our statutes; and is what the criminal ought not to be called upon to undergo. The confinement of the criminal and of the insane in the same building is subversive of that good order and discipline which should be observed in every well-regulated prison.[vii]

* * *

By 1847, Dorothea Dix had visited 300 county jails and 18 state prisons. In many states, it was becoming increasingly accepted that mentally ill persons belonged in public mental hospitals, and the building of such hospitals was underway. By 1880, there were 75 public psychiatric hospitals for the nation's population of 50 million, and most mentally ill individuals who had previously been in prisons and jails had been transferred to the hospitals. This was clearly shown by the results of the 1880 federal census, which included a count of all "insane persons." In fact, the 1880 census is the most complete enumeration of mentally ill people ever carried out in the United States, before or since. In that census, only 397 "insane persons" were found in prisons and jails, compared with 58,609 other prisoners who were not insane. *Thus, in 1880, "insane persons" constituted less than 1 percent (specifically 0.7 percent) of the American prison and jail population*.[viii]

From the 1870s until the 1970s, it was widely assumed in the United States that mentally ill individuals did not belong in prisons and jails but rather in mental hospitals, where they could receive asylum and treatment. Most studies during that period reported comparatively low prevalence rates of mentally ill persons in prisons and jails. For example, a 1930 study of almost 10,000 arrestees reported that just 1.5 percent of them were psychotic at the time of arrest.[ix] Thus, for approximately 100 years, the problem of mentally ill persons in prisons and jails appeared to have been solved. These individuals were treated as patients, not as criminals, and were sent to mental hospitals for treatment.

From 1970 to the Present

All of this began to change with the emptying of the state mental hospitals beginning in the 1960s. Widely referred to as deinstitutionalization, this was probably the most well-meaning but poorly planned medical-social policy of twentieth-century America; it has been reviewed elsewhere.[x] Because the majority of patients being discharged from the hospitals were not given follow-up psychiatric care and relapsed into psychosis, some inevitably committed misdemeanor or felony acts, usually associated with their untreated mental illness, and were arrested.

By the early 1970s, the effect of deinstitutionalization on the prison and jail population was becoming apparent. In a seminal article published in 1972, Marc Abramson, a psychiatrist in San Mateo County, California, noted a rapid increase in mentally ill individuals in the San Mateo County jail and called it the "criminalization of mentally disordered behavior." He noted that the trend was also affecting state prisons, where "many more men are being sent to prison who have serious mental problems." He quoted a prison psychiatrist as saying: "We are literally drowning in patients." Prophetically, Abramson foresaw the possible future consequences of these changes:

> There may be a limit to society's tolerance of mentally disordered behavior. If the entry of persons exhibiting mentally disordered behavior into the mental health system of social control is impeded, community pressure will force them into the criminal justice system of social control. Further, if the mental health system is forced to release mentally disordered persons into the community prematurely, there will be an increase in pressure for use of the criminal justice system to reinstitutionalize them. . . . Those who castigate institutional psychiatry for its present and past deficiencies may be quite ignorant of what occurs when mentally disordered patients are forced into the criminal justice system.[xi]

In 1973, hearings were held by the California State Senate to discuss this problem. Sheriffs from several counties confirmed that they were seeing a sharp increase in mentally ill persons in their jails. By the mid-1970s, this increase was being noted in many states, and in 1978 and 1979, the federal General Accounting Office (GAO) carried out a study of psychiatric care in state and federal prisons. In 1980, another study was published on "500 defendants in need of psychiatric treatment" that concluded emptying the hospitals has "forced a large number of these deinstitutionalized patients into the criminal justice system."[xii] In 1982 and 1983, Dr. H. Richard Lamb and his colleagues at the University of Southern California published two rigorous studies of mentally ill inmates in the Los Angeles County Jail and cited multiple other studies indicating that the problem was getting worse.[xiii]

Thus, by the early 1980s, three decades ago, it was clear that deinstitutionalization was resulting in a progressive increase of mentally ill individuals in the criminal justice system. Discharging individuals with serious mental illnesses without ensuring that they received proper treatment in the community was a prescription for sure disaster.

* * *

Since the early 1980s, the situation has become predictably and progressively worse. Headlines such as "Mentally ill flood prisons"[xiv] have been seen increasingly often, and some officials in the 1980s estimated that 10 percent of prison and jail inmates had serious mental illnesses; such estimates contrasted with estimates of 5 percent a decade earlier. Furthermore, there was little doubt where the mentally ill inmates were coming from: a 1988 study of 132 patients discharged from an Ohio state hospital reported that 17 percent of them were arrested within six months.[xv]

During the 1990s, the situation continued to deteriorate. An extensive 1992 survey of 1,371 jails reported how minor offenses, usually associated with untreated mental illness, caused

many mentally ill individuals to be arrested. The survey also detailed the problems associated with placing mentally ill individuals in jails, including the worsening of their psychiatric symptoms; abuse, assault, and rape; and suicide.[xvi] By 1998, a federal Department of Justice survey noted that "16 percent of State prison inmates" and "16 percent of those in local jails reported either a mental condition or an overnight stay in a mental hospital."[xvii]

As deinstitutionalization has continued during the past decade, the situation in the nation's prisons and jails has grown increasingly deplorable. In Atlanta, following the closure of the Georgia Mental Health Institute, "the number of inmates [in the county jail] being treated for mental illness . . . increased 73.4 percent." Following the closure of the Northwest Georgia Regional Hospital, the head of the local county jail reported that "prisoners with mental problems . . . increased by 60 percent."[xviii] A 2006 report by the Department of Justice reported that 15 percent of inmates of state prisons and 24 percent of inmates in local jails were psychotic.[xix] Higher estimates of serious mental illness for individual institutions are increasingly being reported, such as 30 percent for Ohio's Stark County Jail and Missouri's Boone County Jail; 40 percent for Texas's El Paso County Jail and Alabama's Tuscaloosa County Jail; 44 percent for Pennsylvania's Erie County Jail; and 60 percent for Iowa's Black Hawk County Jail.[xx]

* * *

Perhaps the most alarming aspect of the present situation is that such numbers no longer elicit much professional or public reaction. In 2009, the Subcommittee on Human Rights and the Law of the U.S. Senate Committee on the Judiciary held hearings on "Mental illness in U.S. prisons and jails" with little media coverage. In 2010, the Treatment Advocacy Center reported that in the United States as a whole "there are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals"; the worst states, such as Arizona and Nevada, had almost 10 times more.[xxi] In 2012, it was reported that 12 percent of all adult psychiatric patients who were receiving treatment in the San Diego County public system were incarcerated within a one-year period.[xxii] In 2013, it was reported that 28 percent of all individuals with schizophrenia and bipolar disorder who were receiving treatment by the Connecticut Department of Mental Health were involved in the criminal justice system in a two-year period and that such individuals cost the taxpayers twice as much as individuals with schizophrenia and bipolar disorder who were not involved in the criminal justice system.[xxiii] Half a century ago, such reports would have elicited spirited public discussion and proposals for reform; now they elicit a collective public yawn.

Problems Associated with Putting Mentally Ill Persons in Prisons and Jails

The practice of putting seriously mentally ill persons into prisons and jails was abandoned in the middle of the nineteenth century in the United States. The reasons behind the abandonment of this practice included the fact that it was widely regarded as inhumane and that it also caused multiple problems for those who are mentally ill, for other prisoners, and for the prison and jail officials. In view of these well-known problems, the re-adoption of this practice in the late twentieth century is incomprehensible. It suggests that the learning curve among public mental health officials and elected state officials who have sanctioned this practice must be relatively flat.

Among the problems associated with placing seriously mentally ill individuals into prisons and jails are the following:

1. **Mentally ill prisoners remain in prison and jail longer than regular prisoners and thus contribute to overcrowding.**

   Mentally ill prisoners remain in prison and jail longer than other prisoners because they are less likely to obtain bail and are more likely to break the rules, thus failing to get a reduction in their sentence for good behavior. In Florida's Orange County Jail, the average stay for all inmates is 26 days; for mentally ill inmates, it is 51 days. In New York's Rikers Island Jail, the average stay for all inmates is 42 days; for mentally ill inmates, it is 215 days. In one study, mentally ill jail inmates were twice as likely (19 percent versus 9 percent) to be charged with facility rule violations. In another study in the Washington State prisons, mentally ill inmates accounted for 41 percent of infractions, although they constituted only 19 percent of the prison population. In a county jail in Virginia, 90 percent of assaults on deputies were committed by mentally ill inmates.[xxiv]

2. **Mentally ill prisoners, especially those not being treated, cause major behavioral problems in prisons and jails.**

   Prisons and jails are unpleasant environments even on the best of days. However, when they are overcrowded and have multiple individuals who are loudly hallucinating or manic, they become living hells. In an Oklahoma prison, it was reported that "the screams, moans and chanting are normal. The noise level rises as the sun goes down. . . . One inmate believes he is in a prisoner of war camp in Vietnam while another screams that communists are taking over the facility." A deputy at Mississippi's Hinds County Detention Center said: "They howl all night long. If you're not used to it, you end up crazy yourself." One inmate in this jail was described as having "tore up a damn padded cell that's indestructible, and he ate the cover of the damn padded cell. We took his clothes and gave him a paper suit to wear, and he ate that. When they fed him food in a Styrofoam container, he ate that. We had his stomach pumped six times, and he's been operated on twice."[xxv]

   Much of the behavior exhibited by mentally ill prisoners is bizarre. In Montana, a man "tried to drown himself in the jail toilet," and in California, inmates tried to

escape “by smearing themselves with their own feces and flushing themselves down the toilet.”[xxvi] Such behavior is disturbing to other prisoners and to staff, often resulting in the abuse of the mentally ill prisoner and placement in solitary confinement.

3. Mentally ill prisoners are disproportionately abused, beaten, and/or raped.

Mentally ill prisoners are victimized much more frequently than other prisoners. According to a 2007 prison survey, “approximately one in 12 inmates with a mental disorder reported at least one incident of sexual victimization by another inmate over a six-month period, compared with one in 33 males inmates without a mental disorder.” Among female mentally ill inmates, this difference was three times higher than among male mentally ill inmates.[xxvii]

In 2003, Congress passed the Prison Rape Elimination Act. Subsequently, a National Prison Rape Elimination Commission undertook a five-year study of the problem. The report, issued in 2009, indicated that having a serious mental illness was a major risk factor for prison rape. It is also a major problem in jails. For example, in 2013 Joaquin Cairo, diagnosed with schizophrenia, was arrested for criminal mischief and admitted to the psychiatric unit of the Dade County Jail in Miami. Within days he suffered a fractured pelvis when he was “violently slammed into a bed by a fellow inmate during an attempted rape”; he subsequently died from the injuries.[xxviii]

4. Mentally ill prisoners often become much sicker in prison and jail, especially if they are not being treated.

As everyone who works in prisons and jails is aware, mentally ill prisoners who are not being treated often become much more symptomatic while incarcerated. Since mentally ill prisoners are permitted to refuse medication in most correctional settings except under exceptional circumstances, this causes major problems. Jail officials can thus be legally sued in many states if they forcibly medicate mentally ill prisoners without their consent, yet can also be held legally responsible for the consequences of such prisoners’ psychotic behavior. It is a situation that is grossly unfair both to the mentally ill prisoners and to prison and jail officials.

One of the most dramatic illustrations of this problem is self-mutilation by mentally ill prisoners. Such incidents are not new (e.g., “Man who blinded self is moved from prison,” *Atlanta Constitution*, Mar. 8, 1985), but they appear to be becoming more frequent:

> *Georgia, 2002*: “A schizophrenic man who was jailed after wandering into traffic and knocking on doors late at night gouged out his own eyes in his cell.” (*Charleston Gazette*, July 20, 2002)

North Carolina, 2007: Mario Phillips, diagnosed with schizophrenia, "cut his genitals with a razor while he was locked up waiting to go to trial." *(Fayetteville Observer*, Oct. 3, 2007)

Florida, 2007: Mark Kuzara, who "has a history of mental illness and self-mutilation," cut open his abdomen in the Polk County Jail. After the wound had been stapled, "Kuzara removed the staples at the hospital with his mouth and ate them. . . . Inmates gave Kuzara pen caps, bolts and paper that he would shove into the open wound. Kuzara also made himself vomit up meals, throwing up into the open wound." (*Lakeland Ledger*, Dec. 4, 2007)

Texas, 2009: Andre Thomas, diagnosed with schizophrenia, "plucked out his right eye . . . while in the Grayson County Jail five days after his arrest." Four years later, in a Texas state prison, Thomas "removed his [other] eye and ate it in a bizarre outburst." (*Wall Street Journal* blog, Mar. 20, 2008)

Minnesota, 2013: Michael Schuler, who "was psychotic and had taken methamphetamine," stabbed out both of his eyes with a pencil in the Hennepin County Jail. Previously, he had been observed "standing naked in his cell, standing in his own feces, screaming gibberish," but he "refused to take his medication." (Tom Lyden, *KMSP-TV* bio/email, Feb. 26, 2013)

This last case illustrates the impossible situation confronting prison and jail officials on a regular basis. Mr. Schuler refused medication, so he was not involuntarily medicated, which might have led to a lawsuit brought by him. But because he was not given medication, he blinded himself and then sued the jail for "providing negligent care when he was suffering from mental illness." Thus, prison and jail officials are blamed if they act and also blamed if they do not.

5. Mentally ill prisoners are much more likely to spend time in solitary confinement.

Solitary confinement usually involves keeping prisoners in cells by themselves for 23 hours a day, allowing prisoners only one hour for showers and to exercise by themselves. Human interactions are limited, with meals usually being passed into the cell. It is variously called disciplinary segregation, administrative segregation, supermax, security housing units (SHU), special management units (SMU), control units, or simply "the hole."

As the number of seriously mentally ill prisoners has increased in recent years, an increasing number of them have ended up in solitary confinement. In New York prisons in 2003, it was estimated that approximately one-quarter of prisoners in solitary confinement were mentally ill, while in Colorado prisons in 2013 "prisoners with moderate to severe mental illness now make up the majority of those in solitary."[xxix] Mentally ill prisoners who refuse to take medication are

especially likely to end up in solitary confinement, both because they are so disruptive and sometimes for their own protection.

The effect of solitary confinement on mentally ill prisoners is almost always adverse. The lack of stimulation and human contact tends to make psychotic symptoms worse. Thus, it is not surprising that many of the incidents of self-mutilation and suicide by mentally ill prisoners take place when they are in solitary confinement. This has led to lawsuits against state corrections officials in several states, including Connecticut, Massachusetts, New Mexico, Ohio, Texas, and Wisconsin.[xxx]

6. Suicides in prisons and jails occur disproportionately more often among prisoners who are mentally ill.

Suicides in prisons and jails occur, as would be expected, disproportionately among prisoners who are mentally ill. A study of 132 suicide attempters in the King County, Washington, jail system reported that 77 percent of them had a "chronic psychiatric problem," compared with 15 percent among the rest of the jail population. Interestingly, a history of substance abuse was not more prevalent among the suicide attempters compared to the rest of the jail population.[xxxi] Similarly, a study of 154 completed suicides in the California prison system reported that "73 percent had a history of mental health treatment."[xxxii]

The threat of suicide by prisoners is one of the biggest problems for corrections officials. It necessitates the careful screening of newly admitted prisoners for suicide potential and having a system of suicide watch for those at greatest risk. Since many such individuals have to be monitored every 15 minutes or watched continuously, this involves extra personnel and is one reason the cost of caring for mentally ill prisoners is much higher than the cost for other prisoners. Suicides by prisoners are also a common source of lawsuits brought against prisons and jails, thus further increasing costs.

7. Mentally ill prisoners cost the county and state much more than other prisoners.

Since mentally ill prisoners stay longer than other prisoners, it is not surprising that they also cost significantly more. In Florida's Broward County Jail in 2007, the difference was $130 versus $80 per day. In Texas prisons in 2003, mentally ill prisoners cost $30,000 to $50,000 per year, compared to $22,000 for other prisoners. In Washington State prisons in 2009, the most seriously mentally ill prisoners cost $101,653 each, compared to approximately $30,000 per year for other prisoners. And these costs do not include the costs of lawsuits increasingly being brought against county jails, such as the suit brought in New Jersey in 2006 by the family of a "65-year-old mentally ill stockbroker [who was] stomped to death in the Camden County Jail."[xxxiii]

Much of the cost of mentally ill prisoners comes from medication costs. In the Iowa prison system, for example, the cost of psychiatric medication increased 28-fold between 1990 and 2000.[xxxiv] One solution to this problem is to have the

family of the mentally ill prisoner supply the medication, which is allowed in some places. The risk, however, is that this could be used as a way to get illegal drugs into the prison or jail. In addition, the prison or jail could be held legally responsible and sued if something went wrong. For this reason, many jurisdictions do not allow this practice. Yet, if the mentally ill prisoner does not receive medication in a timely manner, the prison or jail may also be sued. Once again, the corrections system has been placed in the unfair position of being liable to lawsuits no matter what they do.

8. Mentally ill prisoners are much more likely than regular prisoners to return to prison or jail in a "revolving door" phenomenon.

Because of the widespread failure of the public mental health treatment system, most mentally ill prisoners do not receive follow-up treatment when they leave prison or jail. As a consequence, they often end up re-arrested and become "frequent flyers," individuals who repeatedly recycle through the criminal justice system. Mentally ill individuals constitute at least half of all frequent flyers, according to most surveys.

A study of frequent flyers in a Florida jail defined them as having had at least "10 prior incarcerations within the prior 5 years." Among this group, "almost 50 percent were known to the jail mental health unit or mental health professionals in the community, or had been prescribed psychotropic medications at some time."[xxxv] Looked at another way, a study of mentally ill individuals in the Los Angeles County Jail reported that 88 percent of them had had a previous psychiatric hospitalization, and 95 percent had had a previous arrest.[xxxvi]

Mentally ill "frequent flyers" thus contribute to prison and jail overcrowding and costs. In a valiant attempt to reduce this cycle of mentally ill individuals returning to his jail, Sheriff Tom Dart, the director of the Cook County Jail in Chicago, announced in 2013 that he was setting up his own mental health office and 24-hour helpline to help the mentally ill individuals who were being released from his jail.[xxxvii]

* * *

In summary, it has been known for almost 200 years that confining mentally ill persons in prisons and jails is inhumane and fraught with problems. The fact that we have re-adopted this practice in the United States in recent years is incomprehensible. Prison and jail officials are being asked to assume responsibility for the nation's most seriously mentally ill individuals, despite the fact that the officials did not sign up to do this job; are not trained to do it; face severe legal restrictions in their ability to provide treatment for such individuals; and yet are held responsible when things go wrong, as they inevitably do under such circumstances. This misguided public policy has no equal in the United States.

Chapter 2

Legal Background for Treating Mentally Ill Persons in Prisons and Jails

Given the large number of seriously mentally ill individuals in our prisons and jails and the associated problems as described in the first chapter, the question becomes how these individuals can be treated for mental illness. Many of the seriously mentally ill inmates will accept medication voluntarily. Others, especially those who are not aware of their own illness (in other words, those who have anosognosia), will not accept medication voluntarily because they think there is nothing wrong with them.

These conditions raise complex legal issues that require balancing an individual's constitutional right to be free from unwanted intrusions and the government's obligation to protect its citizens from harm. The purpose of this chapter is to describe the legal authority for administering medication over an inmate's objection when the inmate is in need of psychiatric treatment by addressing five fundamental questions.

1. **What can prisons and jails do when an inmate refuses medication, despite all efforts to encourage compliance? Can medication be administered, despite an inmate's refusal?**

   As the number of prison and jail inmates with mental illness has increased, so have corrections system resources for addressing the special needs of this population. At a minimum, most jails have mental health screening services. The scope of other available correctional mental health services ranges from mental health counselors to psychiatric inpatient units. This is not to imply all jails provide enough services. Most jails are unable to provide services that are adequate to meet the needs of inmates with mental illness. Medication, which ameliorates psychotic symptoms and severe mood disturbances, is the most important aspect of treatment for the vast majority of inmates with mental illness. But no matter how robust a facility's resources and protocols for encouraging treatment compliance, there will always be inmates who refuse psychotropic medication.

   Because a prison or jail inmate's right to refuse psychiatric medication has been held to be protected by the United States Constitution,[xxxviii] the government may not infringe upon it without first meeting the basic requirements of the Due Process Clause of the 14th Amendment. This has both substantive and procedural dimensions.

   Substantively, the guarantee of due process requires the government to identify a recognized governmental interest that is substantial enough to justify the infringement on the inmate's liberty. In the present context, the government's interest may arise under its: (1) *police powers* to protect any and all citizens from imminent and substantial risk of harm; and/or (2) *parens patriae* powers to protect citizens who are particularly vulnerable or unable to care for themselves.[xxxix]

Procedurally, due process requires the government to provide the citizen whose rights are at stake an opportunity to challenge its proposed action via a process that is adequate in light of both the severity of the contemplated intrusion and the urgency of the government's need for it. Accordingly, when the government seeks to prevent a substantial risk of imminent harm, its procedural obligation is less exacting than it would be in the presence of a mere *likelihood* of *eventual* harm.[xl]

It is worth noting that the same constitutional principles apply in determining an individual's right to refuse food, drink, or other medications, such as insulin, regardless of whether the individual is a patient in a psychiatric hospital, a civilly committed outpatient, a parolee subject to court-ordered medication, or an inmate in a correctional facility.

2. What can be done if an inmate refuses medication and becomes imminently dangerous?

An inmate with psychiatric symptoms such as psychosis or mania who refuses medication may subsequently experience a sudden and unanticipated escalation in the severity of symptoms, thereby becoming imminently dangerous to self or others. Under these circumstances, a physician may determine that medication is the safest and most effective means of addressing the emergency. Because medication over objection impinges on the inmate's right to refuse medication, the inmate must be afforded an opportunity to avoid the government intrusion. In constitutional terms, the government must satisfy the inmate's due process rights. Even in an emergency, when there is no time for a lengthy decision-making process, the government is still obligated to provide an inmate some process before the "emergency involuntary administration of psychotropic medication," which usually requires an intramuscular injection. At a minimum, the inmate will be offered an opportunity and encouragement to consent to treatment. While the nature of an emergency limits the process that can be provided to the inmate prior to obtaining authorization for involuntary medication, it also puts limits on the authorization itself. The authorization may be limited to allowing only one injection, or the duration of the authorization may be limited to 72 hours or less. Some jail and prison protocols include a process for a subsequent review of involuntary medication authorizations to verify that decisions were justified. If a physician determines that the inmate continues to need medication after the emergency authorization has expired, a more substantial process of review is required.

3. What happens when it's not an emergency, but an inmate's deteriorating symptoms increase his likelihood of becoming a danger to self or others or decrease his ability to provide for self-care?

This is the question posed in the survey of jails and prisons for this report. The tragic incidents documented in Chapter 3 demonstrate just how critical a question it is. Inmates who linger untreated in jails and prisons become increasingly more vulnerable to their symptoms and the resulting victimization or violence. Rather than triggering the government's *police powers*, as in an emergency, authorization of nonemergency involuntary psychotropic medication must be justified under the government's *parens patriae* powers. The intrusion upon the inmate is as substantial as it is in an emergency,

but the relative lack of urgency heightens the government's duty to provide the inmate an opportunity to meaningfully challenge the restriction of his liberty.

4. What process is due under the U.S. Constitution when a prison or jail seeks authorization for administration of nonemergency involuntary psychotropic medication?

In 1990, the United States Supreme Court held that an inmate with mental illness need not be imminently dangerous before being medicated over his objection and that authorization may be determined in an administrative hearing rather than a judicial one.

In the seminal case of *Washington v. Harper,* 494 U.S. 201 (1990), Walter Harper, a Washington state prison inmate, sued the state of Washington claiming that his due process rights were violated when antipsychotic medication was administered over his objection without the state first providing a judicial hearing. He also alleged that medication could not be administered over his objection unless a judge found him incompetent to make his own medical decisions.

Washington v. Harper addressed only *antipsychotic* medications (also known as neuroleptics) used to treat psychoses. Injectable medications are not limited to antipsychotics and virtually all state involuntary medication policies govern both antipsychotics and other psychotropics. Only a few state policies make a distinction between antipsychotic medications and other psychotropics (e.g., Massachusetts and Minnesota).

Pursuant to the Washington State Department of Corrections policy, authorization for the involuntary administration of antipsychotic medications was decided in an administrative hearing conducted before a three-member special committee consisting of a psychiatrist and a psychologist, neither of whom may be involved in the inmate's treatment at the time of the hearing (referred to in some states as a nontreating psychiatrist and a nontreating psychologist) and a representative of the correctional facility. The inmate was afforded procedural protections, including notice of the hearing, an opportunity to be heard and to present witnesses, and a right to appeal the committee's decision. The policy empowered the committee to authorize medication only upon a finding by the psychiatrist member and at least one other member that the inmate met the criteria stated in the policy.

> The Supreme Court upheld Washington's policy, reasoning that:
>
> "There can be little doubt as to both the legitimacy and the importance of the governmental interest presented here. There are few cases in which the State's interest in combating the danger posed by a person to both himself and others is greater than in a prison environment . . . We confront here the State's obligations, not just its interests. The State has undertaken the obligation to provide prisoners with medical treatment consistent not only with their own medical interests, but also with the needs of the institution. Prison administrators have not only an interest in ensuring the safety of prison staffs and administrative personnel, but also the duty to take reasonable measures for the prisoners' own safety."[xli]

The Court rejected Harper's claim that medication could not be administered over his objection if he was competent to provide informed consent but refused to do so. The Court also upheld the state's criteria for administering involuntary medication, which required that an inmate with mental illness be "gravely disabled" or pose a "likelihood of serious harm" to himself, others or property. The Court based its decision on prison officials' interest in maintaining a safe environment to protect corrections officers and prison staff, as well as the obligation to provide for the medical needs of its prisoners.

5. How does the United States Supreme Court's decision in *Washington v. Harper* influence prison and jail policies and procedures for nonemergency administration of involuntary psychotropic medication today?

State prison policies are easier to characterize than local jail policies. The majority of prison policies (thirty-one states) involve administrative hearings based on the *Washington v. Harper* decision. As noted by the Court:

> "Nor can it be ignored that requiring judicial hearings will divert scarce prison resources, both money and staff's time, from the care and treatment of mentally ill inmates."[xlii]

Indeed, the formalities and filing requirements involved with court proceedings can be both time-consuming and cumbersome, which may delay treatment or discourage an application for treatment from being filed altogether. Thirteen states (California, Florida, Hawaii, Louisiana, Maine, Massachusetts, Minnesota, New Hampshire, New Mexico, Rhode Island, Vermont, Virginia, and Wisconsin) require a judicial hearing as noted in the state summaries in Chapter 3. The purpose of the hearing, like that of the administrative hearing, is to determine whether the inmate meets the criteria for involuntary treatment. Five states (Iowa, Maryland, New York, Pennsylvania, and South Carolina) and the District of Columbia do not allow nonemergency involuntary medication and instead require the inmate to be civilly committed to a state psychiatric hospital for treatment. One state (Arkansas) did not disclose its policies for this report.

The criteria that an inmate must meet vary from state to state as well. The most common criteria are based on the *Washington v. Harper* "gravely disabled" and "likelihood of serious harm" standards. Only six states (Hawaii, Louisiana, Massachusetts, Minnesota, New Mexico, and Vermont) require a finding that the inmate lacks capacity for informed consent – the standard that Harper argued was constitutionally required. New Mexico requires that a guardian be appointed by the court to make treatment decisions.

County jails employ the same types of procedures as prisons use for medication over objection and the same legal principles apply. However, there is a significant amount of variability from one county to the next making it difficult to draw any generalizations.

A state-by-state review of policies for "non-emergency administration of involuntary psychotropic medication" is presented in Chapter 3.

Chapter 3

The State Survey

Methods, Definitions, and Results

Half a century ago, in 1964, there were slightly fewer than 500,000 individuals with serious mental illnesses in the state psychiatric hospitals. The first effective antipsychotic and antidepressant medications had been discovered a few years earlier, and therefore most of these individuals were receiving treatment for the first time.

Now, 50 years later, there are approximately 35,000 individuals with serious mental illnesses remaining in the state psychiatric hospitals. The majority of these individuals are there because they have committed a crime and been court-ordered to the hospital as forensic patients.

Where did the other patients who were in the state psychiatric hospitals in 1964 go? Some of them are living in their own homes, in board-and-care homes, or in nursing homes. Others are living on the streets or in public shelters. A large number are in prisons and jails, charged with misdemeanor or felony offenses, many of which are a direct consequence of their untreated mental illness. They are one reason, along with the drug laws and mandatory sentencing, that most prisons and jails are overcrowded. The present survey was undertaken to ascertain the current situation regarding individuals with serious mental illness in the prisons and jails of each state.

Methods

Capacity of state prisons: The average daily population numbers for state prisons were taken from the *2012 Directory* (73rd edition) of the American Correctional Association.

Prison treatment policies: This information was collected by Mary Zdanowicz, J.D. Some state policies and procedures for the nonemergency administration of psychotropic medication in prison are specified in statute. More often, they are contained in state departments of correction policies, operating procedures, etc. Many of these are available on the Internet. However, in some states, involuntary psychotropic medication procedures are protected for security purposes and may only be obtained through state freedom of information statute requests. Arkansas is the only state that did not respond to a request for information about its policy on involuntary medication in the state correctional system.

Capacity of jails: In most cases, the jail capacity was taken from the online jail directory of the American Jail Association as of August 2013. Since the rated capacity is available for all jails, but the average daily population is only available for some jails, the former was used. However, in some cases the online information was found to be out-of-date and was corrected by direct inquiry.

Jail treatment policies: This information was collected by Mary Zdanowicz, J.D. Unlike prison policies, which are consistent within each state, jail policies in counties within a state may be significantly diverse. Unless preempted by state law, each county determines how its jails are administered. There are two exceptions: (1) states with statutes governing an inmate's right to refuse treatment in jails and (2) a handful of states in which jails and prisons are consolidated and administered by the Department of Corrections. Otherwise, the only way to determine what jails are doing is to conduct interviews of jail personnel in every state.

There are more than 3,000 counties in the United States, each with its own laws and governing bodies. Consequently, it is virtually impossible to accurately represent the practices of all counties within a state. For example, three Washington state counties employ three different procedures in jails to obtain authorization to medicate over objection. One county has a *Washington v. Harper* administrative process (see Chapter 2); another obtains a judicial court order; and the third seeks involuntary commitment to a state hospital when an inmate needs treatment. For this study, an analysis of jails was conducted through interviews with a range of professionals, including sheriffs, jail administrators, corrections officers, prosecutors, public defenders, county mental health departments, and staff and contracted professionals providing mental health services in jails, including psychiatrists, nurses, and social workers.

The jail treatment procedure that is identified in the narrative for each state is not necessarily used in all counties in that state. It is typically the one that, based on interviews, offers the best likelihood that a jail can treat an inmate who refuses medication and is at risk of harm or grave disability due to mental illness.

Percentage of inmates in prisons who are seriously mentally ill: This, of course, varies widely among the prisons within each state. The average numbers used herein were taken from a 2006 survey of the Department of Justice (Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, September 2006, NCJ 213600). The survey reported that "an estimated *15 percent* of State prisoners . . . reported symptoms that met criteria for a psychotic disorder." These estimates were based on studies done in 2004. Based on our review of studies done previously and subsequently to this 2006 report, we believe this number is reasonable.

Percentage of inmates in jails who are seriously mentally ill: This also varies widely among jails within each state. A study by Steadman et al., based on inmate interviews in jails in Maryland and New York in 2002-2006, reported that 16.7 percent of inmates (14.5 males, 31.0 females) exhibited symptoms of serious mental illness (schizophrenia, schizoaffective, bipolar, major depression, brief psychotic disorder) within the previous month. However, 31 percent of inmates – almost certainly including many with a serious mental illness – refused to participate in the study (Steadman et al., Prevalence of serious mental illness among jail inmates, *Psychiatric Services* 2009;60:761–765). The Department of Justice study by James and Glaze, cited above, based on 2002 data, reported 24 percent of jail inmates with symptoms of a psychotic disorder. Given that these surveys were done eight to 12 years ago – and in light of evidence the problem has gotten worse – we believe using an average of *20 percent* of jail inmates as being seriously mentally ill is reasonable and possibly overly conservative.

Information on prison and jail conditions: Because there is limited systematic federal or state information on prison and jail conditions, news accounts and published reports were used.

Individual state mental hospital beds: There is no single source for these numbers, which are changing by the month as states continue to downsize and merge hospitals. The best sources appear to be the website maintained by *U.S. News and World Report* and the websites maintained by the state departments of mental health. For several states, it was necessary to call the state hospital for clarification. In general, the numbers cited are higher than the actual current bed capacity since downsizing has continued after the collection of the numbers used in this study.

Total state mental hospital beds: Information on how states rank on their total number of public psychiatric beds per capita was taken from E. Fuller Torrey, Doris A. Fuller, Jeffrey Geller et al., *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals, 2005–2010*, Treatment Advocacy Center, 2012.

Expenditures for mental health services by state: This information was taken from *Funding and Characteristics of State Mental Health Agencies, 2010*, Substance Abuse and Mental Health Services Administration, 2010. The report is based on 2008 state data and is the most recent report available.

Assessment of efforts at jail diversion by state: This information is taken from Brian Stettin, Frederick J. Frese, and H. Richard Lamb, *Mental Health Diversion Practices: A Survey of the States*, Treatment Advocacy Center, August 2013. The report assessed the use of mental health courts and Crisis Intervention Team (CIT) training to divert mentally ill individuals from the criminal justice system.

Definitions

Anosognosia: A condition found in some individuals with serious mental illness whereby they are unaware of their own illness. This lack of awareness or "lack of insight," as it is sometimes called, is caused by the effects of the mental illness on the parts of the brain that we use to think about ourselves.

Assisted outpatient treatment (AOT): A legal provision available in 45 states and the District of Columbia whereby individuals with serious mental illness who have a history of specific behavior such as dangerousness to self or others (the specific behaviors differ somewhat depending on state law) may live in the community on the condition that they follow their prescribed treatment plan, e.g., *Kendra's Law* in New York; *Laura's Law* in California..

Distinction between prisons and jails: In general, prisons house individuals convicted of felonies and sentenced to more than one year. They are funded by the state. Jails house individuals who are awaiting trial and those who have been sentenced to less than one year, usually for misdemeanor crimes or violations such as disorderly conduct or minor traffic violations. They are funded by the county. However, some states, such as Pennsylvania and

Louisiana, refer to their jails as “prisons,” and many prisons are called “correctional centers” or other names. Also confusing is the fact that Alaska, Connecticut, Delaware, the District of Columbia, Hawaii, Rhode Island, and Vermont more or less combine their prisons and jails into single correctional facilities.

Emergency vs. nonemergency medication over objection: The administration of psychotropic medication to an inmate who refuses to accept it voluntarily may occur (1) under emergency circumstances, when an inmate experiences a sudden and unanticipated escalation in the severity of symptoms, thereby becoming imminently dangerous to self or others; or (2) in a nonemergency, when treatment is needed to prevent an inmate’s psychiatric condition from deteriorating to the point at which he or she is unable to care for self or likely to cause some harm to self or others. In an emergency, psychotropic medications are typically administered by intramuscular injection. In a nonemergency, psychotropic medications may be administered orally or by intramuscular injection.

Forensic patients: Individuals confined to psychiatric hospitals because they have been charged with or convicted of breaking a law and suffer from psychiatric disorders. Included are those found not guilty by reason of insanity.

Informed consent: Patient permission for a medical treatment or intervention with full knowledge of possible risks and benefits. Informed consent has two required components: (1) a physician must provide adequate information about the proposed treatment to the patient; and (2) the patient must have the capacity to use the information appropriately in the decision-making process. Generally, the physician must inform the patient about: (a) the nature and purpose of the proposed treatment; (b) potential benefits and risks; and (c) alternative treatments, including the risks and benefits. Capacity to consent requires that the patient: (a) understand the information disclosed in the informed consent process; (b) appreciate the information as it relates to his/her own circumstances; (c) use reason in the decision-making process; and (d) express a choice.

Psychotropic medications: Medications used to treat psychiatric disorders. There are two categories of psychotropic medications: (1) antipsychotic medications (also known as neuroleptic medications), which are used to treat psychotic symptoms, such as hallucinations, delusions, and paranoia; and (2) nonpsychotic psychotropic medications such as antidepressants, mood stabilizers, and anti-anxiety medication.

Serious or severe mental illness: These terms are used differently by different people and are usually not further defined. The definition of “severe mental disorders” as recommended by the National Advisory Mental Health Council in 1993 included schizophrenia, schizoaffective disorder, bipolar disorder, autism, and severe forms of depression, panic disorder, and obsessive compulsive disorder (*American Journal of Psychiatry* 1993;150:1457). The use of the terms “serious” and “severe” mental illness in this study refers to schizophrenia, schizoaffective disorder, bipolar disorder, and major depression with psychotic features.

Substituted judgment vs. best interest legal standards: Medical choices made by a judge, guardian, or other decision maker on behalf of a patient who lacks capacity to make an informed decision about treatment are based on one of two legal standards: (1) substituted

judgment involves making a choice about medical treatment based on what the patient would have chosen when competent; or (2) a decision based on the best interest of the patient including balancing factors such as treatment efficacy, side effects, and prior response to treatment.

Results

Alabama

Background

The largest public institution holding mentally ill individuals in Alabama is the Jefferson County Jail in Birmingham; approximately 20 percent, or 483 of its 2,413 inmates, are thought to have serious mental illness. The largest remaining state mental hospital is Bryce Hospital, with 268 beds. Alabama has virtually no jail diversion programs and is among the states spending the least on public psychiatric treatment programs.

In the Tuscaloosa County Jail, 40 percent of the inmates "receive some form of psychiatric care." The county sheriff stated that "the jail is the worst place for someone with a mental illness. . . . The problem is, someone [with mental illness] gets off their meds and a family member doesn't know what to do, so they call the Sheriff's Office. The [person] may end up in jail for 30 to 60 days or even six months for a $300 misdemeanor most people would get out on in a day" (TuscaloosaNews.com, Apr. 19, 2012). This is one cause of jail overcrowding.

In 1971, it was estimated that five percent of state prisoners were mentally ill, but in 2007 it was estimated that this figure had risen to 20 percent. The largest prisons, such as the Limestone Correctional Facility, with 2,415 inmates, today probably hold more seriously mentally ill individuals than Bryce Hospital does. The state prisons are said to be "turning into de facto mental health treatment centers." "We more or less are criminalizing mental illness," the Corrections Commissioner told the state legislature (*Athens News Courier*, Dec. 21, 2007). The mentally ill prisoners are one reason why the prisons are overcrowded; for example, the Ventress Correctional Facility in Clayton was built in 1990 for 650 prisoners; in 2011 it held 1,665 (*Huffington Post*, Nov. 22, 2011). Put severely mentally ill prisoners into such crowded conditions, and you have a prescription for disaster, leading to lawsuits; this is exactly what Alabama is experiencing.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Alabama Department of Corrections (AL DOC) regulations allow for nonemergency involuntary administration of medication based on a determination that an inmate:

> (1) presents a substantial likelihood of serious physical harm towards self or others;

(2) presents a substantial likelihood of significant property damage;

(3) is incapacitated to the extent that he is unable to perform basic, life-sustaining functions such as eating and drinking; or

(4) manifests severe deterioration in routine functioning by repeated and escalating loss of cognitive or volitional control over personal actions as a result of the serious mental illness.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by an Involuntary Medication Review Committee consisting of one psychiatrist (chair), one licensed psychologist, and one other health professional (either a master's level psychologist, a social worker, or a registered nurse). The decision to medicate the inmate requires a majority vote of the committee; the psychiatrist must be in the majority.

Note: AL DOC mental health treatment data for March 2013 are available on the Internet. The census in the Residential Treatment Units at the end of that month was 246 inmates. Forty inmates (16 percent) had involuntary medication orders. Eight involuntary medication hearings/reviews were conducted during the month. No emergency involuntary medication incidents were reported, perhaps because the use of nonemergency procedures reduced the incidence of psychiatric emergencies.

Jails

State law does not prohibit Alabama county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others. Based on information derived from interviews, however, Alabama jails instead petition for civil commitment to a state psychiatric hospital for inmates who are in need of treatment. The shortage of hospital beds prevents the transfer of inmates, so jails must manage the inmates' symptoms with means other than medication, such as restraints, seclusion, or direct observation.

Alaska

Background

Mentally ill prisoners are one reason Alaska's prisons and jails are chronically overcrowded. In 2007, a study of Anchorage Jail inmates reported that "about 40 percent have a mental illness – half of them serious, for example with bipolar and schizophrenic disorders" (*Anchorage Daily News*, Dec. 31, 2007). The overcrowding was so severe that three prisoners were being assigned per cell, and some prisoners were being sent to a private prison in Arizona. Since the Anchorage Jail currently holds about 1,430 inmates, this means approximately 286 of them

have a serious mental illness; this is more than three times the number of mentally ill individuals (80) in the Alaska Psychiatric Institute.

A major source of this problem has been the poor follow-up treatment of mentally ill individuals released from the hospital. Alaska has a very active patients' rights lobby that, through numerous lawsuits, has made it very difficult to treat mentally ill individuals who are not aware of their illness, i.e., who have anosognosia. Alaska already has among the fewest psychiatric beds per capita of any state; efforts in process to shut down additional beds are likely to make the problem worse.

Current Laws Governing Treatment in Prisons and Jails

The Alaska Department of Corrections (AK DOC) is responsible for all inmates in the state; there are no county jails. AK DOC nonemergency involuntary medication policies apply to pretrial detainees and sentenced inmates in the state's correctional facilities.

AK DOC policy allows for involuntary administration of medication on a nonemergency basis if a determination is made that the inmate presents likelihood of serious harm or is gravely disabled.

> *Gravely disabled* is defined as a condition in which the prisoner, as a result of a mental disorder:
>
> > (1) is in danger of serious physical harm resulting from his or her failure to provide for essential human needs of health or safety; or
> >
> > (2) manifests a severe deterioration in routine functioning as evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.
>
> *Likelihood of serious harm* is defined as:
>
> > evidence of substantial risk of physical harm to self or others, or to the property of others.

Alaska uses the gravely disabled standard frequently rather than waiting for an individual to deteriorate until there is a risk of serious harm. Authorization of nonemergency involuntary medication is determined in a *Washington v. Harper* administrative proceeding by a Mental Health Review Committee consisting of two licensed mental health professionals, one of whom must be a psychiatrist. The committee's decision to approve involuntary administration of medication must be unanimous.

Note: The Law Project for Psychiatric Rights (PsychRights) challenged the AK DOC Involuntary Psychotropic Medication policy in a lawsuit in 2004 but did not prevail. The organization's mission is to "mount a strategic legal campaign against forced psychiatric drugging." Alaska Supreme Court, *Bavilla v. Alaska Dep't of Corrections*, No. S11432.

Arizona

Background

Based on inmate population trends, the number of patients in the Arizona State Hospital (338 beds) is almost certainly exceeded by the number of seriously mentally ill individuals in the state prisons at Eyman (5,186 inmates), Lewis (5,088), Florence (4,491), or Perryville (3,455) and by the number of seriously mentally ill inmates in the Maricopa and Pima County Jails. This should surprise no one, since the state has ranked near the bottom for many years on virtually every measure of care for such patients as well as on state mental health expenditures. The consequences of failing to treat mentally ill prisoners were tragically illustrated by a video of the suicide of Anthony Lester, diagnosed with schizophrenia, in the State Prison at Tucson. Lester, who had stopped his medication, cut his neck, wrists, and legs and then slowly bled to death as four prison guards wandered around his cell, watching him but making no effort to help (*Arizona Daily Mail*, Mar. 1, 2012). Lester's family is now suing the state for $3 million.

Jared Loughner represents another example in Arizona of why not treating seriously mentally ill individuals does not save money. The involuntary hospitalization program to which Loughner should have been referred by Pima Community College officials had had its funds sharply cut by the state legislature two months prior to the time college officials were deciding what to do about Loughner, whose psychosis was obvious to everyone. Whatever money the state legislators thought they were saving is minor compared to the costs and consequences of Loughner's actions.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Arizona's Department of Corrections (AZ DOC) technical manual allows for involuntary administration of medication based on a determination that an inmate is either severely impaired or the inmate's conduct presents a likelihood of serious harm.

> *Likelihood of serious harm* is a substantial risk that physical harm will be inflicted by an inmate upon at least one of the following:
>
> (1) his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm to one's self;
>
> (2) another, as evidenced by behavior which has caused such harm or places another person or persons in reasonable fear of sustaining such harm; or
>
> (3) the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Psychotropic Medication Review Board consisting of one nontreating psychiatrist, one nontreating psychologist, and one deputy warden or associate deputy warden. The decision to medicate the inmate requires a majority vote of the board; the psychiatrist must be in the majority.

Jails

Based on survey information, jails may petition a court for an involuntary, nonemergency, outpatient treatment in order to treat an inmate involuntarily. In some counties, Community Crisis Mobile Teams evaluate inmates in jail and assist jail personnel in completing a petition for involuntary, nonemergency, outpatient treatment. The County Attorney's Office files the petition with the Superior Court. If the court finds by clear and convincing evidence that the proposed patient, as a result of mental disorder, is a danger to self, a danger to others, persistently or acutely disabled, or gravely disabled and in need of treatment and is either unwilling or unable to accept voluntary treatment, it can order an inmate to receive involuntary outpatient treatment. There does not appear to be anything that would preclude a jail from administering medication involuntarily under an outpatient order.

Arkansas

Background

The Arkansas State Hospital has 220 beds, but more seriously mentally ill individuals can probably be found in the state prisons at Grady (1,910 inmates) or Malvern (1,130 inmates) or at the Pulaski County Regional Jail in Little Rock (1,673 inmates). That is to be expected in a state that ranks near the bottom in almost every mental illness treatment indicator – per capita expenditures, number of public psychiatric beds, and programs for diverting mentally ill persons from jails.

The consequences of criminalizing mental illness are as predictable as they are tragic. In 2010 in the Sebastian County Jail, Ashley Kaufman, age 27 and diagnosed with bipolar disorder, killed another prisoner, age 64 (*Times Record*, Apr. 20, 2012). Four years earlier, Donald Winters, age 60 and diagnosed with schizophrenia, died in the Benton County Jail. He had been arrested for criminal trespass but, because of his acute psychosis, was ordered by a judge to be taken to the state hospital, which as usual had no beds. While he waited in jail, "he refused to eat or be medicated" and had to be "restrained at times because he was seen banging his head and limbs on a metal toilet seat." After again being refused admission to the state hospital, "he died after three days of refusing food and water, believing he was about to be executed" (*Arkansas Democrat-Gazette*, Jan. 5, 2006). Like most such tragedies, this one resulted in a lawsuit against the state. The money saved from the failure to treat such individuals is often lost in the lawsuits that follow.

Current Laws Governing Treatment in Prisons and Jails

Prisons

The Arkansas Department of Corrections did not respond to either informal inquiries or a formal request under the Arkansas Freedom of Information Act § 25-19-101 et seq. for its policy on nonemergency involuntary administration of psychotropic medication.

Upon further investigation, some information about Arkansas's policy is provided in cases in which inmates challenged the administration of medication over objection while they were in prison. A description of the Arkansas policy that was in place in 1993 is described in *Walton v. Norris*, 59 F.3d 67 (8th Cir. 1995):

> if an inmate objected to taking medication prescribed by a treating psychiatrist, and the psychiatrist believed that the inmate suffered from a mental disorder and was gravely disabled or likely to harm himself, others, or property, then the medication could be administered involuntarily. The inmate, however, was entitled to a hearing before the Mental Health Review Committee. Arkansas Department of Correction Policy No. 275. In this case, the committee unanimously found that Walton suffered from paranoid schizophrenia, that he had become violent when taken off of his medication in the past, and that mandatory injections were needed to prevent him from becoming psychotic again.

The court upheld the policy as it applied to the plaintiff, but by the time the decision was issued in 1995 the policy had been modified. Changes in the policy were not provided. (*Id.* at note 4*).* More recently an inmate brought suit against AR DOC alleging he was involuntarily medicated without any hearing in violation of the AR DOC policy, *Hernandez v. Molden,* No. 5:09-cv-00328-JLH-JTK (Eastern District Court of Arkansas). The plaintiff, Hernandez, could not produce a copy of the policy but asserted that the policy was described in another case, *Doby v. Hickerson*, 120 F.3d 111 (8th Cir. 1997). At the time the *Doby* case was decided, the policy required a hearing and cited *Washington v. Harper.* According to an order issued by the judge in in the *Hernandez* case in April 2012, the attorney for the AR DOC was unaware of any policy concerning involuntary medication of inmates. The court provided an opportunity for AR DOC to address the issue of applicable policies in its summary judgment motion.

Jails

State law does not prohibit Arkansas county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to self or others. Based on survey information, however, Arkansas jails instead petition the court for an order to medicate an inmate involuntarily. Court orders are not used frequently.

California

Background

For a state with 38 million people – 1 in every 8 Americans lives in California – there are almost no public psychiatric beds available for individuals with serious mental illnesses. The State Hospital Department lists a total of 4,652 beds at Metropolitan, Patton, Napa, and Atascadero state hospitals, but 88 percent of them are reserved for mentally ill individuals who have been charged with crimes (forensic patients). Another state hospital at Coalinga is used almost exclusively for sexually violent predators. For mentally ill individuals who need to be hospitalized briefly to become stabilized on medication, this leaves few options. In fact, 26 of the state's 58 counties have no psychiatric inpatient beds whatsoever, public or private.

In their absence, it is not surprising that many mentally ill individuals end up in the county jails and state prisons. The Los Angeles County Jail is de facto the largest "mental institution" in the state and is usually in the running for the dubious honor of being the largest psychiatric institution in the nation. In Fresno County, 16 percent of all inmates need antipsychotic drugs, qualifying the jail as "the largest inpatient psych unit for the mentally ill in our community" (*KFSN*, June 18, 2013; *Fresno Bee*, Aug. 14, 2013). In Santa Barbara County, 25–30 percent of jail inmates are "on psychotropic medication" (*Noozhawk*, May 26, 2011). In Sonoma County, 30 percent of jail inmates "require some degree of mental health supervision" (*Press Democrat*, July 31, 2013). The recurring headlines tell the story: "Mentally ill defendants languish in jail from lack of hospital space" (*Tribune News*, Jan. 4, 2014); "Warehousing mentally ill defendants in county jails must stop" (*Tribune News*, Jan. 7, 2014); "Report examines high costs of jailing mentally ill" (*Santa Barbara Independent*, Jan. 9, 2014).

The consequences are as predictable as they are tragic. Headlines such as "Jail Suicides Reach Record Pace in State" have become increasingly common (*Los Angeles Times*, June 16, 2002). In the Los Angeles County Jail, Steven Pendergast, recently released from a mental hospital, was beaten to death by his cellmates because he "was mumbling to himself" (*New York Times*, May 23, 2004). And Thomas Ligenfelter, mentally ill, "middle-aged and frail," was stomped to death by his cellmate with paranoid schizophrenia. "His face was smashed in, his neck broken and bones crushed" (*Press Enterprise*, Oct. 13, 2007).

California state prisons also saw an increase in inmates with mental illness "from 19 percent in 2007 to 25 percent in 2012," according to the California Department of Corrections and Rehabilitation (*Sacramento Bee*, May 22, 2012). Almost 11,000 prison inmates, or approximately nine percent of the total, are held in isolation (Associated Press, Dec. 19, 2013). The suicide rate in California prisons is twice the national average (*New York Times*, Apr. 10, 2013), and the U.S. Supreme Court found that the treatment of mentally ill individuals in California's prisons was "cruel and unusual." The quality of life for mentally ill people in these prisons can be inferred from a report about a man who recently visited the mental health unit of San Quentin Prison:

> In order to enter the unit he had to put on a protective suit and full mask to protect him from body fluids which may be thrown at him. He entered the lower

> unit of the 4 tiers and once inside said there was screaming, yelling, & pleading and banging's that went on non-stop the entire time he was in there. He said it was eerie and sickening. He asked the guards if it ever got quiet and they said that at about 3 am the noise somewhat subsided but never stops completely and that it starts to increase again at daybreak. They said the prisoners are totally psychotic because they cannot be forced medications and so they hear voices, live with fears, and can't sleep. He said they are in these cages because they can not survive in the general population. The holding cells are called cages; are in fact very much a cage, a 5 x 9 cage fencing that holds each prisoner 23 out of the 24 hour days. For 1 hour each day they are transferred to a larger cage, also indoors, for some room to move about. They are fed in the cage. He said the whole experience was horrifying (Anonymous, Aug. 19, 2013).

The state corrections situation is likely to get worse. California's prisons are under court order to downsize, so thousands of prison inmates are being transferred to county jails not staffed to care for the most mentally ill among them. When these individuals are then released from the jails, they are not being provided with aftercare. Thus, it is probably not coincidental that both property crimes and violent crimes increased in California in 2012, whereas nationally these rates decreased (*City Journal*, Autumn 2013, p. 67). One thing that would improve the situation would be the widespread use of assisted outpatient treatment (AOT), known as Laura's Law, which has the potential to sharply decrease the number of mentally ill individuals who end up in jail. In a pilot program in Nevada County, AOT reduced the days incarcerated by mentally ill individuals by 97 percent (Tsai, *The Resident's Journal*, June 27, 2012).

Current Laws Governing Treatment in Prisons and Jails

Prisons

State law allows the California Department of Corrections and Rehabilitation (CA DCR) to initiate involuntary administration of medication on a nonemergency basis if a determination is made that the inmate:

> (1) is gravely disabled and lacks the capacity to consent to or refuse treatment with psychiatric medications; or
>
> (2) is a danger to self or others if not medicated.

A hearing must be held before an administrative law judge, who must find clear and convincing evidence the inmate meets the criteria for nonemergency involuntary medication.

Note: On September 30, 2012, the governor signed AB 1907, which amended the California Penal Code in order to terminate a permanent injunction stemming from *Keyhea v. Rushen*, 178 Cal.App.3d 536 (1986). The bill incorporated the procedural requirements specified in the injunction. The bill also clarified the dangerousness criteria to reflect that inmates who are a danger to self or others need not also lack the capacity to refuse treatment.

Jails

State law allows counties to initiate involuntary administration of medication on a nonemergency basis if a determination is made that the inmate:

> (1) is gravely disabled and lacks the capacity to consent to or refuse treatment with psychiatric medications; or
>
> (2) is a danger to self or others if not medicated.

A hearing must be held before a superior court judge, a court-appointed commissioner or referee, or a court-appointed hearing officer, who must find by clear and convincing evidence that the inmate meets the criteria for nonemergency involuntary medication.

Note: AB 1907, referenced above, also extended the prison procedures for nonemergency involuntary medication to county jails so that jails may now administer nonemergency involuntary medication. The bill also provides that an inmate need not be transferred to a county mental health facility for involuntary medication unless it is otherwise medically necessary.

Colorado

Background

The largest de facto "mental institution" in Colorado is the Denver County Jail: an estimated 546 inmates (20 percent of 2,730 total inmates) have a serious mental illness. The largest remaining state psychiatric hospital at Pueblo has only 398 patients, and two-thirds of those are forensic patients who have been court-ordered to the hospital.

In 2008, it was reported that "one in every five inmates in the seven-county Denver metro area has a serious mental illness" and that they "spend 5½ times longer in jail than average inmates" (*Denver Post*, Apr. 19, 2008). Colorado's county sheriffs have said the rapidly increasing number of mentally ill jail prisoners was the "top problem facing sheriffs statewide. By default we've become the mental health agencies for the individual counties" (*Pueblo Chieftain*, Sept. 22, 2007). A 2013 report on the state prisons noted that "nearly 90 Colorado prisoners with serious mental illness were locked in solitary confinement this year – and many had been there for at least four years. . . . Prisoners with moderate to severe mental illness now make up the majority of those in solitary" (*Denver Post*, July 23, 2013). In December 2013, the state issued an order prohibiting use in the future of solitary confinement for prisoners with "major mental illness" (Associated Press, Dec. 12, 2013). Colorado residents with severe mental illness are increasingly ending up in prisons and jails because most public psychiatric beds have been closed, and outpatient services have gone from bad to worse. For example, Fort Logan Mental Health Center – regarded as a national model for psychiatric

services half a century ago – now has fewer than 100 patients and is no longer highly regarded.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Colorado Department of Corrections (CODOC) regulations allow for nonemergency involuntary administration of medication based a determination that the inmate presents a serious threat of harm to self or others or is gravely disabled.

> *Gravely disabled* means an inmate is:
>
> > (1) in danger of serious physical harm due to their inability or failure to provide themselves the essential human needs of food, clothing, shelter, and medical care; or
> >
> > (2) lacking judgment in the management of their resources and in the conduct of their social relations to the extent that their health or safety is significantly endangered, and they lack the capacity to understand that this is so.
>
> *Serious threat of harm* means that:
>
> > (1) there is a substantial risk that physical harm will be inflicted by an inmate upon his person, as evidenced by threats, attempts to commit suicide, or inflicting personal harm to oneself; or
> >
> > (2) danger to others may be shown by evidence of injurious acts, attempts, or threats.

Risk may be shown by evidence of injurious acts, attempts, or threats. Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by an Involuntary Medication Hearing Committee consisting of a psychiatrist, a psychologist, and one other mental health clinician. The decision to medicate the inmate requires the vote of a majority of the committee; the psychiatrist must be in the majority.

Jails

Based on survey information, Colorado jails may petition a court to order nonemergency involuntary administration of medication in the jails. However, this is done only on rare occasions when there is an extreme risk of harm to the inmate. The difficulty in obtaining an order may depend on the judge's disposition toward involuntary treatment. It is extremely difficult to secure a bed in a state psychiatric hospital due to the shortage of beds.

Note: In April 2012, the Colorado Department of Human Services (CO DHS) settled a lawsuit in which it was alleged that it could take up to six months to transfer inmates from jail to a

psychiatric hospital for pretrial, court-ordered competency evaluations and restorative treatment. Under the settlement, pretrial detainees must be transferred within 28 days of the court order. Inmates who need hospitalization because they refuse medication and are in need of treatment were not included in the lawsuit. It is likely they will have to wait even longer for a placement, as the CO DHS will most likely focus primarily on admitting pretrial detainees to fulfill the deadlines under the settlement.

Connecticut

Background

The Connecticut Department of Corrections operates a combined jail-prison system with 14 prisons. The Garner prison – which is located in Newtown, site of the 2012 Sandy Hook Elementary School mass shooting – accepts only seriously mentally ill prisoners and holds more mentally ill individuals (640) than the Connecticut Valley Hospital (604), the largest remaining state mental hospital. One of the state mental hospitals Connecticut shut down at one time held 4,000 patients and was also located in Newtown. As in several other states, a prison for mentally ill individuals has replaced a hospital for mentally ill individuals.

A 2011 survey reported that 18 percent of Connecticut's prison population was receiving psychotropic medication, up from 13 percent in 2003 (TheDay.com, Mar. 23, 2011). The large number of mentally ill inmates has contributed to the overcrowding. One corrections official noted that the prisons have "become society's mental health provider" and that judges and prosecutors are sending mentally ill individuals to prison because there is nowhere else to send them (*New Haven Register*, Sept. 30, 2007).

Shifting the burden of mentally ill individuals to the prisons has been expensive. The annual cost of care for a mentally ill prisoner in Connecticut is 2.5 times the cost for other prisoners (TheDay.com, Mar. 23, 2011). A study of Connecticut's Medicaid patients found that one in every four with a serious mental illness became involved with the justice system during a two-year period and the cost of their care was double the cost of those who did not become involved with the justice system (Swanson et al., *Psychiatric Services*, July 2013). Connecticut legislators, like those in many states, have made the mistake of thinking they could save money by not treating individuals with serious mental illnesses.

Current Laws Governing Treatment in Prisons and Jails

The Connecticut Department of Correction (CT DOC) is responsible for all inmates in the state; there are no county jails. CT DOC nonemergency involuntary medication policies apply to pretrial detainees and sentenced inmates in the state's correctional facilities.

CT DOC allows for involuntary administration of medication on a nonemergency basis when less restrictive or less intensive measures have been employed and have been judged by the treating psychiatrist or Advanced Practice Registered Nurse to be inadequate in preventing

rapid deterioration of the inmate's mental state. Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by an Involuntary Medication Administrative Panel consisting of one nonreferring psychiatrist, one health services staff person, and one patient advocate. The panel must find, by a unanimous decision, that involuntary medication is indicated because the inmate's condition will rapidly deteriorate without medication or the psychiatric disabilities with which the inmate has been diagnosed will continue unabated. If a unanimous decision is not reached, the case is referred to the Mental Health and Psychiatric Services director or designee for review.

Delaware

Background

Delaware is another small state that combines its prison and jail systems. In 2007, a state official claimed that "approximately a third of Delaware's [correctional system] inmates suffer from mental illness" (*Delaware News Journal*, Nov. 29, 2007). Thus, the correctional centers in Smyrna (2,568 inmates) and Georgetown (1,090 inmates) probably hold more individuals with serious mental illnesses than does the state psychiatric hospital in New Castle.

Lawsuits alleging poor psychiatric care of prisoners and a failure to discharge patients from the state hospital led to two U.S. Department of Justice investigations and a subsequent settlement in 2007. This has led to some improvements, such as mental health courts in all three Delaware counties, which have helped to divert some mentally ill individuals away from the correctional system.

Current Laws Governing Treatment in Prisons and Jails

The Delaware Department of Correction (DE DOC) is responsible for all inmates in the state; there are no county jails. DE DOC nonemergency involuntary medication policies apply to pretrial detainees and sentenced inmates in the state's correctional facilities.

DE DOC policy allows for involuntary administration of medication on a nonemergency basis if a determination is made that, without medications, continued decompensating of the inmate's mental health is likely, so that there is a substantial likelihood that the inmate:

(1) will harm himself or others;

(2) will cause substantial property damage;

(3) will be unable to care for himself, so that his health and/or safety is endangered; or

(4) would be incapable of participating in any treatment plan which would offer the inmate a realistic opportunity to improve his condition.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Treatment Review Committee consisting of a

nontreating psychiatrist, a nontreating psychologist, and the Institutional Administrator or designee, who serves as the committee's chair. The committee's decision to approve involuntary administration of medication must be unanimous.

Note: DE DOC's policy is unique in that it provides specific examples of the types of behavior that might indicate the need for nonemergency involuntary medication. An example of an inmate who is unable to care for himself is:

> an inmate diagnosed with schizophrenia who, as a result of his illness, stops showering for an extended period of time and becomes malodorous and at risk of infection and, as such, may provoke others and become a target of hostility.

An example of an inmate who is incapable of participating in a treatment plan that will improve his condition is:

> an inmate diagnosed with schizophrenia who, as a result of irritability, hostility, and paranoia, is unable to cooperate with correctional officers, clinicians, or other inmates, so that he incurs disciplinary charges that extend the time he is incarcerated.

District of Columbia

Background

The newly rebuilt St. Elizabeths Hospital in Washington has 292 patients. The DC Jail has 1,750 inmates. If it is assumed that 20 percent of them have a serious mental illness, then those 350 mentally ill prisoners would be more numerous than all the patients at St. Elizabeths Hospital. In fact, as early as 2005, it was reported that 33 percent of DC Jail inmates were taking "psychotropic medications" (*Street Sense*, Jan. 10, 2005).

The DC Jail has had a major problem with inmate suicides, including four in the 10-month period between December 2012 and October 2013. A subsequent report severely criticized the jail for placing mentally ill inmates "naked and in isolation for days." For example, in December 2012, Michael English, suffering from paranoid delusions, hung himself in jail. English was charged with having stabbed a friend who had become the subject of English's delusions. English's parents had been trying unsuccessfully to get him into treatment (Washington Post Online, Dec. 9, 2012; A. C. Davis, *Washington Post*, Nov. 11, 2013).

The District has spent large amounts of money in recent years trying to improve its mental health services, but the main beneficiaries appear to have been the private contractors who operate group homes and outpatient services. Services continue to be mediocre, as can be measured by the abundance of untreated seriously mentally ill individuals among the homeless population and the high percentage of mentally ill inmates. Another indicator of the direction of things was the recent closing of the Green Door, the District's only clubhouse day program for

adults with severe mental illness and the city's best rehabilitation program for mentally ill individuals.

Current Laws Governing Treatment in Prisons and Jails

The District of Columbia Department of Corrections (DC DOC) is responsible for all inmates. DC DOC nonemergency involuntary medication policies apply to pretrial detainees and sentenced inmates in the District's correctional facility. The DC DOC manual indicates that involuntary administration of medication "will be used only when an inmate is imminently dangerous" to himself or others. The manual also indicates that health services staff shall follow the medical provider's policy. The DC DOC medical provider does not have a policy for involuntary administration of medication. Instead, an inmate in need of nonemergency administration of medication must be involuntarily committed to the District's only psychiatric hospital.

Note: It is extremely difficult to have an inmate committed. Based on the survey, there have been as few as three commitments in the last five years.

Florida

Background

The Dade County Jail system in Miami, which holds 6,075 inmates, is, de facto, the largest "mental institution" in the state. Its problems were vividly described by journalist Pete Earley in his book 2006 book, *Crazy*. Mentally ill prisoners "screech and cower at unseen demons. They pace furiously and rip their paper gowns off. They urinate on the floor and bathe in the toilet." A jail psychiatrist said, "I don't even try to describe to people what's going on here. It's beyond talking about" (*Miami Herald*, Nov. 15, 2007). But, in fact, tragedy looms for mentally ill individuals in the jails of virtually every county in the state. In Broward County, 23 percent of the jail inmates are on psychotropic drugs; they stay eight times longer than other inmates; and the cost of their care is 63 percent more than that of other inmates (*Miami Herald*, Nov. 15, 2007). In the Hillsborough County Jail, 19 percent of the men and 42 percent of the women "struggle with some form of mental illness" (*Tampa Tribune*, Oct. 31, 2013).

The reason so many mentally ill individuals end up in prisons and jails is because they don't receive treatment in the community. John Beraglia, "psychotic but only sporadically on medication," had been arrested 120 times before being killed in a confrontation with a sheriff (*Miami Herald*, Feb. 12, 2004). Henry Farrell, diagnosed with bipolar disorder, has been arrested 190 times (*Sun Sentinel*, Feb. 24, 2009). Johnny Goode, diagnosed with schizoaffective disorder, was arrested in Palm Beach County 49 times in 40 months (*Palm Beach Post*, Jan. 31, 2010). A recent study of 4,056 Florida residents with schizophrenia or bipolar disorder demonstrated that taking medication significantly reduced the chances of being arrested (Van Dorn et al., *Psychiatric Services* 2013;64:856–862).

A telling commentary on the future of Florida's services for mentally ill persons was the 2007 proposal to build new jails in Dade and Broward Counties to house only mentally ill inmates. It was said that they would be "the first county jails ever to be built specifically for inmates with chronic and severe mental illness" (*Miami Herald*, Nov. 15, 2007). Some people in 1840 had a similar idea except at that time they called the new institutions asylums or hospitals.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Florida law allows a warden of a Florida Department of Corrections (FL DOC) institution containing a mental health treatment facility to petition the circuit court serving the county in which the mental health treatment facility is located to seek an order authorizing nonemergency administration of medication. The court will order nonemergency involuntary medication if it determines by clear and convincing evidence the inmate is mentally ill and the requested treatment is essential to the care of the inmate. The court must consider the following factors in substituting its decision concerning treatment for the inmate's decisions:

(1) the inmate's expressed preference regarding treatment;

(2) the probability of adverse side effects;

(3) the prognosis for the inmate without treatment; and

(4) the prognosis for the inmate with treatment.

Jails

Based on the survey, there is at least one county in Florida that has a standard operating procedure for obtaining a court order for nonemergency involuntary administration of medication. After evaluating an inmate, a nontreating psychiatrist shall prepare an affidavit stating that medication is:

(1) necessary to prevent the inmate from harming self or others; and

(2) the inmate's care and treatment are in jeopardy without such medication.

The psychiatrist's affidavit and a request for hearing is submitted to the court, which determines whether to issue an order for nonemergency administration of medication.

Note: The process is used in extreme situations only. According to people who have experience with the process, the process has become more difficult in recent years as a result of opposition from public defenders. In some cases, an attorney's opposition may be related to trial strategy. A public defender may be concerned about the effect treatment will have on trial competency, particularly when it is in question. In other cases, public defender objections may be strictly ideological, based on a belief that those with mental illness have an absolute civil right to refuse treatment.

Georgia

Background

The largest remaining state mental hospital in Georgia is Central State Hospital, with 423 patients. However, the jails in DeKalb, Cobb, Fulton, and Gwinnett Counties – each of which has 2,000 or more inmates – probably each hold as many seriously mentally ill individuals as does the state hospital. The mentally ill individuals in the jails are the same ones who were discharged when the state hospitals closed. When the Northwest Regional State Hospital closed, officials at the Floyd County Jail said "prisoners with mental problems increased by 60 percent" (*Rome News-Tribune*, Dec. 19, 2011). When the Georgia Mental Health Institute closed, the Gwinnett County Jail "population of inmates with mental illness increased dramatically" (*Gwinnett Daily Post*, July 30, 2006). In December 2013, Southwestern State Hospital was closed, so the trend is continuing. The sheriff of Baldwin County put it succinctly: "I'm the director of the Baldwin County Mental Health Hospital known as the Baldwin County Jail" (*Rome News-Tribune*, Feb. 6, 2011).

Sheriffs in Georgia have noted that shifting mentally ill individuals from state-financed hospitals to county-financed jails also shifts the cost of their care from the state to the counties. As Sheriff Ted Jackson of Fulton County noted, "The county taxpayers are paying for something the state should be covering. Locking up people because they are mentally disturbed is unfair to them and to the county taxpayers who are footing the bill. It just isn't right" (*Rome News-Tribune*, Dec. 19, 2011). Of course, if these mentally ill individuals had received timely and effective treatment before committing crimes and been given appropriate follow-up and treatment as outpatients, most of them would not have ended up in either hospitals or jails.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Georgia Department of Corrections (GA DOC) operating procedures allow for nonemergency involuntary administration of medication based a determination that:

> (1) the inmate is currently dangerous to self or others, and there is no expectation of improvement; or
>
> (2) there exists a probability of a deterioration of the inmate's mental condition as supported by the inmate's medical history, and it is determined that:
>
> > (a) such a deterioration would result in behavior that would be life-endangering to the inmate or others; or
> >
> > (b) without medication the inmate would be incapable of participating in any treatment plan that would give him a realistic opportunity to improve his condition.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Mental Health Due Process Committee. The committee consists of the Deputy Warden of Care and Treatment or designee, a professional member of the mental health staff (counselor, mental health nurse, or psychologist), and a medical staff member (RN, NP, PA, or physician). None of the members may be involved in the inmate's current treatment.

Jails

State law does not prohibit Georgia county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others.

Based on survey information, Georgia jails petition a court for involuntary civil commitment for inmates who refuse medication and are in need of treatment. In some instances, jails may have a contract with a local hospital to provide psychiatric services in the jail. The contract may include provisions that allow for placement of an inmate who meets commitment criteria in the local hospital for stabilization. Placement in a state psychiatric hospital is "problematic," according to an individual who was familiar with the process.

Hawaii

Background

Hawaii is another small state that operates a combined jail-prison system. The two largest correctional facilities, in Honolulu and Waipahu, both hold more seriously mentally ill individuals – assuming that 20 percent of inmates are so affected – than are held at Hawaii State Hospital. In fact, the situation is actually worse, since – according to the *2012 Directory* of the American Correctional Association – 1,900 additional male inmates from Hawaii were being held in prisons in Arizona to relieve the overcrowding in Hawaii (*Directory*, p. 242).

Having so many mentally ill individuals in the correctional facilities has caused major problems. For example, at the Oahu Community Correctional Center, popularly known as the Honolulu Jail, a 32-year-old inmate with paranoid schizophrenia killed his 76-year-old cellmate in March 2013. Advocates said that because of state budget cuts "more mentally ill people are winding up in Hawaii's jails" (*Hawaii News Now*, Mar. 13, 2013).

Such cuts have been severe and have even included abolishing the Assertive Community Treatment (ACT) teams, one of the few effective components of the outpatient treatment system. Such fiscal cuts led to "a 33 percent increase in admissions" to the state hospital from 2011 to 2012 and an increase in readmissions of the same patients (*KHON2*, Aug. 24, 2012).

Current Laws Governing Treatment in Prisons and Jails

The Hawaii Department of Public Safety (HI DPS) is responsible for all inmates in the state; there are no county jails. HI DPS nonemergency involuntary medication policies apply to pretrial detainees and sentenced inmates in the state's correctional facilities.

HI DPS policy allows for involuntary administration of medication on a nonemergency basis with a court order. The Office of Attorney General initiates a request for an "Order to Treat" from the Court. A request for an Order must document that:

> (1) the inmate has a history of severe and persistent mental illness and, based on the inmate's treatment history and current behavior, is now in need of treatment to prevent a relapse or deterioration that would predictably result in the person becoming imminently threatening or dangerous to self or others; and
>
> (2) the inmate's current mental status or the nature of the inmate's disorder limits or negates the inmate's ability to make an informed decision to voluntarily seek or comply with recommended evaluation or treatment.

A panel consisting of a nontreating physician, the medical director, the Mental Health Branch administrator, and the warden must review renewal of court orders.

Idaho

Background

In Idaho, the two remaining state psychiatric hospitals together hold only 145 patients. The Ada County Jail in Boise (838 inmates) and the state prison in Kuna (1,653 inmates) probably both hold more individuals with serious mental illnesses than the two hospitals combined. The problems are predictable. In one month in 2013, "guards found four inmates 'hanging from sheets' at prisons and jails around the state." In one prison, "guards worked to calm a mentally ill male prisoner who had stripped naked and was wailing for his mother." The director of the Department of Corrections noted, "We are seeing an increased level of severity that is very, very concerning. We really need to pay attention from a mental health standpoint" (*Idaho Press-Tribune*, July 11, 2013). In 2013, the governor proposed building a new mental health facility at the state prison, but this has not happened (*Idaho Statesman*, Jan. 13, 2014).

For a state that ranks near the bottom in state mental health expenditures per capita and that abolished the use of the insanity defense 40 years ago, expectations should be modest. In fact, the quality of care in the two state hospitals is surprisingly good, if you can gain admission. But as these hospitals continue to be downsized, most mentally ill persons who need to be hospitalized are ending up in prisons and jails.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Idaho Department of Correction (ID DOC) standard operating procedures allow for involuntary administration of medication on a nonemergency basis if a determination is made that an inmate is gravely disabled and/or poses a likelihood of causing harm to himself, others, or property.

> *Gravely disabled* is defined as a condition in which a person, as a result of a physical or mental disorder:
>
> > (1) is in danger of serious physical harm resulting from a failure to provide his essential human needs of health or safety; or
> >
> > (2) manifests severe deterioration in routine functioning as evidenced by repeated and escalating loss of cognitive or volition control over his actions and is not receiving such care as is essential for his health or safety.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by an Involuntary Medication Hearing Committee consisting of a deputy warden, a nontreating psychologist, and nontreating psychiatrist. The nontreating psychiatrist serves as chair of the committee. A majority vote of the committee is required for approval; the chair-psychiatrist must be in the majority.

Jails

State law does not prohibit Idaho county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others. Based on survey information, Idaho jails petition the courts for involuntary civil commitment when inmates refuse medication and are in need of treatment. Rather than committing inmates to the state hospital, the Idaho Department of Health and Welfare (ID DHW) may determine that the disposition for commitment is to the jail that petitioned for treatment. Jails are authorized to medicate over objection following procedures for civilly committed patients.

Note: In 2012, the ID DHW assigned nine out of 25 (36 percent) inmates who were civilly committed to be treated in the jail. Like many jails across the country, the jail has a housing unit specifically designed for inmates requiring a higher level of mental health care who cannot be housed in the general population.

Illinois

Background

The Cook County Jail, with 9,700 inmates, is the largest de facto "mental institution" in Illinois and one of the largest in the United States. Assuming that 20 percent of the prisoners are seriously mentally ill, 2,068 mentally ill individuals – more than the number of mentally ill individuals in all five remaining state psychiatric hospitals *combined* (1,860) – are held there. Cook County Sheriff Tom Dart appears to be the only official in the state who understands the magnitude of the problem. He says that "he had no idea when he took the job of sheriff that he would also become the state's mental health provider." Regarding the closing of psychiatric clinics and state hospitals and dumping the patients into jails, Dart says, "I can't conceive of anything more ridiculously stupid by government than to do what we're doing right now" (NPR.org, Jan. 20, 2014). In 2011, he threatened to file a lawsuit against the state for "allowing the jail to essentially become a dumping ground for people with serious mental health problems" (*ABC-7 News*, May 20, 2011). More recently he released a shocking video showing the bizarre behavior of his inmates in an effort to help the public understand the problem (*CBS Local*, Feb. 13, 2013). And he has started his own psychiatric aftercare program for mentally ill inmates leaving his jail (*Southwestern Star*, Aug. 6, 2013). As Dart summarized the problem, "The heart of it is that we are not a mental health facility. These people shouldn't be here" (*CBS Local*, Feb. 13, 2013).

The situation is no better elsewhere in the state. At the McLean County Jail, the length of stay for mentally ill inmates increased from six days in 2010 to 18 days in 2013. The reason, according to one official: "We don't have any other place to take them. There's no outlet so they're staying longer" (Pantagraph.com, July 24, 2013). And, in the state prison, "about 15 percent of the state's 45,470 inmates receive care for a mental disorder" (*Bloomington Pantagraph*, May 30, 2008). The prison maintains special psychiatric treatment units at the Dixon and Pontiac Correctional Institutions.

Current Laws Governing Treatment in Prisons and Jails

Prisons

The Illinois Administrative Code specifies procedures for the nonemergency administration of involuntary psychotropic medication in the Department of Corrections (IL DOC) institutions. An inmate must be gravely disabled or pose a likelihood of serious harm to self or others. Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Treatment Review Committee composed of two nontreating mental health professionals, including one physician. Both members must agree before medication can be administered over objection. The members of the committee must complete a training program in the procedural and mental health issues involved.

Jails

The Illinois Administrative Code County Jail Standards contain provisions related to treatment of mentally ill inmates. For example:

> Procedures shall be in place for the emergency involuntary or voluntary administration of medications, including psychotropic medications.

The procedure of one jail was criticized by the Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission, which investigates jail inmate complaints. In a complaint by an inmate who was involuntarily medicated, the HRA recommended the term "gravely disabled" be removed from the jail's hospital policy:

> Involuntarily administered psychotropic medication must be given only under the order and authorization of a physician/psychiatrist. Ideally, all treatment should be given with informed consent of the patient. Involuntarily administered psychotropic medication may be used when the patient poses an imminent or persistent threat to self or others or is gravely disabled.

However, the HRA does not have enforcement authority, and therefore the jail was not under any obligation to change its protocols.

Indiana

Background

The largest remaining state psychiatric hospital in Indiana is Richmond State Hospital, with 213 beds. The state prisons at Westville and Bunker Hill, both of which hold more than 3,000 inmates, each hold approximately twice as many mentally ill individuals as the state hospital, assuming that 15 percent of their populations are seriously mentally ill. The Marion County Jail in Indianapolis, where it has been reported that "40 percent . . . are mentally ill," also has more mentally ill inmates than the state hospital (*RTV 6*, July 4, 2013). At the Howard County Jail in Kokomo, "17 percent of the overall population . . . are taking psychotropic drugs to treat a mental illness"; its director calls the jail "the largest mental health facility in north-central Indiana that isn't designated as such" (*Kokomo Perspective*, Oct. 2, 2013).

In 2008, the American Civil Liberties Union filed a lawsuit against the state Department of Corrections for its excessive use of solitary confinement for mentally ill prisoners. In 2013 a federal judge criticized the Department of Corrections for acting "deliberately indifferent" toward the plight of its almost 6,000 mentally ill inmates. In January 2014 the Department of Corrections opened a 264-bed mental health unit at the Pendleton Correctional Facility (*Journal Gazette*, Feb. 5, 2014). We used to call such institutions state mental hospitals before we closed most of them; now we call them prison mental hospitals. The broken Indiana mental health treatment system results in many seriously mentally ill individuals ending up in prison or

jail sooner or later. For example, in 2013 a young man with bipolar disorder who had stopped his medications was arrested. During the following three months he was transferred from the jail to a psychiatric hospital, back to jail, back to the psychiatric hospital, back to jail, and finally back to the psychiatric hospital – five transfers in all (personal communication, July 28, 2013). It is difficult to imagine a more costly, less therapeutic system than this.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Indiana Department of Correction (IN DOC) Health Care Services Directives allow for involuntary administration of medication on a nonemergency basis if a determination is made that the inmate is gravely disabled or exhibits severe deterioration in routine functioning or poses a likelihood of serious harm to self, others, or the property of others.

> *Gravely disabled* means a condition in which the individual:
>
> > (1) as a result of mental illness, is in danger of impending harm because the individual is unable to provide for his/her food, clothing, shelter or other essential human needs; or
> >
> > (2) has a substantial impairment or an obvious deterioration of judgment, reasoning or behavior that results in the individual's inability to function independently.
>
> *Severe deterioration in routine functioning* means:
>
> > evidence of repeated and escalating loss of cognitive or volitional control over his/her actions and, therefore, not receiving such care as is essential for health or safety.
>
> *Likelihood of serious harm* means:
>
> > evidence of substantial risk of physical harm to self, or physical harm to others, or to the property of others.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Medical Treatment Review Committee consisting of three or more members appointed by the IN DOC medical director or designee. At least two members must be physicians, and at least one of those must be a psychiatrist. The decision to medicate the inmate requires a simple majority vote of the committee.

Jails

State law does not prohibit Indiana county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental

disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others. Based on survey information, jails can petition the court for an involuntary, nonemergency, outpatient treatment order to treat an inmate involuntarily if the inmate is dangerous. The process is used infrequently.

Note: An average size county jail reported that petitions for court orders are made only approximately twice per year.

Iowa

Background

The largest state psychiatric hospital at Mount Pleasant holds only 78 patients, and all four state hospitals together total only 231 patients. The Polk County Jail in Des Moines, with 2,500 inmates, has more seriously mentally ill individuals than all four state hospitals together. Similarly, the state prisons at Fort Dodge, Newton, Anamosa, Clarinda, and Mount Pleasant – all of which hold more than 1,000 prisoners – each have more individuals with serious mental illness than the largest state hospital does. In 2011, when the Black Hawk County sheriff reported that "60 percent of the inmates in his jail are mentally ill . . . twice the national average," it was at first thought to be an aberration (*Eastern Iowa News Now*, Apr. 3, 2011). But in Iowa, such a number is not an aberration. In 2014, the Linn County sheriff reported that three-fourths of his jail population "is on some sort of psychotropic medication" at any given time (*The Gazette*, Mar. 4, 2014). Among the inmates of the state prisons, "more than 25 percent are diagnosed with serious mental illnesses, such as schizophrenia or bipolar disorder," according to the director of the Iowa Department of Corrections (*Des Moines Register*, Feb. 25, 2014).

Doug Newby puts a human face on mental health services in Iowa. Diagnosed with severe schizophrenia, he was arrested for "urinating on a friend's porch." During his three months in the Wapello County Jail, he was confined to a small cell by himself because of his outbursts. "He rarely left the cell, where he remained naked and incoherent much of the time. . . . He often kept his mouth full of loose tea leaves or orange peels which he let fall to the floor when [the corrections officer] tried to give him medication." The jail attempted to get him transferred to a state hospital, "but administrators there refused to take him, saying he was too difficult to control." As Newby's court-appointed lawyer summarized it: "He was too crazy for the mental health unit" (*Des Moines Register*, June 29, 2013).

This is what happens in a state that is among the stingiest in state mental health expenditures per capita and among the states making the least effort at jail diversion programs. The re-incarceration rate among mentally ill males in the state prisons is twice the rate of non–mentally ill prisoners, and among females, three times as high (*Des Moines Register*, July 30, 2011). Headlines such as "State Pays Woman Who Blinded Herself in Prison" (*Des Moines Register*, May 28, 2009) have become more frequent. Court awards are costly, and the incarceration of mentally ill prisoners is far more expensive than it is for other prisoners. The

Iowa legislature is mistaken in thinking it is saving money by not treating seriously mentally ill people.

Current Laws Governing Treatment in Prisons and Jails

Prisons

The Iowa Department of Corrections (IA DOC) civilly commits inmates in need of treatment to its licensed forensic psychiatric hospital. Involuntary treatment procedures are determined according to statutes governing Department of Human Services involuntary commitment and treatment.

Jails

State law does not prohibit Iowa county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others. Based on survey information, Iowa jails petition for a court order to involuntary commit inmates in need of treatment to a psychiatric hospital. It is difficult to have inmates committed to state psychiatric hospitals due to a shortage of beds.

Note: By statute, the hospital serves inmates from both IA DOC prisons and county jails. However, there is no evidence that this happens.

Kansas

Background

Mentally ill individuals in Kansas are much more likely to end up in jail or prison than in a public psychiatric hospital because almost no hospital beds are available. The largest remaining state psychiatric hospital in Kansas is Larned, with 457 beds. However, 190 of them are for forensic patients who have criminal charges against them and have been ordered to the hospital by the courts; 177 more beds are for a sexual predator treatment unit; and only 90 beds are a general psychiatric facility. Even if an individual is fortunate enough to get admitted to the general psychiatric unit, the average length of stay is only five days, far less time than is needed to stabilize an individual in psychiatric crisis.

In Shawnee County, it is claimed that “16 percent of inmates at the county jail suffer from mental illnesses” (*Topeka Capital-Journal*, Jan. 7, 2010). In Johnson County, a study found that “about 17 percent of . . . jail inmates were mentally ill.” However, the mentally ill inmates included “almost half of [all inmates] booked 20 times or more” (*Kansas City Star*, Mar. 13, 2013). Such revolving-door inmates include people like Robert Gilmore, diagnosed with paranoid schizophrenia, who was arrested eight times in three weeks in Lawrence (*Lawrence*

Journal-World, Apr. 9, 2006). At the Sedgwick County Jail, "nearly a third of those in jail take some kind of medication for a mental illness." A study of 49 seriously mentally ill inmates in the jail reported they each had been arrested an average of seven times in the previous year (*Wichita Eagle*, Apr. 30, 2009). In Kansas state prisons, the problem is equally dire; in January 2014, the state Director of Corrections reported that "thirty-eight percent of the state's prison population has a mental illness," which is an increase of 126 percent since 2006 (*Wichita Eagle*, Jan. 22, 2014).

Current Laws Governing Treatment in Prisons and Jails

Prisons

Kansas Department of Corrections (KS DOC) policy and procedures allow for involuntary administration of medication on a nonemergency basis if a determination is made that the inmate is gravely disabled, exhibits severe deterioration in routine functioning, or poses a likelihood of serious harm to self, others, or the property of others.

> *Gravely disabled* means:
>
> > a condition in which the individual is in danger of serious physical harm resulting from the individual's failure to provide for essential human needs of health or safety as a result of a mental disorder.
>
> *Likelihood of serious harm* is evidenced by a:
>
> > substantial risk of physical harm to self or others, or to the property of others.
>
> *Severe deterioration in routine functioning* is evidenced by:
>
> > repeated and escalating loss of cognitive or volitional control over his or her actions by an inmate who is failing to provide for his or her own essential health and safety needs.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Mental Health Treatment Review Committee composed of two nontreating physicians. At least one member must be a psychiatrist. Both committee members must approve nonemergency involuntary treatment.

Jails

Based on survey information, jails in Kansas can petition the court for an involuntary, nonemergency, outpatient treatment in order to treat an inmate involuntarily if the inmate is judged to be dangerous. The process is used infrequently.

Kentucky

Background

The Eastern Kentucky State Prison in West Liberty (1,705 inmates) and the Louisville Jail (1,353 inmates) both hold approximately the same number of individuals with serious mental illness as do the two state hospitals, Western State (205 patients) and the newly rebuilt Eastern State (239 patients). The county jails are plagued by revolving-door inmates who are mentally ill. According to an official at the Louisville Jail, "their average stay is about 18 days and in the past five years they have been in jail 140 times" (*Courier-Journal*, Nov. 24, 2012).

Kentucky's prisons have also had increasing problems associated with the rising number of mentally ill prisoners. Such problems were graphically demonstrated in 2013 by a series of photographs, entitled "Trapped," taken in the Kentucky State Reformatory by photographer Jenn Ackerman. They include pictures of an inmate in a spit mask, to prevent him from spitting at the doctors or correctional officers, and they visually illustrate how difficult such living situations are both for the mentally ill inmates and for those who have to take care of them. As Ackerman summarized it: "The reason for my project wasn't to show how terrible the conditions were in the prison; it was to [ask], 'Is it really where we want these men to get treatment?' We need to focus our energy on finding funding for mental health before this ever happens. The only place many of these men have been able to get treatment has been in prison" (*Slate*, Apr. 1, 2013).

Current Laws Governing Treatment in Prisons and Jails

Prisons

Kentucky Department of Corrections (KY DOC) policies and procedures allow for nonemergency involuntary medication if an inmate suffers from a mental disorder and poses a likelihood of serious harm to self, others, or property, or if the inmate is gravely disabled.

> *Likelihood of serious harm* means:
>
> > a risk that a patient may inflict physical harm upon himself as evidenced by verbal or written threats, gestures, past behaviors or attempts to inflict physical harm on one's self, upon another, or upon the property of others.
>
> *Gravely disabled* means a condition resulting from a mental disorder:
>
> > (1) which causes a person to be in danger of serious physical harm resulting from a failure to provide for his own essential human needs for health or safety; or
> >
> > (2) in which the person manifests severe deterioration in routine functioning as evidenced by repeated and escalating loss of cognitive and volitional

control over his actions and is not receiving care essential for personal health and safety.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by an Involuntary Medication Hearing Committee composed of a nontreating psychiatrist and a nontreating psychologist as well as a high-ranking staff member who serves as chair of the committee. A majority of committee members must approve nonemergency involuntary treatment; the psychiatrist must be in the majority.

Jails

State law does not prohibit Kentucky county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others. Based on the survey information, at least one jail has used a *Washington v. Harper* procedure in the past. Typically, Kentucky jails petition for civil commitment to state or community psychiatric facilities.

Note: Kentucky's high rate of suicides in jails prompted the Kentucky legislature to invest in a new statewide program for integrating mental health services provided to jails. One component is a Telephonic Triage service to assist jails in assessing the safety of an inmate with mental illness. Based on telephonic assessments, recommendations are made for additional follow-up services that may include a face-to-face visit by local mental health professionals to evaluate inmates for civil commitment to a psychiatric facility.

Louisiana

Background

The Louisiana State Prison at Angola has 5,058 inmates; assuming 15 percent of them are seriously mentally ill, Angola would be the largest "mental institution" in the state. The prison has been sued for mistreatment of prisoners so many times it has lost count. When the prison was sued in 1999, the case was said to be "the latest in a string dating back more than 30 years" and was dismissed by the secretary of the department of corrections as "just another lawsuit" (*Times-Picayune*, Oct. 30, 1999).

As for jails, consider the Orleans Parish Prison in New Orleans, a jail recently cited as "among the worst in the nation . . . [where] sexual assault is rampant. So is the use of contraband. So is negligent classification by prison staffers who place violent inmates in the same units with inmates who are less so. . . . As is always the case, those inmates with severe mental illness are the most vulnerable to the pervasive atmosphere of lawlessness that exists within the prison" (TheAtlantic.com, June 11, 2013).

Louisiana is another state that is among the stingiest in expenditures for public mental illness services. It is severely short of public psychiatric beds, yet its response has been to recently close another state mental hospital. As the sheriff of Washington Parish noted in response to a homicide by a mentally ill man who had just been released from jail: "With the closing of mental health facilities, local jails and prisons became the keepers of mentally ill persons who acted out in the community. . . . Local jails and prisons do not have the resources to provide the level of care that is required. . . . With diminished inpatient mental health treatment programs, the public can expect more tragic incidents such as this to occur" (*The Daily News*, Oct. 26, 2012).

Current Laws Governing Treatment in Prisons and Jails

Prisons

State law governs the administration of nonemergency treatment of prison inmates. An inmate who refuses treatment may be medicated over objection for no more than 15 days if a physician or psychiatrist certifies that treatment is necessary to prevent harm or injury to the inmate or to others. If treatment for a longer period is deemed necessary, a petition must be filed with the court. Treatment shall continue while the hearing is pending. The inmate may continue to be medicated over objection if the patient is not competent.

Nonemergency mental health treatment is defined in the Louisiana Department of Public Safety and Corrections (LA DPSC) policy as a situation in which the result of no treatment increases the danger of harm to self or others. While the statute does not require that an inmate lack decisional capacity for the initial 15-day medication period, the LA DPSC policy specifically states:

> it is the Secretary's policy that an offender, who has the decisional capacity to give informed consent, after being fully informed of the risks and benefits of treatment, has the right to accept or refuse treatment in writing.

Jails

Based on the survey of jails in Louisiana, at least one parish has policies and procedures to address mentally ill offenders who refuse treatment. If a psychiatrist or physician certifies that treatment is necessary to prevent harm or injury, an inmate may be treated for 15 days. If continued treatment is necessary, a petition must be filed in a court of competent jurisdiction setting forth the reasons for the treatment. Treatment may continue while the hearing is pending.

Maine

Background

In Maine, the Cumberland County Jail in Portland (500 inmates) and the Maine State Prison in Warren (712 inmates) probably both hold more seriously mentally ill individuals than does Riverview, the largest remaining state mental hospital (92 patients). Riverview itself has had major problems handling violent patients. As a result, as noted below, the state legislature in 2013 funded a special 32-bed unit within the state prison to hold mentally ill individuals who are too violent to be incarcerated in jails or hospitalized. Severe overcrowding in both the county jails and the state prison has been partially caused by the increasing number of mentally ill individuals who end up in them, as the state's public mental illness treatment programs continue to deteriorate. In 2007, then-Governor John Baldacci proposed to have the state assume control of all the county jails, some of which "could be transformed into short-term lockups or specialty facilities for people with mental illnesses" (*Sun Journal*, Aug. 31, 2007). Before we began criminalizing mentally ill individuals in the United States, such facilities would have been called state mental hospitals. The Maine prison is similarly troubled by mentally ill inmates, many of whom are put into solitary confinement. Legislation to ban the use of solitary confinement for mentally ill prisoners was introduced in 2010 but voted down by the Maine legislature (*Psychiatric News*, Sept. 3, 2010).

Current Laws Governing Treatment in Prisons and Jails

Prisons

The Maine Department of Corrections (ME DOC) is authorized by statute to administer medication involuntarily if an inmate poses a likelihood of serious harm and lacks the capacity to make an informed decision regarding medication.

Likelihood of serious harm is defined to mean:

> (1) a substantial risk of physical harm to a person, as manifested by that person's recent threats of, or attempts at, suicide or serious self-inflicted harm;
>
> (2) a substantial risk of physical harm to other persons, as manifested by a person's recent homicidal or other violent behavior or recent conduct placing others in reasonable fear of serious physical harm; or
>
> (3) a reasonable certainty that a person will suffer severe physical or mental harm as manifested by that person's recent behavior demonstrating an inability to avoid risk or to protect the person's self adequately from impairment or injury.

In order to obtain authorization to administer medication involuntarily, an application for a hearing must be submitted to the Superior Court in the county where the correctional facility is located. The court must find by clear and convincing evidence the inmate meets the criteria for involuntary medication.

Note: On August 20, 2013, Maine adopted a law that authorizes: (1) creation of mental health units in correctional facilities; (2) a procedure for administering medication without consent in a mental health unit of a correctional facility; and (3) transfer of certain forensic patients and county jail inmates awaiting treatment for restoration of competency or treatment under a civil commitment. Prior to enactment of the law, ME DOC was not authorized to administer medication involuntarily. Inmates were treated in a designated state psychiatric hospital. Forensic patients, who once constituted one-half of the hospital's population, occupied three-quarters of the hospital beds at the time the bill was passed. The bill was enacted as an emergency measure to address the loss of federal funding for the state hospital, which accepts forensic patients, due to overcrowding and dangerous conditions.

Jails

Based on survey information, Maine jails petition for civil commitment to a state psychiatric hospital for inmates who are in need of treatment. This is rarely done, since the shortage of hospital beds prevents the transfer of inmates. Jails must manage the inmates' symptoms with means other than medication, such as restraints, seclusion, or direct observation.

Note: A recent change in the law allows the Commissioner of the Department of Health and Human Services to transfer the commitment of jail inmates to a prison mental health unit when "no suitable bed is available" in the state psychiatric hospital. A sheriff in Maine said that he did not expect that the new law would alleviate the long waiting lists for beds and that mentally ill jail inmates would continue to suffer without treatment.

Maryland

Background

In Maryland, the largest public institution for individuals with psychiatric illnesses is the 900-bed Patuxent Institution in Jessup, a correctional facility under the Department of Public Safety and Correctional Services specifically for prisoners with severe mental illness and substance abuse. It is a troubled facility in which three patients were killed by other patients between September 2010 and October 2011 (*Baltimore Sun*, Nov. 2, 2012). The largest state mental hospital, Spring Grove Hospital Center (380 beds), holds fewer mentally ill inmates than the Baltimore County Jail, which has 2,200 inmates.

Studies in 2002 reported that 16 percent of male and 33 percent of female jail inmates had a "serious mental illness" in Montgomery and Prince George's Counties (Steadman et al., *Psychiatric Services* 2009;60:761). More recent estimates for all serious mental illness among all jail inmates are 25 percent for Montgomery and Howard Counties (WJZ.com, July 20, 2010; *Baltimore Sun*, Jan. 7, 2013).

The involuntary treatment of mentally ill individuals is especially difficult in Maryland, one of only five states without a law allowing for assisted outpatient treatment (AOT). The failure to

treat mentally ill people in the community carries over to the prisons and jails, where a failure to treat mentally ill inmates produces many tragic outcomes. In 2011, for example, Rohan Goodlett – diagnosed with schizoaffective disorder – used a razor to slash a fellow inmate and a correctional officer. Goodlett had been charged with two senseless homicides, was acutely psychotic, and yet had not been treated for six months at the time of the razor slashings. When medicated, Goodlett was said to be "a very different person. He's very polite. He's intelligent" (*Washington Post*, Sept. 2, 2011).

Current Laws Governing Treatment in Prisons and Jails

Prisons

The Maryland Department of Public Safety and Correctional Services (MD PSCS) has jurisdiction over the prison system in Maryland and the pretrial detainees and sentenced inmates in the Baltimore City Correctional Center. MD PSCS has been trying to get legislative authority to administer medication over objection for several years. If an inmate is refusing medication and is in need of treatment, the prison must obtain a certificate for admission to one of the state psychiatric hospitals. Once stabilized, the inmate returns to prison or the Baltimore jail. If the inmate again refuses medication, the process starts over again. When asked how long it takes to get a bed once the certificate for hospitalization is obtained, the representative said that "it takes months."

Jails

Information published by a county Department of Correction and Rehabilitation (DOCR) indicates that Maryland jails rely upon civil commitment to a state psychiatric hospital if an inmate refuses medication and presents a risk of harm. The level of security needed for an inmate's treatment determines whether admission is made to the state's forensic hospital or one of the other state psychiatric hospitals. The DOCR psychiatric nurse arranging for the inmate's admission must obtain preapproval from the state's Central Admission and Referral Center (CARC) prior to any hospital admission.

Note: Many states now use a centralized admission unit, such as the CARC, to control admissions to psychiatric hospitals. These units serve as "gatekeepers" and have authority to deny transfer of a patient to a state hospital, even if the patient meets civil commitment criteria. States are able to control the census of psychiatric hospitals using "pre-approval procedures."

Massachusetts

Background

Making the assumption that 20 percent, or 400, of the 2,000 inmates in Boston's Suffolk County Jail are seriously mentally ill, that number exceeds the number of patients (369) in Tewksbury, the largest remaining state mental hospital in Massachusetts. Bridgewater State

Hospital, part of the state prison system, holds 350 mentally ill prisoners. In 2012, the Massachusetts Sheriffs' Association reported that "42 percent of inmates in the county jail system have a form of mental illness and 26 percent have major mental illness" (*WWLP*, Feb. 2, 2012). The jails have had a very high suicide rate among the mentally ill inmates and also a large number of prisoner self-mutilations (*Daily Free Press*, Dec. 12, 2007). Typical among such cases was John Pappageris, a 51-year-old man with "a lengthy history of mental illness" who was serving time for breaking and entering. While in prison he "ate batteries" and mutilated himself, then finally hung himself (*Boston Globe*, July 16, 2010). The prison system is similarly troubled, as exemplified by the prison in Bridgewater, originally made famous by the 1967 movie *Titicut Follies*.

Massachusetts has several problems that exacerbate the situation. It is among the states that make the least effort to divert mentally ill individuals from jails. Although one new state hospital has opened in Worcester, the state continues to eliminate public hospital beds despite evidence that public psychiatric beds are already far too few in number. It is one of only five states that do not have a law allowing for assisted outpatient treatment (AOT); thus, the court-ordered treatment of mentally ill individuals in the community who are known to be dangerous but are not aware of their own illness is very difficult to achieve. Some of them commit crimes due to their untreated mental illness and thus end up in jail or prison.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Massachusetts Department of Corrections (MA DOC) procedures do not permit nonemergency involuntary administration of psychotropic medication for inmates who have the capacity to make an informed decision. For inmates who lack the capacity to make an informed decision and refuse medication, the policy makes a distinction in the procedures for involuntary administration of antipsychotic medications and other psychotropic medications, such as mood stabilizers or antidepressants. Regarding antipsychotic medications: A court order is required for the administration of antipsychotic medication to an inmate who lacks the capacity to provide informed consent. The court must make a determination that the inmate is incompetent and, if so, approve the administration of medication only if the court determines that the inmate would consent to treatment if competent (this is called "substituted judgment"). A medical guardian is appointed to monitor the treatment plan authorized by the court, called a "Rogers" treatment plan. Regarding non-antipsychotic medications: Non-antipsychotic medication cannot be administered to an inmate who lacks the capacity to provide informed consent without the approval of a legal guardian or a health care agent. However, neither a guardian nor a health care agent may provide consent if the inmate refuses, in which case a court order is required.

Note: The MA DOC policy is uniquely comprehensive and detailed with respect to emergency mental health procedures, such as constant observation or therapeutic restraints. This could be due to the fact that inmates who are not deemed incompetent may not be involuntarily medicated *except* in an emergency.

Jails

If an inmate with mental illness refuses medication and is in need of treatment, jails in Massachusetts seek to have the inmate admitted to a state psychiatric hospital. Jails report it is not difficult to have a patient transferred to the state's forensic hospital.

Note: It is important to note that, according to community mental health providers and families in Massachusetts, it is virtually impossible to have someone admitted who is not in the criminal justice system.

Michigan

Background

Michigan's largest remaining state hospital, the Walter P. Reuther Psychiatric Hospital, has only 220 beds. Michigan also has nine state prisons that each have 1,700 or more inmates. If 15 percent of these prisoners are seriously mentally ill, each of these prisons would have more mentally ill individuals than the largest state psychiatric hospital. As early as 1999, a study of inmates in three county jails reported that "one-third were seriously afflicted, suffering from schizophrenia, bipolar, and other psychotic disorders" (*Detroit Free Press*, Nov. 27, 2011). A 2010 study of inmates in the state's prisons reported that 20 percent "had severe mental disabilities." Among these mentally ill prisoners, two-thirds had received no treatment in the previous year (*Detroit Free Press*, Nov. 27, 2011). Muskegon County sheriff Dean Roesler said that the closing of the state hospitals has "created absolute chaos as far as the criminal justice system" (*Muskegon Chronicle*, Dec. 16, 2013).

The numbers tell the story. Half a century ago there were 20,000 mentally ill individuals in Michigan's state hospitals, and the total state prison population was 10,000. Today, there are 1,000 mentally ill individuals in state hospitals, and the total prison population is 51,000 (*Toledo Blade*, Jan. 4, 2008). The situation was succinctly summarized by journalist Phil Power: "The state closed the mental hospitals largely to save money – but it has long been clear that this was short-sighted. It costs a lot to use prisons or local jails to do a job for which they are vastly unsuited: Serve as treatment centers for the mentally ill" (*Grosse Pointe Today*, Dec. 6, 2011).

Current Laws Governing Treatment in Prisons and Jails

Prisons

Michigan Department of Corrections (MI DOC) policies allow for nonemergency involuntary administration of medication based on a determination that an inmate is mentally ill and that the proposed mental health services are suitable to the prisoner's condition. Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Hearing Committee consisting of a psychiatrist, a fully licensed

psychologist, and a bachelor's-degree level mental health professional. None of the committee members may be involved in the inmate's current treatment. A majority of committee members must approve nonemergency involuntary treatment; the psychiatrist must be in the majority.

Jails

State law does not prohibit Michigan county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others. Based on survey information, however, Michigan jails seek a court order to hospitalize an inmate. Nonetheless, it can be very difficult to admit an inmate for involuntary treatment due to a shortage of hospital beds.

Note: A large county jail in Michigan reported that it seeks court orders for hospitalization four to six times a month. For inmates who are not hospitalized, other means are used to protect the inmates, such as cells with cameras that allow around-the-clock surveillance.

Minnesota

Background

The largest public institution for seriously mentally ill individuals in Minnesota is the Security Hospital at St. Peter. Its 400 patients are restricted to forensic cases and sex offenders. For mentally ill individuals who need brief hospitalization for medication stabilization, there are very few options, since the remainder of the state hospital system has been virtually closed. In Minneapolis, many end up in the Hennepin County Jail, which, "on any given day holds 100 to 200 inmates with severe psychiatric disorders. . . . They represent one-quarter of the jail's population" (*Post Review*, Oct. 2, 2013). Even 10 years ago, it was reported that 30 percent of the inmates of the Dakota County Jail were taking antipsychotic drugs and that 60 percent of all medications given at the Hennepin County Jail were "for the treatment of a mental illness" (*Pioneer Press*, Sept. 8, 2003).

As Minnesota Senator Al Franken recently summarized the situation: "We've been using our criminal justice system as a substitute for a well-functioning mental health system – we've sort of criminalized mental illness and addiction" (*Minnesota Public Radio*, July 26, 2013). Similarly, a county attorney said, "In my opinion, we've gone back to the dark ages. . . . It's a tiny segment of the mentally ill, but we are failing them" (*Star Tribune*, Oct. 26, 2013).

The consequences of putting mentally ill people into prisons and jails are often tragic. Since 2000, 35 inmates in the county jails and 27 inmates in the state prisons have killed themselves, many known to be seriously mentally ill. Between 2011 and 2013, the state paid out more than $1 million "to settle negligence lawsuits related to jail suicides" (*Star Tribune*, Nov. 23, 2013). In 2012, Michael Schuler – suffering from psychosis and hearing voices –

stabbed out both of his eyes with a pencil in the Hennepin County Jail. He had refused medication, and a decision had been made to not medicate him involuntarily. His condition continued to deteriorate until he was "standing naked in his cell, standing in his own feces, screaming gibberish," at which point he mutilated himself. He subsequently sued Hennepin County and accepted a $1 million settlement (*KMSP*, Feb. 26, 2013; *Star Tribune*, Oct. 22, 2013). This proves yet again that, aside from its inhumanity, failing to treat seriously mentally ill individuals is a costly mistake.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Minnesota Department of Corrections (MN DOC) procedures do not permit nonemergency involuntary administration of psychotropic medication for inmates who have the capacity to make an informed decision. For inmates who lack the capacity to provide informed consent and refuse medication, the policy makes a distinction in the procedures for involuntary administration of antipsychotic medications and other psychotropic medications. Regarding antipsychotic medications: Antipsychotic medication cannot be administered to an inmate who lacks the capacity to provide informed consent and refuses medication without a court order. The court must make a determination of incompetence and approve the administration of medication based on any preference the inmate may have expressed about medication while competent. If there is no evidence of the inmate's preference, the court must consider the following factors:

(1) the person's family, community, moral, religious, and social values;

(2) the medical risks, benefits, and alternatives to the proposed treatment;

(3) past efficacy and any extenuating circumstances of past use of antipsychotic medications; and

(4) any other relevant factors.

Regarding other medications: If an inmate refuses other psychotropic medication, a court must appoint a guardian if the inmate is found to be incompetent. The guardian may consent to treatment.

Jails

Based on survey information, Minnesota jails must seek a court order for civil commitment to a state hospital to secure treatment for an inmate who refuses medication.

Note: A sheriff in a large county said mentally ill inmates who have been ordered to the custody of the Minnesota Department of Human Services are often not transferred due to a shortage of hospital beds. As a result, inmates remain in the jail for weeks and even months.

Mississippi

Background

The situation in Mississippi's county jails is grim. "About two-thirds of the 594 inmates at the Hinds County Detention Center [in Jackson] take anti-psychotic medication" (Clarionledger.com, Jan. 31, 2011). According to a jail deputy: "They howl all night long. If you're not used to it, you end up crazy yourself." The sheriff said, "I signed on for law enforcement to be a sheriff, not a psychiatrist or mental health professional, [and] don't claim to be, but that's the position I've been thrust into." An official in the Lafayette County Jail noted, "We really have a broken mental health system. It's just not even hardly in the 20th century" (*Clarion Ledger*, Aug. 16, 2010).

The situation in the state prisons is even grimmer. The East Mississippi Correctional Facility is state-owned but operated under contract by a private provider. It has been specially designated as a facility for "prisoners with special needs and serious psychiatric disabilities." A lawsuit filed by the ACLU in May 2013 described the conditions there:

> Many cells lack light and working toilets, forcing prisoners to use trays or plastic bags that are tossed through slots in their cell doors. Rats often climb over prisoners' beds, and some prisoners capture the rats, put them on makeshift leashes, and sell them as pets to other inmates. . . . Among the hundreds of mentally ill prisoners at EMCF [East Mississippi Correctional Facility] are many whose untreated illnesses lead to extreme behaviors such as screaming, babbling, throwing excrement and starting fires. Suicide attempts are frequent, some are successful. Other prisoners engage in gross acts of self-mutilation, including electrocution, swallowing shards of glass and razors, and tearing into their flesh with sharp objects. Defendants [prison officials] deny prisoners even rudimentary mental health treatment and, last year, reduced access to psychiatric care (Cohen, "One of the Darkest Periods in the History of American Prisons," *Atlantic Monthly*, June 9, 2013).

Such is the state of public psychiatric care in 2013.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Mississippi Department of Corrections (MS DOC) policy allows for nonemergency involuntary administration of medication based on a determination that the inmate would present a danger to himself, others, or property, or he would become gravely disabled.

Gravely disabled is:

> (1) a condition in which a person, as a result of mental disorder is in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety; or
>
> (2) a condition in which a person manifests severe deterioration in routine functioning as evidenced by repeated and escalating loss of cognitive or volitional control over his actions and is not receiving such care as is essential for his health or safety.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Special Hearing Committee consisting of a psychiatrist, a psychologist, and one other health professional. None of the committee members may be involved in the inmate's current treatment. The decision to medicate the inmate requires a majority vote of the committee; the psychiatrist must be in the majority.

Jails

State law does not prohibit Mississippi county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others.

Based on survey information, however, Mississippi jails do not administer nonemergency medication involuntarily. Jails seek an emergency transport order from the court to transfer the inmate to a state psychiatric hospital. It is easier to get a transfer order for inmates who have misdemeanor charges as opposed to felony charges. Inmates who have insurance can go to the county hospital.

Missouri

Background

Fulton State Hospital, opened in 1851 and now falling apart, is said to be "the state's largest inpatient facility," with 376 patients (*Missouri Times*, Aug. 26, 2013). In fact, the state prisons in Bonne Terre (2,654 inmates) and Farmington (2,614 inmates) probably each have more seriously mentally ill individuals than the state hospital has. In 2006, the Missouri Department of Corrections estimated 20 percent of the prison population was mentally ill, a figure that had steadily increased since 1997 (*Missourian*, Dec. 17, 2007). The superintendent of the prison at Farmington also noted the increase: "They get sentenced to prison rather than getting treated in mental health units" and "are more susceptible to being preyed upon by other offenders" (*KSDK Channel 5*, Nov. 16, 2006). In 2011, another prison official called the situation "the

criminalization of the mentally ill – it's a huge problem. . . . The responsibility for helping people with mental illness has, by default, gone to jails and prisons" (*News-Press*, Mar. 5, 2011).

Missouri's jails are even worse off. In Boone County, "at least 30 percent" of the inmates are said to be mentally ill (*Missourian*, Dec. 17, 2007). In Greene County, a jail official said, "We see a lot of substance-induced psychosis, and we are seeing increasingly more individuals coming in with chronic mental health conditions such as schizophrenia and bipolar disorder" (*KY3 News*, Aug. 3, 2011). Meanwhile, at the Municipal Corrections Institute in Kansas City, an official reported "seeing an alarming increase in the number in inmates with mental illness since his 20 years at the city jail." He added, "Screaming, cussing at people that aren't there, not knowing where they are or what day of the week it is. . . . I don't think jail is the place for them" (*KCUR TV*, Oct. 1, 2007).

Current Laws Governing Treatment in Prisons and Jails

Prisons

Missouri Department of Corrections (MO DOC) policy allows for nonemergency involuntary administration of medication in cases of clinical necessity, which occurs when mental illness interferes with an inmate's functioning in the institution, yet no immediate danger exists. *Clinical necessity* includes inmates who:

(1) are gravely disabled;

(2) pose a future likelihood of harm to self or others if treatment is not instituted;

(3) evidence delusions, hallucinations, or other thought disturbances; or

(4) suffer from severely diminished institutional adjustment.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a committee composed of a consulting psychiatrist, the associate superintendent, and the regional manager of Mental Health Services.

Note: On September 4, 2012, the United States Court of Appeals, Eighth Circuit, found that Missouri's policy satisfied the plaintiff's minimum due process protections, *Green v. Dormire*, No. 11–2251 (8th Cir. Sep. 4, 2012).

Jails

State law does not prohibit Missouri county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others.

Missouri jails can seek a court order to administer involuntary medication on a nonemergency basis, but it is not common. In some cases, a jail may seek guardianship for an inmate who lacks capacity and is refusing treatment.

Montana

Background

Montana State Hospital has 174 patients. Montana State Prison has 1,495 inmates, with an estimated 15 percent, or 224, of them having a serious mental illness. Given its size and sparse population, Montana is a very difficult state in which to provide good services for mentally ill individuals. County jails are often used to hold mentally ill individuals awaiting transportation to the state hospital. Many county jails are badly overcrowded because of the number of mentally ill inmates. One county official called jails “the very worst place” for people with mental illness (*Independent Record*, Dec. 17, 2013). The treatment of mentally ill individuals in the state prison, both voluntary and involuntary, has also been problematic. In 2007, the warden of the prison suggested building a special unit for mentally ill prisoners, another indication that the state mental health treatment system had failed to treat these individuals in the community. NAMI Montana has been helpful in trying to focus attention on this problem.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Montana Department of Corrections (MT DOC) policy requires that voluntary treatment be provided unless it is determined the offender is gravely disabled or a significant danger to self or others. The policy cites *Washington v. Harper* as a reference for its involuntary administration of medication procedures. However, the policy provides no further details.

Jails

State law does not prohibit Montana county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others.

Based on survey information, jails in Montana do not seek court orders for involuntary treatment orders, because the process is too burdensome. If an inmate deteriorates so much he or she becomes dangerous, a jail may petition for civil commitment to a state psychiatric hospital. It is difficult to get an inmate admitted to the hospital due to the shortage of beds. A jail administrator said it is not uncommon for inmates to be admitted for a stay of 30 to 90 days, stabilized with medication, and returned to jail, where they stop taking the medication. Then the whole process must start again.

Nebraska

Background

The largest remaining state psychiatric hospital in Nebraska is Lincoln, with 250 beds. However, the Douglas County Jail in Omaha has 1,453 inmates; assuming that 20 percent, or 291 of them, have a serious mental illness, the jail is de facto the largest "mental institution" in the state. In almost every county, headlines such as "Mental Illness Huge Problem in Local Jails" (*NTV*, July 6, 2011) can be found. As the director of the Lancaster County Jail notes, "We are struggling like every jail across the country with our mentally ill inmates. . . . We're a jail, not a hospital" (*Lincoln Star Journal*, Dec. 21, 2005). The Dodge County Jail experienced two suicides in two months. In one case, the inmate's physician had told jail officials his patient was suicidal and the inmate had asked for treatment, but none was forthcoming. As usual, the suicide resulted in a lawsuit and $850,000 payout (*Omaha World Herald*, June 29, 2010). Withholding treatment does not save money. A major problem is that the county jails are being used to hold mentally ill individuals awaiting a psychiatric bed in a hospital. The problem is that, unless the person has insurance coverage or is independently wealthy, there are no beds. Nebraska's prison system is equally troubled. In July 2013, an inmate with paranoid schizophrenia was released without any follow-up treatment; within three weeks, he had killed four people (*The Republic*, Jan. 7, 2014).

Current Laws Governing Treatment in Prisons and Jails

Prisons

Nebraska Department of Correctional Services (NE DCS) regulations allow for nonemergency involuntary administration of medication based on a determination the inmate is gravely disabled or poses a likelihood of serious harm to self/others or their property.

> *Gravely disabled* is a condition in which a person, as a result of a mental disorder:
>
> > (1) is in danger of serious physical harm resulting from a failure to provide for his/her essential human needs of health or safety; or
> >
> > (2) manifests severe deterioration in routine functioning as evidenced by repeated and escalating loss of cognitive or volitional control over his/her actions and is not receiving such care as is essential for his/her health or safety.
>
> *Likelihood of serious harm* is:
>
> > (1) a substantial risk that physical harm will be inflicted by an individual upon his/her own person, as evidenced by threats or attempts to commit suicide or to inflict physical harm on one's self;

(2) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior that has caused such harm or that places another person or persons in reasonable fear of sustaining such harm; or

(3) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior that has caused substantial loss or damage to the property of others.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Hearing Committee consisting of a psychiatrist (or a psychiatrically specialized nurse practitioner or physician assistant) and a psychologist. A NE DCS attorney serves as chair, presiding over the hearing, facilitating the process, and preparing the report of the committee's findings and decision. None of the committee members may be involved in the inmate's current treatment. A decision to medicate the inmate requires a majority vote of the committee; the psychiatrist must be in the majority.

Jails

In 2008, the University of Nebraska conducted an assessment of mental health needs in the state's criminal justice system. The report indicated that when a jail in Nebraska cannot provide the treatment needed by an inmate with a severe mental illness, the inmate may be transferred to a state correctional facility. Inmates transferred from jails to state facilities are called "safekeepers" because they are transferred for safekeeping in the state facility.

Between 2000 and 2008, 1,365 jail inmates were sent to the Department of Correctional Services as "safekeepers" an average of 170 per year. The report noted that about 95 percent of the inmates were sent from rural jails, reflecting challenges managing behavior in local jails, difficulty accessing behavioral health resources, and challenges in coordination between justice and mental health in rural communities.

An extensive strategic plan was developed, including plans to implement police Crisis Intervention Teams, forensic diversion programs, etc. With respect to jails, the only recommendation was to improve mental health screening. Improving the ability of jails to provide treatment for inmates in need of treatment was not addressed.

Note: The reports can be found at *Nebraska Justice Behavioral Health Initiative Needs Assessment* and *Nebraska Justice Behavioral Health Initiative Strategic Plan*

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Nevada

Background

The largest state psychiatric hospital in Nevada is the Rawson-Neal Hospital in Las Vegas, with 190 beds. Nearby, the Clark County Jail has more than 3,700 inmates; assuming 20 percent, or 740, of them have a serious mental illness, the jail would have almost four times more mentally ill individuals than the hospital. The High Desert State Prison, with 2,860 prisoners, probably also exceeds the hospital in its number of mentally ill inmates.

None of this should be surprising. For many years, Nevada has had among the fewest public psychiatric beds per capita in the nation and has been among the stingiest states in state spending for mental health services. The sheriff of Clark County has said that "between 25 and 30 percent of [jail] inmates are in need of psychiatric medication at any one time" and "once released, they often have no access to the medication they need" (*Las Vegas Sun*, Jan. 27, 2013). Among the psychiatric cases at the jail, schizophrenia is said to be the most common diagnosis (*Las Vegas Review-Journal*, Feb. 2, 2013). Among the psychiatric cases with multiple admissions to the jail, 87 percent were charged only with trespassing (*Nevada Appeal*, Jan. 30, 2014). The one thing Nevada has done to improve services recently was to pass legislation authorizing outpatient commitment (AOT), becoming the 45th state to do so. If properly used, AOT can markedly decrease the number of mentally ill individuals in the prisons and jails. Assisted outpatient treatment can also markedly decrease petitions for involuntary commitment to the hospital; in Iowa, Ohio, New York, and North Carolina, such petitions decreased by 75 percent. In Nevada, such petitions more than doubled between 2005 and 2012 (*Las Vegas Review-Journal*, Feb. 2, 2013).

Ultimately, the solution to the problem of mentally ill people in Nevada's prisons and jails depends on providing good follow-up to these individuals once released and making sure they continue to take their medication. As one Clark County Jail official noted: "It is a revolving door. We see folks time after time. . . . It's one of those systemic problems, that more often than not, the jails and prisons end up dealing with persons that have mental illness rather than preventive measures on the front end, due to lack of funding. You end up paying for it one way or another" (*8 News Now*, Mar. 27, 2013).

Current Laws Governing Treatment in Prisons and Jails

Prisons

Nevada Department of Corrections (NV DOC) regulations allow for nonemergency involuntary administration of medication based a determination that medication is a necessary part of an inmate's treatment plan and would prevent deterioration. Authorization of nonemergency involuntary medication is determined by a Medical Review Panel consisting of the warden or designee, a psychiatrist, and a psychologist. Neither physician may be currently involved in the care of the inmate.

Jails

State law does not prohibit Nevada county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others. Based on survey information, civil commitment is the means used to obtain nonemergency, involuntary administration of medication. There is a large county jail that has a robust mental health program in its facility that rarely needs to seek civil commitment for inmates with mental illnesses. However, most counties in Nevada are rural, with small populations, and encompass large geographic areas. These counties have limited resources. One sheriff said the local state mental health office takes the position it will not visit inmates in the jail. Civil commitment is the only viable option, but it involves transporting an inmate to another county once a judge's order is obtained. Despite the small size of the jail, mentally ill inmates are a significant issue.

New Hampshire

Background

New Hampshire State Hospital in Concord has 130 beds. The State Prison for Men, a few blocks from the hospital, has 1,407 inmates, of which an estimated 15 percent, or 211 prisoners, have a serious mental illness. It is likely that the Hillsborough County Jail in Nashua, with 700 inmates, also has at least as many mentally ill individuals as the state hospital.

It is hard to believe that 20 years ago New Hampshire was rated as having among the best public mental health services in the country, and the state hospital was second to none. Those days are long gone. The county jails are overrun with mentally ill inmates, hospital emergency rooms are overwhelmed with acutely mentally ill patients waiting for a psychiatric bed, and police on the streets see the consequences of the broken mental health system every day. For example, in 2011 there were six police officer–related shootings in New Hampshire; four of them involved people with "mental health issues" (*WMUR-9*, Sept. 22, 2011).

The four state prisons have also experienced an influx of mentally ill inmates. In 2012, the State Prison for Men in Concord opened a new wing specifically to house mentally ill inmates, bringing to 100 the number of beds for the most seriously mentally ill (*Union Leader*, May 31, 2012). Twenty years ago, most of those inmates would have been receiving treatment at the state hospital.

Current Laws Governing Treatment in Prisons and Jails

Prisons

New Hampshire Department of Corrections (NH DOC) regulations do not provide procedures for nonemergency involuntary administration of medication. If an inmate repeatedly refuses critical medications, the medical director is to consider:

(1) transfer to a more appropriate facility;

(2) further assessment of competence; and/or

(3) guardianship.

All inmates to be transferred to facilities for the severely mentally ill shall be provided a hearing concerning the transfer unless the inmate signs a voluntary waiver.

Jails

Based on survey information, New Hampshire jails petition for civil commitment to the state psychiatric hospital for inmates who are in need of treatment. However, New Hampshire is experiencing a severe shortage of state hospital beds.

Note: The shortage of state psychiatric hospital beds is so severe that the state added new beds in June 2013. In November 2013, New Hampshire's governor Maggie Hassan noted that the new beds and other measures implemented in the state "do not appear to be alleviating the wait for beds or the crisis in our emergency rooms."

New Jersey

Background

Greystone Park, with 549 patients, is the largest remaining state psychiatric hospital in New Jersey. The Essex County Jail in Newark (2,434 inmates) and the Hudson County Jail in Kearny (2,300 inmates) probably have almost that number of seriously mentally ill individuals in their populations. These people end up in jail because the number of public psychiatric beds continues to shrink, with Hagedorn State Hospital being the most recent to close. The state has made virtually no effort to divert mentally ill individuals from jails by using mental health courts. The only positive development has been the recent implementation of assisted outpatient treatment (AOT) in selected counties and the excellent leadership on mental health issues of state senator (and former governor) Richard Codey.

Dumping the state's mentally ill population into prisons and jails is not only inhumane but sometimes fatal. Take, for example, the case of Joel Seidel, described as a 65-year-old "frail retired stockbroker" with untreated bipolar disorder. He was put in the Camden County Jail for violating a restraining order; his family was told this was the only way to get him admitted to a

psychiatric hospital. He was then placed in a cell with an inmate "who had a long history of violence" and had previously been charged with having raped another inmate. At the time, the jail, which was "designed to hold 1,200 inmates, had 1,800 inmates . . . with as many as four people sleeping in cells originally designed to hold one." Seidel was "stomped to death more than 100 times" by his cellmate; Seidel's family then sued the county for "millions of dollars" (*Courier Post*, June 14, 2006).

Current Laws Governing Treatment in Prisons and Jails

Prisons

New Jersey Department of Corrections (NJ DOC) regulations allow for nonemergency involuntary administration of medication based a determination that:

(1) there is substantial likelihood of serious physical harm to the inmate or to others;

(2) there is a substantial likelihood of significant property damage;

(3) the inmate is unable to care for himself or herself so the inmate's health or safety is endangered; and/or

(4) the inmate is incapable of participating in any treatment plan which would offer the inmate a realistic opportunity to improve his or her condition.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Treatment Review Committee consisting of a psychiatrist, a psychologist, and the correctional facility administrator or designee. No committee member may be currently involved in the inmate's treatment. The regulations do not specify what vote is required of the committee to authorize treatment.

Note: On September 4, 2012, the United States Court of Appeals, Eighth Circuit, found that New Jersey's regulations satisfied the plaintiff's minimum due process protections, *Santos v. Bush*, No. 12–2963 (3rd Cir. Nov. 6, 2012).

Jails

State law does not prohibit New Jersey county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others. Based on survey information, New Jersey jails seek admission to state psychiatric hospitals for inmates who are in need of treatment. The shortage of hospital beds prevents the transfer of inmates, and jails must manage the inmates' symptoms with means other than medication, such as restraints, seclusion, or direct observation. New Jersey has a limited number of beds for inmates from county jails. New Jersey's Centralized Admissions Department serves as a "gatekeeper" and is authorized to deny admission to state hospitals even if a screening service deems that a patient meets commitment criteria.

New Mexico

Background

The New Mexico state hospital in Las Vegas has 198 patients. The Bernalillo County Jail in Albuquerque, which holds 2,236 inmates, almost certainly has more mentally ill individuals, probably twice as many, as the state hospital. Mentally ill inmates are a problem in all of the state's jails. For example, in the Doña Ana County Jail in Las Cruces, 36 percent of the inmates "receive mental health services," and the jail is said to be the "de facto state mental hospital for southern New Mexico" (*Las Cruces Sun-News*, July 12, 2012; Mar. 2, 2011).

New Mexico's problems originate in the fact that it has among the fewest public psychiatric beds per capita of any state and is among the stingiest in state mental health expenditures. It is also one of only five states that do not have a law allowing for assisted outpatient treatment (AOT), which has been proven to decrease arrests and incarcerations of mentally ill individuals. AOT was introduced twice in the state legislature, but both times was opposed by the state's Division of Behavioral Health. In Albuquerque between 2010 and 2012, there were 24 police officer–related shootings; in 11 of the 24 cases, the person shot had "a history of mental illness, substance abuse, or both" (PoliceOne.com, NM, May 8, 2012).

Current Laws Governing Treatment in Prisons and Jails

Prisons

Under New Mexico Department of Corrections (NM DOC) policy, nonemergency involuntary administration of medication is allowed only if a court has appointed a mental health treatment guardian, and psychiatric treatment is clinically necessary to treat a mental disorder.

Jails

A New Mexico jail's Psychiatric Services Policy states that treatment refusal will be reviewed and considered within the Mental Health Code and the laws of the State of New Mexico. New Mexico statutes require court appointment of a treatment guardian for administration of medication against an inmate's expressed will. Thus, New Mexico jails can seek the appointment of a treatment guardian who could authorize nonemergency involuntary medication for an inmate.

New York

Background

With 12,200 inmates, Rikers Island Jail in New York City is the largest de facto "mental institution" in New York State and one of the largest in the country. A 2011 estimate suggested that one-third of male prisoners there and two-thirds of female prisoners were mentally ill

(*NY-1*, Sept. 30, 2011). If we use a more conservative estimate of 20 percent, that would be 2,440 individuals with severe mental illness, equivalent to three-quarters of the 3,300 mentally ill individuals in all of the state's mental hospitals combined.

As the state mental hospitals have been downsized and closed, there has been a concomitant increase in mentally ill persons in the county jails and state prisons. Even 10 years ago, it was estimated that 17 percent of the inmates in the Erie County Jail were mentally ill; 20 percent in the Onondaga County Jail; 25 percent in the Niagara County Jail; and 30 percent in the Monroe County Jail (*Buffalo News*, July 22, 2002). Another study of inmates in the jails in Albany and Rensselaer Counties reported 17 percent of the males and 40 percent of the females had a serious mental illness, narrowly defined (Steadman et al., *Psychiatric Services* 2009;60;761).

In the state prison system, it has been estimated "about 12 percent of the state prison population is afflicted with a serious mental illness. . . . The state's prisons, by default, have taken the place of psychiatric centers" (*Poughkeepsie Journal*, Feb. 11, 2008). Especially problematic in New York has been the use of solitary confinement for mentally ill prisoners and a high rate of suicides among prisoners so confined. Between half and three-quarters of the prison inmates in solitary confinement were mentally ill, and one-third engaged in cutting or other forms of self-mutilation (*The Real Cost of Prison Weblog*, Feb. 24, 2010). One man with schizophrenia was incarcerated for 15 years, 13 of which were spent in solitary. "He showed [a reporter] his arms, covered with scars from self-mutilation, and a 5-inch scar on his neck from when he slashed his own throat in a suicide attempt" (*Ithaca Journal*, July 23, 2004). Until the the city's Department of Corrections announced it was stopping the use of solitary confinement for mentally ill inmates in January 2014 (*Wall Street Journal*, Jan. 5, 2014), solitary confinement was also a problem in New York's Rikers Island Jail, where 15 percent of all inmates – half of them mentally ill – were reported to be confined in isolation (*New York ABC Local*, Nov. 7, 2013). One month later, the state similarly announced that it was putting some restrictions on the use of solitary confinement in the state prisons (*New York Times*, Feb. 19, 2014).

Current Laws Governing Treatment in Prisons and Jails

Prisons

By statute, New York Department of Correctional Services (NY DOCS) inmates who meet commitment criteria are committed to the Central New York Psychiatric Center (CNYPC), which is operated by the New York Office of Mental Health (NY OMH). Mental health services in the prison are provided under a memorandum of agreement between NY DOCS and NY OMH. NY DOC operates special units providing psychiatric services where inmates may be assessed for involuntary admission to CNYPC pursuant to New York Correction Law 402. NY DOC policy does not otherwise address mentally ill inmates who refuse medication and are in need of treatment.

Note: In 2007, NY DOCS and NY OMH reached a settlement agreement with Disability Advocates, Inc., a legal services group that filed a lawsuit on behalf of prison inmates with severe mental illness. In the settlement, NY OMH agreed to add a 20-bed hospital ward at the

CNYPC for DOCS inmates. At the time of the settlement, NY OMH identified 2,825 inmates as seriously mentally ill and subject to the settlement's terms.

Jails

By New York State statute, if a physician in a jail certifies that an inmate is in need of involuntary care and treatment, the inmate will be examined by a physician designated by a hospital director. If the physician finds the inmate has a mental illness that is likely to result in serious harm to self or others and for which care in a psychiatric hospital is appropriate, the inmate should be involuntarily committed to the hospital.

> *In need of involuntary care and treatment* means that:
>
> > a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and the person's judgment is so impaired that he is unable to understand the need for such care and treatment.
>
> *Likely to result in serious harm* means:
>
> > (1) a substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself; or
> >
> > (2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear or serious physical harm.

North Carolina

Background

With the recent closure of Dorothea Dix Hospital in Raleigh, North Carolina is down to three state mental hospitals, the largest being the Central Regional Hospital, with 398 beds. The Mecklenburg County Jail in Charlotte (1,904 inmates) and Wake County Jail in Raleigh (1,568 inmates) probably both have at least as many mentally ill individuals as does the state hospital. According to the Wake County authorities, 40 percent of the jail population "suffer from chronic mental illness" (*News Observer*, June 24, 2013). As Dorothea Dix Hospital in Raleigh was closing late in 2012, a new prison hospital for 216 mentally ill prisoners was opening directly across the street. They should simplify the deinstitutionalization process by just transferring the patients directly from the hospital to the prison.

There is probably no state where mental health services have deteriorated as much as they have in North Carolina over the last decade. The efforts to privatize the system have been a

disaster, enriching a few private providers but leaving most seriously mentally ill individuals and their families to fend for themselves. The answer, of course, is simple and was again demonstrated by a study released by researchers at North Carolina State University. The report concluded: “Providing medication and counseling for psychiatric patients after they are released from hospital stays could significantly reduce the number of mentally inmates in jail, a new study shows. Researchers followed 4,056 people for seven years after hospital treatment and found that those who received government-subsidized medications or outpatient mental health services as a follow up were much less likely to get into legal trouble than those who did not” (*News Observer*, June 24, 2013). North Carolina’s mental health officials and legislators apparently do not read their own studies.

Current Laws Governing Treatment in Prisons and Jails

Prisons

The North Carolina Department of Correctional Services (NC DCS) Policy and Procedure Manual allows for nonemergency involuntary administration of medication if:

> there is evidence of current deterioration or worsening of the inmate’s diagnosed condition, which, if not treated, is likely to produce acute exacerbation of the inmate’s condition such that the safety or life of the inmate or others would be endangered.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by an Involuntary Psychotropic Medication Committee consisting of a psychologist, a psychiatrist, and a mental health nurse (RN). None of the committee members may be involved in the inmate’s current treatment. The decision to medicate the inmate requires a majority vote of the committee; the psychiatrist must be in the majority.

Jails

State law does not prohibit North Carolina county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to self or others. However, in North Carolina, jails try to get inmates who refuse medication and need treatment into a state psychiatric hospital. As in many states, it is very difficult to get a bed.

North Dakota

Background

The North Dakota State Hospital in Jamestown has 140 patients; the state is one of the few in which the state hospital holds more mentally ill individuals than any prison or jail does. However, the Cass County Jail in Fargo, with 540 total inmates, is catching up. The mentally ill inmates in this jail are said to be the most problematic. As noted by one jail official, "Twenty percent of the people who are mentally ill take up 80 percent of our time" (*Fargo Forum*, May 8, 2006). In 2006, it was said the jail was spending $8,000 a month on medicine for mentally ill inmates, and the amount has increased significantly since that time. In recent years, the state's oil boom has brought with it additional psychiatric problems because of the increase in population. A psychiatrist noted in 2012 that emergency room admissions with a primary diagnosis of psychosis had doubled in the past year: "The major growth that we've seen in people coming would be psychosis, or thought disorders where they're experiencing delusions or hallucinations" (*KFYR-TV*, June 15, 2012).

Current Laws Governing Treatment in Prisons and Jails

Prisons

North Dakota Department of Corrections and Rehabilitation (ND DCR) procedures allow for nonemergency involuntary administration of medication if an inmate:

> (1) constitutes a likelihood of serious harm to that inmate or others, of property destruction; or
>
> (2) is gravely disabled.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by committee consisting of a psychiatrist, a nurse, and a unit manager. The decision to medicate the inmate requires a majority vote of the committee; the psychiatrist must be in the majority.

Note: In 2003, a United States District Court found that North Dakota's policy satisfied the plaintiff's minimum due process protections, *Roberson v. Goodman*, *296 F.Supp.2d 1051 (2003*).

Jails

North Dakota requires that jail inmates be prescreened by the county to determine if the inmate meets the standard for commitment to a state hospital. According to an individual who was interviewed, mental health staff will prescreen inmates who refuse medication and need treatment. If an inmate meets criteria, county prescreening staff will conduct an evaluation. The jail representative said it is "next to impossible" to get agreement from the prescreeners. The county and state have taken the position that mentally ill inmates are "safe in jail" and therefore do not need to be transferred to a state hospital. Not surprisingly, the person who was interviewed believes the real issue is a shortage of beds and who will pay the bill.

Ohio

Background

In Ohio, the criminalization of people with severe mental illness is almost complete. The largest of the six remaining state psychiatric hospitals, Summit Behavioral Healthcare Hospital in Cincinnati, has 291 beds. The Franklin County Jail in Columbus (2,200 inmates) and the Cuyahoga County Jail in Cleveland (1,765 inmates) as well as 10 state prisons, each with more than 2,000 inmates, may each hold more individuals with serious mental illnesses than the state hospital does.

The Corrections Center of Northwest Ohio, a regional jail, claims that 25 percent of its inmates are "on psychotropic medication" (*Toledo Blade*, Aug. 30, 2009). In Stark County, "roughly 30 percent of the jail population suffers from a mental illness. . . . [They] kick, punch, bite and spit on the workers there and, worse yet, hurl human waste at them" (*Canton Rep*, Oct. 19, 2011). In Summit County, "40 percent of them have mental health issues," and Sheriff Drew Alexander announced in 2012 that "the county jail no longer will accept violent mentally ill and mentally disabled people." "These people need to be in a [mental] hospital," he said. "They don't need to be in a jail. . . . I think it's barbaric what we're doing to these people" (*WEW News 5*, May 13, 2011; *Akron Beacon Journal*, Feb. 13, 2012, and May 7, 2010). The cost of medicating mentally ill inmates got so high in the Cuyahoga County Jail that the sheriff opened his own pharmacy (*Plain Dealer*, Nov. 5, 2001).

Ohio's prisons have also seen a sharp increase in seriously mentally ill prisoners. In 2005, *Frontline* took its cameras inside an Ohio prison and documented the problems associated with mental illness in a piece titled "The New Asylums." The director of the Ohio Department of Corrections observed, "In addition to being the director of the Department of Corrections, I became a de facto director of a major mental health system."

Current Laws Governing Treatment in Prisons and Jails

Prisons

Ohio Department of Rehabilitation and Correction (OH DRC) policy allows for the nonemergency administration of involuntary psychotropic medication based upon clear and convincing evidence there is a substantial likelihood of serious harm to self or others or a substantial likelihood of significant property damage, or that the inmate is gravely disabled.

> *Gravely disabled* is a condition in which a person, as a result of serious mental illness:
>
> > (1) is in danger of serious physical harm resulting from a failure to provide for his/her essential physical needs of health or safety; or

(2) manifests severe deterioration in routine functioning as evidenced by repeated and escalating loss of cognitive or volitional control over his/her actions.

Likelihood of serious harm is a substantial risk that:

(1) serious physical harm will be inflicted by an individual upon his/her person as evidenced by threats or attempts to commit suicide or inflict physical harm to one's self;

(2) serious physical harm will be inflicted by an individual upon another as evidenced by behavior which has caused such harm or which placed another person in reasonable fear of sustaining such harm; or

(3) significant damage will be done by an individual to the property of others as evidenced by recent behavior which has caused loss of, or damage to, the property of others.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by an Involuntary Medication Committee consisting of a psychiatrist (who serves as chair), a psychologist or licensed independent social worker, and one other authorized mental health professional. None of the committee members may be involved in the inmate's current treatment. A majority of committee members must approve nonemergency involuntary treatment; the psychiatrist must be in the majority.

Jails

A County Sheriff's Office Jail Policies and Procedures manual includes a protocol for dealing with an inmate who is experiencing a mental health emergency. An inmate mental health emergency includes:

(1) signs of severe depression;

(2) drastic mood changes;

(3) signs of suicide or suicidal tendencies; or

(4) hallucinations.

A mental health professional is paged to come to the jail to conduct an emergency evaluation. The mental health counselor provides a crisis assessment and arranges to facilitate an admission to a mental center. If necessary the corrections officer will isolate the inmate to a holding cell or the Isolation Detention Cell.

Transferring inmates from jails to a state psychiatric hospital can be very difficult in Ohio. One county found the state's hospital admission prescreening system was an obstacle to transferring patients. In recent years, the county has been able to facilitate transfers by obtaining a judge's order. Court orders for hospitalization of inmates are not issued frequently, perhaps six times a year in that county.

Oklahoma

Background

Oklahoma's largest remaining state mental hospital is the Forensic Center, with 200 beds. The county jails in Oklahoma City (2,900 inmates) and Tulsa (1,800 inmates) almost certainly hold more mentally ill individuals does than the state hospital. Indeed, a 2014 estimate claims that one-third of the inmates in the Tulsa Jail "need mental health care" (NewsOn6.com, Feb. 14, 2014). The two state prisons in Lexington (Assessment and Reception Center, 1,450 inmates; Joseph Harp Correctional Center, 1,371 inmates) may do so as well. At the "Joe Harp" prison, as it is known, 40 percent of the inmates "are on psychiatric medication. . . . The most unstable inmates are housed in 'Fantasy Island,' the nickname for the acute-care unit. . . . One inmate believes he is in a prisoner of war camp in Vietnam, while another screams that communists are taking over the facility." One mentally ill inmate, about to be released, acknowledged that he would not take medication once he left, because "a genie" in his rectum told him he didn't need it (*Wall Street Journal*, May 3, 2006). According to a 2014 report, in the past five years the number of state prison inmates "diagnosed with mental illness has nearly doubled from 20 percent to 36 percent" (*Norman Transcript*, Feb. 4, 2014). A psychologist who toured the state's prisons in the 1970s remembers them as being "filled with hardened criminals." When he returned to the prisons more recently, he said "they looked like psychiatric hospitals" (*Oklahoma Watch*, Feb. 15, 2014).

The county jails in Oklahoma noted an increasing number of mentally ill inmates as the state hospitals were downsized and closed. In Tulsa, 12 percent of the patients discharged from Eastern State Hospital ended up in jail within six months of leaving the hospital (*Tulsa World*, Sept. 3, 2000). In 2013, a class action lawsuit was filed against the jail on behalf of a woman with bipolar disorder and medical problems who died in the jail (NewsOn6.com, July 9, 2013). At that time, 16 percent of the jail inmates were taking psychotropic drugs, and mentally ill inmates were said to be "a fast-growing category," according to the sheriff (NewsOn6.com, Jan. 14, 2014). As early as 2001, the sheriff of Oklahoma County, John Whetsel, characterized his jail as "the state's largest mental facility" and added, "It's almost a crime to put many of them here, because we are not really a hospital" (*Daily Oklahoman*, Nov. 5, 2001). More recently, Whetsel claimed that most of the crimes resulting in the incarceration of mentally ill individuals are due to their being "off their medication" or to other "mental health issues" (*Oklahoman*, July 14, 2013).

Current Laws Governing Treatment in Prisons and Jails

Prisons

Oklahoma Department Corrections (OK DOC) policy allows for the nonemergency administration of involuntary psychotropic medication based on a demonstration by a preponderance of the evidence, that:

> (1) there is substantial likelihood of serious physical harm to the offender or to others;

(2) there is a substantial likelihood of property damage that may result in harm to himself or others;

(3) the offender is unable to care for himself/herself so that his/her health and/or safety is endangered; and/or

(4) the offender is gravely disabled.

Likelihood of serious harm is defined as:

(1) a substantial risk that serious physical harm will be inflicted by the offender upon his/her person, as evidenced by threats or attempts to commit suicide or inflict physical harm to oneself; or

(2) a substantial risk that serious physical harm will be inflicted by the offender upon another as evidenced by behavior which has caused such harm or which placed another person in reasonable fear of sustaining such harm.

Gravely disabled is a condition in which an inmate, as a result of a serious mental illness:

(1) is in danger of serious physical harm resulting from a failure to provide for his/her essential physical needs of health or safety; or

(2) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his/her actions.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Medication Review Committee consisting of a psychiatrist, a psychologist or licensed independent social worker, and one other authorized mental health professional. None of the committee members may be involved in the inmate's current treatment. A majority of committee members must approve nonemergency involuntary treatment; the psychiatrist must be in the majority.

Jails

By statute, jail inmates with pending criminal charges cannot be involuntarily committed to a private psychiatric hospital. They may only be committed to a star psychiatric hospital. In a Memorandum of Agreement between the U.S. Department of Justice and a large Oklahoma county, the county agreed to provide policies and procedures for mental health assessments in the jail. County policies refer only to assessments and some community mental health services, such as a Program of Assertive Community Treatment (PACT) and a part-time psychiatrist.

Oregon

Background

The Oregon State Hospital in Salem, with 335 beds, is the largest remaining state mental hospital. However, the Oregon State Penitentiary, also in Salem, has 1,933 prisoners, approximately 15 percent of whom, or 290 individuals, are mentally ill. And the Snake River State Prison in Ontario, with 3,034 inmates, almost certainly has more mentally ill individuals than the state hospital. Both Snake River and the state penitentiary have special mental health units; the unit in the latter, with 187 beds, was created by modifying the supermax unit. One prison official said that "it reminded him of scenes from *One Flew Over the Cuckoo's Nest*" (*The Oregonian*, June 20, 2011). In 2013, it was said that one-third of the 14,000 state prison inmates "needed mental health treatment" in a one-month period (*San Francisco Gate*, Nov. 11, 2013).

Oregon's jails have also been flooded with an increasing number of mentally ill inmates. In 2003, 39 percent of the inmates in the Umatilla County Jail were taking psychotropic medications (*Hermiston Herald*, May 30, 2003). In the Benton County Jail, an inmate sang continuously for 48 hours. In the Multnomah County Jail, a 54-year-old woman with bipolar disorder lies "curled naked in the fetal position, calling for her mother." In the Washington County Jail, Mark Ray, diagnosed with schizophrenia, was jailed 11 times in 12 months for minor infractions such as disorderly conduct, criminal mischief, and panhandling. In jail, he is a major management problem, including eating his feces and causing infected "shin wounds the size of half dollars, gouged with his own fingernails." The cost of his jail care for six months was $101,713, including excess staff time, hospital bills, repairs to broken jail property, and medications; six months' care for an average inmate is $7,243. Once discharged, Ray rarely takes his medication because he "prefers heroin to his antipsychotic prescriptions." In the past, he has been hospitalized for long periods in the state hospital and says, "I probably need to go back to the state hospital, but nowadays they keep crazy people in jail" (*The Oregonian*, Jan. 6, 2002).

Current Laws Governing Treatment in Prisons and Jails

Prisons

Oregon Department of Corrections (OR DOC) regulations allow for the nonemergency administration of involuntary psychotropic medication through a hearing before an independent examining physician who may approve involuntary administration of psychotropic medications only if is determined that good cause exists and the involuntary administration of psychotropic medications is in the inmate's medical interest.

Good cause exists if it is found that:

(1) the inmate is suffering from a mental disorder, and as a result of the disorder:

(a) the inmate is gravely disabled; or

(b) the inmate's behavior creates a likelihood of serious harm to self or others;

and

(2) the inmate:

(a) is deemed not competent to give informed consent to administration of psychotropic medications; or

(b) has refused to give informed consent to the administration of psychotropic medications;

and

(3) the use of psychotropic medications is clinically indicated for:

(a) restoring or preventing deterioration of the inmate's mental or physical health; or

(b) alleviating extreme suffering; or

(c) saving or extending the inmate's life;

and

(4) psychotropic medications are the most appropriate treatment for the inmate's condition according to current clinical practice;

and

(5) other less intrusive procedures have been considered and the reasons for rejecting those procedures have been documented in the inmate's treatment record;

and

(6) the treating practitioner attempted to first obtain the inmate's written informed consent.

Jails

Oregon jails are very limited in options for dealing with inmates who suffer from severe mental illness. Oregon counties employ a prescreening process to determine if inmates meet criteria for involuntary commitment. One jail reported that when its adminstrators call the local health department for Mental Health Crisis intervention, they are "constantly" told that the inmate doesn't meet criteria for commitment. A jail administrator who was interviewed for the survey described specific instances in which inmates were harmed because the jail lacked the authority to administer medication over objection. One example involved an inmate the administrator believed was suffering from schizophrenia:

> He was so bad that he got to the point where he was smashing his own teeth out of his mouth and attempted to eat a razor blade while shaving one day. We were

> constantly calling our local health department for Mental Health Crisis intervention, but they kept saying that he didn't fit the criteria for commitment. Very frustrating on our part, because he refused to take any meds, and we can't force medicate in jails.

Note: The day the jail administrator was interviewed, an incident occurred involving an inmate who had been in the jail for two months awaiting a court-ordered evaluation in the state hospital for fitness to stand trial. The inmate spat in the face of one of the deputies. As a result, the inmate faced charges for assault on a police officer, and the officer had to undergo testing for blood-borne pathogens. The administrator added, "It's just a very frustrating situation for everyone concerned."

Pennsylvania

Background

The largest remaining state mental hospital in Pennsylvania is Norristown, with 394 beds. However, there are many more mentally ill individuals in the Philadelphia Prison System, which has over 8,000 inmates, and probably also in the county jails in Pittsburgh and York. In the Erie County Jail, 44 percent of inmates "have a serious mental illness [and] their numbers are growing" (*Erie TV News*, July 11, 2012). The Pennsylvania state prisons have been severely criticized by the U.S. Department of Justice for their overuse of solitary confinement. For example, after investigating the state prison at Cresson, they reported, "The department concluded that Cresson's misuse of solitary confinement on prisoners with serious mental illness leads to serious harms, including mental decompensation, clinical depression, psychosis, self-mutilation, and suicide (Andrew Cohen, TheAtlantic.com, June 9, 2013). In 2013, it was also reported that "21 percent of state prison inmates receive mental health services, which equates to more than 10,000 individuals" (*Medfield Press*, Dec. 27, 2013).

The consequences of putting mentally ill individuals in prisons and jails are both tragic and costly. The following Pennsylvania headlines appeared in a recent four-month period:

- Mother of Inmate Who Killed Herself Sues Cumberland County Prison (*Patriot-News*, Apr. 19, 2013)
- Pennsylvania Failing the Mentally Ill (announcing a lawsuit against the state prison SCI-Cresson for the suicide of a mentally ill prisoner in solitary) (*Sharon Herald*, Apr. 28, 2013)
- Wife of Prison Inmate Who Committed Suicide at Lancaster County Prison Files Lawsuit (*Intelligencer Journal*, June 17, 2013)
- Lawsuit Alleges Monroe County Jail's Neglect Led to Inmate's Suicide (*Pocono Record*, July 7, 2013)
- Judge Refuses to Dismiss Lawsuit over Adams County Prison Inmate's Suicide (*Patriot-News*, July 25, 2013)

But perhaps the most telling commentary on Pennsylvania's failure to treat seriously mentally ill individuals was the proposal in 2010 by members of the House Judiciary Committee. They were said to be "looking into the possibility of moving prisoners with mental illnesses into state mental hospitals. . . . That would ease overcrowding and get mentally ill prisoners better treatment" (*WHYY News*, Jan. 27, 2010). Those, of course, are the very same hospitals from which the mentally ill prisoners were originally discharged; they ended up in prisons and jails because they were not treated once they left the hospitals. This proposal has not yet been implemented but has led to an ongoing study of how individuals with mental illness are being treated in the state's criminal justice system.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Pennsylvania Department of Corrections (PA DOC) procedures do not only allow for nonemergency involuntary administration of psychotropic medications. Inmates who refuse medication and are in need of treatment must be civilly committed. In addition:

> Every facility is encouraged to use Psychiatric Observation Cells (POCs) to control problem behaviors such as self-inflicted injury or uncontrolled agitation toward others. These cells can be used for two to three days to further assess suicide ideation or threats until a treatment plan can be developed such as transfer to a Mental Health Unit or return to general population when stable. The use of these cells for longer than three days is discouraged, unless the purpose is to wait for a 304c [court-ordered involuntary commitment] hearing, which can take five to seven days.

Jails

Pennsylvania jails must petition for commitment to a state psychiatric hospital if an inmate refuses medication and is in need of treatment. A psychiatrist for a county behavioral assessment unit, who was also a volunteer at the hospital to which inmates were committed, was quoted as saying, "I've gotten people in there from the jail. You just have to know the right people to call."

Rhode Island

Background

Rhode Island keeps things simple: It has a single combined prison and jail system for 2,995 inmates in Cranston. It also has a single public inpatient mental hospital with 495 beds in Cranston. Like most states, there are more individuals with serious mental illnesses in the prison than in the mental hospital.

Although it is a small state, Rhode Island has big problems. It was once highly regarded nationally for its outpatient mental health centers, but that is no longer the case. In 2012, a state task force reported that hospital emergency rooms were being overrun with cases of untreated mental illness (*KRQE*, Feb. 17, 2012).

There also has been a succession of homicides – including the killing of a Providence police officer – committed by mentally ill individuals not being adequately treated. And in West Warwick, a city of 29,000 people, five persons "described as having mental health issues" died in "police-related incidents" in a six-month period in 2008 (*Providence Journal*, July 1, 2008). Such incidents suggest the mental health treatment system is failing.

Current Laws Governing Treatment in Prisons and Jails

The Rhode Island Department of Corrections (RI DOC) is responsible for all inmates in the state; there are no county jails. RI DOC involuntary medication policies apply to pretrial detainees and sentenced inmates in the state's correctional facilities. The RI DOC policy for involuntary administration of psychotropic medication is under revision. The information presented herein is based on the most recent official policy.

RI DOC's Office of Legal Counsel may file a petition requesting a court order for the involuntary administration of psychotropic medications in Superior Court. An inmate with a severe mental illness must:

> (1) lack the capacity (i.e., be incompetent) to give informed consent regarding the recommended medication(s); and
>
> (2) have a well-documented history of positive response to psychotropic medication(s).

Additionally, the benefits of the recommended medication(s) must outweigh the associated risks. The procedure cites *Washington v. Harper* as a reference but does not include an administrative hearing procedure.

South Carolina

Background

The largest remaining state psychiatric hospital in South Carolina is the G. Werber Bryan Psychiatric Hospital in Columbia, with 198 beds. The Charleston County Jail and the Kirkland Reception and Evaluation Center state prison in Columbia, both of which have more than 1,700 inmates, each have more individuals with serious mental illnesses than does the state hospital, and several of the other state prisons may also.

The state ranks near the bottom on availability of public psychiatric beds, efforts to divert mentally ill individuals, per capita state mental health expenditures, and almost every other measure of treatment for mentally ill individuals. The consequences can be seen in people like

Jerome Anderson, a University of South Carolina graduate and Navy veteran who has bipolar disorder. While in the York County Jail on minor charges, he became manic and "threw urine and feces and spit at jail guards who tried to give him food and medicine days after he threatened to kill a judge and two police officers" (HeraldOnline.com, June 20, 2013). He was therefore sentenced to six years in prison.

The state prisons, in which "about 17 percent of the prison system's 23,000 inmates have serious mental illness," are even worse than the jails. In January 2014 a state judge issued a 45-page order finding the prison system at fault and giving it six months to develop a plan of correction. The order alleged that "inmates were placed in solitary for years, strapped into restraining chairs in painful positions and left naked and in filth in cold, empty cells." According to the report, Jerome Laudman, diagnosed with schizophrenia, was placed in solitary confinement. "More than a week later he was observed lying in his own vomit and feces with 15 to 20 trays of rotting food around him" (*Greenville News*, Jan. 11, 2014).

Current Laws Governing Treatment in Prisons and Jails

Prisons

South Carolina Department of Corrections (SCDC) regulations do not allow for the nonemergency administration of involuntary psychotropic medication. An inmate experiencing psychiatric difficulties may be evaluated for involuntary admission to a hospital. A physician will determine the appropriate level of treatment required at the time of the assessment. The physician may seek involuntary inpatient admission. The policy also provides that a:

> court will evaluate and determine if involuntary outpatient treatment is required at the inmate's assigned institution. If so determined, a Judicial Order for Involuntary Outpatient Treatment will be issued by the court at the time of the hearing.

Jails

State law does not prohibit South Carolina county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others. Based on survey information, jails in South Carolina have inmates evaluated for inpatient commitment if they refuse medication and are in need of treatment. However, in South Carolina it is "difficult to get a bed" in a state hospital.

South Dakota

Background

The South Dakota Human Services Center has 264 patients. The state is one of the few where the state hospital still has more mentally ill individuals than any county jail or state prison, although the South Dakota State Penitentiary, with 1,274 inmates, is not far behind.

Treatment of mentally ill persons in the state's correctional facilities had been a longstanding problem until a series of reforms were implemented beginning in 2010. In 2007, three women in the women's prison – two diagnosed with bipolar disorder – sued the state for allegedly withholding the medication they needed. At the time, it was estimated that "one-third of the prison's 350 inmates suffer mental disorders that require psychiatric medications" (*Sioux City Journal*, Nov. 24, 2007). When the new Minnehaha County Jail was built in 2003, the number of isolation cells was increased from four to 16 to accommodate the increasing number of mentally ill prisoners (*Sioux Falls Argus Leader*, Sept. 15, 2006).

Because of problems with mentally ill persons in the state's prisons and jails, a Governor's Behavioral Health Workgroup was convened in 2011. Among the workgroup's recommendations was a change in the treatment laws that would allow for the involuntary treatment of mentally ill persons in jails after a hearing before a panel of health professionals. Without such a law, it was argued, "county jails have few options other than isolating the prisoner" (*Rapid City Journal*, Jan. 14, 2013).

Current Laws Governing Treatment in Prisons and Jails

Prisons

The South Dakota Department of Corrections (SD DOC) is allowed by statute to administer nonemergency involuntary medication based on a determination that the inmate is likely to improve with treatment and that without treatment the inmate poses the likelihood of serious harm to self or others. Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a panel consisting of a psychiatrist, a physician, and a representative of the warden. None of panelists may have participated in the inmate's current diagnosis, evaluation, or treatment. The decision to medicate the inmate requires a majority vote of the committee; the psychiatrist must be in the majority.

Jails

South Dakota jails are authorized by statute to administer nonemergency involuntary medication based on a determination an inmate suffers from a severe mental illness that is likely to improve with treatment and that without treatment an inmate poses the likelihood of serious harm to self or others. Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a panel consisting of two medical representatives and a representative appointed by the county sheriff. The medical

representatives may include a physician, physician assistant, or nurse practitioner. However, at least one medical representative must be a physician. None of panelists may have participated in the inmate's current diagnosis, evaluation, or treatment. The decision to medicate the inmate requires a majority vote of the committee; the physician must be in the majority.

Note: The Governor's Behavioral Health Workgroup, composed of a variety of stakeholders, recommended that county jails be authorized to administer medication over the objection of an inmate who is in need of treatment. A bill, sponsored by the South Dakota Department of Social Services at the request of the South Dakota Sheriffs' Association, extended the same process used in prisons for nonemergency involuntary administration of medication to the county jails. The bill had broad support and was signed by the governor on March 6, 2013.

Tennessee

Background

The largest remaining state psychiatric hospital in Tennessee is the Western Mental Health Institute in Bolivar, with 247 patients. The Shelby County Jail, with 6,800 inmates, almost certainly holds more seriously mentally ill individuals than all four state psychiatric hospitals combined. As early as 1997, it was said that 40 percent of the jail inmates were "taking medication for mental illness" (*Commercial* Appeal, Apr. 13, 1998). And in 1999, a study reported that "about a third of the state's jail population . . . is mentally ill" (*Commercial* Appeal, Mar. 3, 1999). The number of mentally ill persons in jail was said to have been "dramatically exacerbated after mid-1996 when the state shifted funding for public mental health programs to managed care" (*Commercial Appeal*, Mar. 30, 1999). The situation would be even worse if not for the existence of Crisis Intervention Team (CIT) training, which helps police divert mentally ill individuals away from jail; the CIT program started in Memphis in 1988.

The problem in the state's prisons, where it is said that "one in every three inmates is mentally ill," is almost as bad as in the jails (*News Channel 5*, May 9, 2011). The three largest state prisons – at Henning, Tiptonville, and Wartburg – each have more than 2,300 prisoners; each holds more seriously mentally ill prisoners than the largest state psychiatric hospital.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Tennessee Department of Correction (TN DOC) policies allow nonemergency administration of involuntary medication of an inmate if indicated based on the application of contemporary standards of practice. Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Treatment Review Committee consisting of one psychiatrist and two psychologists who are not directly involved in the treatment of the inmate in question. The policy also specifies that an inmate's continued need

for involuntary treatment may indicate a need to seek the appointment of a fiduciary, who would be empowered to make an informed decision for the inmate.

Jails

State law does not prohibit Tennessee county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to himself or others. Based on survey information, if an inmate is refusing medication and needs treatment, Tennessee jails do not administer medication over an inmate's objection. The only option is emergency commitment to a State Regional Mental Health Institute, which is very difficult.

The Tennessee Department of Mental Health and Substance Abuse Services (TN DMHSAS) posted the following notice on its website:

> A change in state law (Public Chapter 531) effective July 1, 2009 allows the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) to delay admissions at state owned and operated regional mental health institutes (RMHIs) until the facility "has the medical capability, equipment and staffing to provide an appropriate level of care, treatment and physical security to a service recipient in an unoccupied and unassigned bed." This law removes the requirement that RMHIs admit and treat service recipients without regard to whether the RMHI has sufficient resources to do so.

Texas

Background

The North Texas State Hospital, with 692 beds, is the largest remaining state psychiatric hospital. The Harris County Jail in Houston, where "25 percent of the prisoners receive psychotropic medication" (*Bellaire Examiner*, May 18, 2012), has over 8,000 inmates and thus is certainly the largest "mental institution" in the state. In Bexar County, "about 21 percent of the inmates suffer from mental illness" (*San Antonio Express-News*, Aug. 8, 2010). In both Bell and El Paso Counties, "about 40 percent of the inmates" are being treated with psychotropic medications "or need those medicines" (*Texas Tribune*, Dec. 16, 2010; *KWTX*, July 24, 2013).

One of the most depressing aspects of the situation for prison and jail officials is to see the same people repeatedly cycling through their facilities. In Harris County, almost 600 mentally ill individuals "cycled through the jail at least five times in the past two years" (YourHoustonNews.com, May 22, 2013). They include Patricia George, 34 years old and diagnosed with schizophrenia; she has been charged with 31 misdemeanors and 12 felonies and has already spent nine years in jail (*Houston Chronicle*, July 21, 2008).

Texas is among the states with the lowest number of public psychiatric beds and among the stingiest states in per capita mental health spending. Some of the jail overcrowding is directly attributable to having no available psychiatric beds. In 2010, the Bexar County Jail had 100 jail inmates waiting to be transferred to a state hospital, and the Dallas County Jail had 103; since then, the situation has only gotten worse (*San Antonio Express-News*, Aug. 8, 2010).

Current Laws Governing Treatment in Prisons and Jails

Prisons

The Correctional Managed Health Care Committee (CMHCC) serves as the oversight and coordination authority for the delivery of health care services to offenders incarcerated in the Texas Department of Criminal Justice (TDCJ). CMHCC policy allows for nonemergency administration of medication when failure to take medication is likely to result in continued suffering from severe and abnormal mental, emotional, and physical distress or deterioration of the inmate's ability to function independently. A nontreating psychiatrist/psychiatric mid-level practitioner conducts an Administrative Due Process Hearing, which includes the patient, the treating psychiatrist/mid-level practitioner, and a nontreating mental health professional. If treatment is authorized, a Certificate of Non-Emergency Compelled Psychoactive Medication in a Mentally Ill Person is completed and forwarded to the facility clinical director for review. A Quality Improvement/Quality Management Program (QI/QM) committee also reviews all incidents of nonemergency compelled psychoactive medication.

Jails

According to an assistant district attorney in Texas, court orders for involuntary administration of medication in jails are now more common due to fairly recent changes in the criminal code that allow for involuntary medication orders for inmates under court-ordered treatment related to competency in criminal cases. For example, court orders are being issued for inmates who are deemed incompetent if they are committing acts that are dangerous, such as being physically assaultive, head banging, not eating, soiling themselves, etc. Texas law also allows a judge to issue an order for involuntary medication in medication-related emergency, which includes an individual who:

> is behaving in a manner that indicates that he is unable to satisfy his need for nourishment, essential medical care, or self-protection.

This could be used as a basis for medication of inmates who are not under a court order in a criminal case but refuse medication and are in need of treatment.

Note: More information about the changes in Texas law can be found at *Forced Medication in Texas: FAQs*, by Jeanette Kinard and Dorian Thomas.

Utah

Background

The Utah State Hospital has 324 patients. The Utah State Prison holds 3,814 inmates; if 15 percent (572) of them are seriously mentally ill, then the prison is de facto the largest "mental institution" in the state. The Salt Lake County Jail, with over 2,000 inmates, also probably holds more seriously mentally ill individuals than the state hospital does.

Suicides have been a particular problem in the jails. The Davis County Jail has had 73 suicide attempts since 2009. The Weber County Jail has had 13 successful suicides since 2009, four in 2013 alone. The Weber County undersheriff noted, "I've been in this business for over 35 years. I've never seen in-custody suicides as high as they are today. . . . Jails end up being de facto mental institutions" (*Salt Lake Tribune*, Jan. 5, 2014).

As early as 1999, the Salt Lake police chief said he had never seen so many mentally ill people on the streets and in jails (*Deseret News*, Oct. 19, 1999). That was shortly after a mentally ill prisoner, who was refusing to take his medication, died in the state prison after being kept immobile in a restraining chair for 16 hours. Such barbaric treatment was necessitated by a 1980 lawsuit, the outcome of which made it much more difficult to involuntarily medicate mentally ill prisoners (*Deseret News*, Mar. 30, 1997). In July 2013, the state announced additional mental health budget cuts, so the situation will probably get even worse.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Utah Department of Correction (UT DOC) policies allow for nonemergency involuntary administration of medication for an inmate if there is a likelihood of serious harm to self or other or if the inmate is gravely disabled.

> *Gravely disabled* means:
>
> > a condition in which a person, as a result of mental illness, is or will be in danger of serious physical harm resulting from a failure to provide for their essential human needs of health or safety, or manifests or will manifest severe deterioration in routine functioning evidenced by repeated loss of cognitive or volitional control over their actions and is not receiving such care as is essential for their health and safety.
>
> *Likelihood of serious harm* means:
>
> > (1) a substantial risk that significant physical harm will be inflicted by an individual upon their own person, as evidenced by threats or attempts to commit suicide or

inflict physical harm on one's self, or by refusal or inability to accept essential needs for health and safety; or

(2) a substantial risk that significant physical harm will be inflicted by an individual upon another as evidenced by behavior which has caused such harm or placed another person or persons in reasonable fear of sustaining such harm.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Hearing Committee consisting of three mental health clinicians who are not directly involved in the treatment of the inmate's treatment. One member of the committee must be a psychiatrist. The decision to medicate the inmate requires a majority vote of the committee; the psychiatrist must be in the majority.

Jails

The number of inpatient beds for jail inmates is very limited. In one county, only two beds are designated for inmates from the jail. The county's District Attorney developed a policy for a *Washington v. Harper* administrative procedure to authorize nonemergency involuntary administration of medication in the jail. The process is used on a regular basis. There is usually one inmate with an involuntary medication order at any given time in the jail. The jail mental health staff said that the Medication Panel does not always authorize involuntary medication. The sad cases are the inmates who don't quite meet criteria and therefore must go untreated until they deteriorate to the point where they do.

Vermont

Background

It is hard to believe that 25 years ago, Vermont was ranked among the best states in public services for seriously mentally ill individuals; today, it ranks among the worst. When tropical Storm Irene flooded the 54-bed Vermont State Hospital in 2011, officials closed the hospital and simply gave up. Even before the flood, Vermont ranked among the lowest states in public psychiatric beds per population. Today, it is the only state without a public hospital for the hospitalization of psychiatric patients. The private Brattleboro Retreat maintains 14 state-supported beds, and three other hospitals have an additional 18 public psychiatric beds – making 32 beds in all – but most institutionalized mentally ill individuals are in the prisons, such as the Southern State Correctional Facility in Springfield, with 364 inmates. Since there are almost no inpatient psychiatric beds available, "the state has been hiring county sheriffs to 'babysit' mentally ill patients in hospital emergency departments" while waiting for a bed to become available. This typically involves "two sheriffs at a time, sitting next to the patient for 24 hours a day to make sure they don't hurt themselves, or others" (*Vermont Digger*, Dec. 6, 2013).

The website of the Department of Mental Health lists adult outpatient, emergency, and rehabilitation services but no inpatient services. A call to the department to inquire about inpatient beds was answered by a woman who said she had no such information because "this is just an administrative office" (call by EFT, Aug. 6, 2013). The state legislature has approved building a new 25-bed hospital in Berlin.

Current Laws Governing Treatment in Prisons and Jails

The Vermont Department of Corrections (VT DOC) is responsible for all inmates in the state; there are no county jails. VT DOC involuntary medication policies apply to pretrial detainees and sentenced inmates in the state's correctional facilities.

The Commissioner of Mental Health may commence an action for the involuntary medication of a person who is refusing to accept psychiatric medication and has been committed to the custody of the Commissioner of Corrections as a convicted felon and for whom the Department of Corrections and the Department of Mental Health have jointly determined that involuntary medication would be appropriate. A state where median length of time that civilly committed hospital patients remain untreated with involuntary medication is an extreme outlier in the United States at three months. There is no provision for obtaining an order for nonemergency involuntary medication for pretrial detainees who refuse medication and are in need of treatment.

Virginia

Background

Eastern State Hospital, with 300 beds, is the largest remaining state psychiatric hospital in Virginia. The Greensville Correctional Center in Jarratt, the largest state prison, holds 3,006 inmates. If 15 percent (451) of them have a serious mental illness, then the prison is de facto the largest "mental institution" in the state. A January 2014 report from the state Inspector General noted that Virginia's jails hold three times more individuals with serious mental illness (3,554) than do the state hospitals (1,200).

At the Roanoke County Jail, "between 25 and 30 percent of the inmates suffer from mental illness" (*Roanoke Times*, Oct. 15, 2007). A state mental health commission in 2008 estimated that "15 percent of all inmates in state prisons and jails are seriously mentally ill" (*Virginian Pilot*, Jan. 14, 2008). In the Virginia Beach Jail, 90 percent of assaults on jail personnel are "committed by mentally ill inmates." One inmate there was described as "walking [barefoot] in circles in his cell for weeks, leaving a noticeable trail of dead skin cells on the rough concrete floor" (*BBC News*, Feb. 22, 2011). In the Williamsburg Regional Jail, where he was being held on assault charges, a 47-year-old man with bipolar disorder blinded himself. He had previously been a firefighter for 20 years, had helped train police officers how to respond to mentally ill individuals, and had received Virginia NAMI's Outstanding Consumer Achievement Award, but he had stopped taking his medication (*Williamsburg Yorktown Daily*, Oct. 15, 2013). A January

2014 report of the State Inspector General claimed that “the number of mentally ill people in local and regional jails has increased by 30 percent since 2008”; 56 percent of them have “serious mental conditions that most jails are ill-equipped to diagnose or treat.” The report also noted a “lack of coordination between jails and community service boards” (*Richmond Times-Dispatch*, Jan. 13, 2014).

Things are so bad in Virginia that some corrections officials are not only symbolically, but also literally, assuming control of the mental health treatment system. In 2011, when Virginia Beach city officials voted to cut $121,596 in mental health funding, Sheriff Ken Stolle offered to transfer that sum from his jail reserve fund to the mental health program. He said that “the money being cut would dramatically impact the people coming into my jail with mental illness. . . . This is money well spent, and it will decrease the money I’d spend housing them” (*Virginian-Pilot*, May 5, 2011).

All of this is consistent with a longstanding failure in Virginia to prioritize treatment for the sickest mentally ill patients. The poster child is, of course, Seung-Hui Cho, who despite being clearly recognized as being severely mentally ill and briefly hospitalized, was not treated. His subsequent killing of 32 people at Virginia Tech in 2007 made Virginia’s failures world famous.

Current Laws Governing Treatment in Prisons and Jails

Prisons

Virginia Department of Correction (VA DOC) operating procedures require that a court order be obtained for the nonemergency involuntary administration of medication, pursuant to Virginia statute. The court must find, on the basis of clear and convincing evidence, that the prisoner is incapable, either mentally or physically, of giving informed consent to such treatment and that the proposed treatment is in the best interests of the prisoner.

Jails

County jails in Virginia typically manage inmates who refuse medication and are in need of treatment within the jail either by isolating and observing them or by seeking involuntary commitment to a state hospital. It is difficult to transfer an inmate to a hospital due to a shortage of beds. Therefore, the former is the most common practice. Based on information obtained in the survey, at least one county in Virginia has developed a procedure to obtain court-ordered medication for inmates who are severely mentally ill. A Special Justice conducts a special hearing at the jail and issues an order for nonemergency involuntary medication in the jail if it is deemed necessary. The process is rarely used.

Washington

Background

Western State Hospital, with 800 patients, is the largest state psychiatric hospital. The state prison at Monroe has a special psychiatric unit with 500 inmates; it is the second-largest "mental institution" in the state. The annual cost for inmates in this special unit is $101,653 per year, compared to about $30,000 for other prisoners (*Everett Herald*, Nov. 23, 2009). A psychiatrist who has worked at both Western State Hospital and in the prison system estimated that "between 20 and 30 percent of Washington's 16,700 [prison] inmates are mentally ill. . . . We took everyone out of the state hospitals and . . . the same population ended up in prisons and jails" (*Seattle Times*, Oct. 19, 2013).

County jails across Washington have noted an influx of mentally ill inmates. In the Yakima County Jail, "more than 30 percent of inmates are getting [psychiatric] treatment." A jail official acknowledged, "We don't have a good way of taking care of these people" (*KIMA TV*, Aug. 14, 2013). In the Spokane County Jail, the cost of medications is $60,000 per month, with half of all prescriptions being for psychotropic drugs. According to the sheriff, "inmates who should be at Eastern State Hospital are often kept in the jail" (*Spokesman-Review*, July 21, 2013). The Pierce County Jail has seen a "recent spike in mentally ill inmates in the county jail" and has renovated part of the jail specifically to accommodate them. An official noted that "the influx of mentally ill inmates is forcing officers to place violent offenders in less secure areas of the jail" (*News Tribune*, Sept. 11, 2012). The sheriff of the Benton County Jail said his jail "is experiencing a 'mission creep' from a criminal justice institution to one that's increasingly faced with mental health and medical cases." In 2013, the jail had "more than 25 suicide attempts" (*Tri-City Herald*, Nov. 5, 2013).

Current Laws Governing Treatment in Prisons and Jails

Prisons

Washington Department of Corrections (WA DOC) policy allows for nonemergency involuntary administration of medication if an inmate is gravely disabled and/or presents the likelihood of serious harm to self, others, and/or property. Authorization of nonemergency involuntary medication is determined through an administrative proceeding by an Involuntary Antipsychotic Hearing Committee composed of a chairperson, a nontreating psychiatrist, and a nontreating psychologist. The decision to medicate the inmate requires a majority vote of the committee; the psychiatrist must be in the majority.

Note: (1) Gravely disabled is not defined in the policy. (2) Washington's procedure was the subject of the challenge in the *Washington v. Harper* case, in which the U.S. Supreme Court upheld the administrative hearing procedure.

Jails

At least one county has implemented the *Washington v. Harper* administrative procedure in a jail setting to authorize nonemergency involuntary administration of medication in the jail. The process is used on a regular basis and is similar to the WA DOC procedure. It allows for nonemergency involuntary administration of medication if an inmate is gravely disabled and/or presents a likelihood of serious harm to self, and/or others, and/or property. Authorization of nonemergency involuntary medication is determined through an administrative proceeding by an Involuntary Antipsychotic Hearing Committee composed of a chairperson, a nontreating psychiatrist, and a nontreating psychologist (or nontreating psychiatric evaluation specialist when a nontreating psychologist is unavailable). The decision to medicate the inmate requires a majority vote of the committee; the psychiatrist must be in the majority. Jails may also use a judicial hearing process to obtain a court order for involuntary medication. *Washington v. Harper* is the basis for a determination that an order should be issued.

West Virginia

Background

The two largest "mental institutions" in West Virginia are the state prisons at Huttonsville (1,128 inmates) and Mt. Olive (1,071 inmates). If 15 percent of their prisoners are seriously mentally ill, then those numbers (169 and 161) would be greater than the number of patients in the state psychiatric hospitals in Westin (150) and Huntington (110). Both state hospitals have been so chronically overcrowded that, as of 2007, the state was having "to divert about 80 patients a year to private facilities at a cost of about $8 million" (*Charleston Daily Mail*, July 23, 2007). The effects of the hospital overcrowding have been seen in both the prisons and the jails. According to the director of the state's regional jail system, "The state's prisons and jails have become the new mental institutions for thousands of West Virginians. . . . Deinstitutionalization is a myth. We took them out of mental institutions, put them out on the street, and again and again they've ended up in our jails." Between 2000 and 2005, the number of mentally ill people in regional jails almost doubled (*Charleston Gazette*, Jan. 2, 2005). The problem is exacerbated, of course, by the fact that West Virginia has among the fewest public psychiatric beds per capita of any state and is also among the stingiest states in public mental health expenditures.

Current Laws Governing Treatment in Prisons and Jails

Prisons

West Virginia Division of Corrections (WV DOC) policies allow for nonemergency involuntary administration of medication based on a determination by clear and convincing evidence that an inmate suffers from a mental illness and is likely to cause serious harm to himself or others.

Likely to cause serious harm refers to an individual who has:

(1) a substantial tendency to physically harm himself/herself which is manifested by threats of or attempts at suicide or serious bodily harm or other conduct either active or passive, which demonstrates that he/she is dangerous to himself; or

(2) substantial tendency to physically harm other persons which is manifested by homicidal or other violent behavior which places others in reasonable fear of serious physical harm; or

(3) a complete inability to care for himself/herself because of mental retardation.

Authorization of nonemergency involuntary medication is determined through a *Washington v. Harper* administrative proceeding by a Mental Health Committee consisting of a psychiatrist, psychologist, and the Associate Warden of Programs or designee. None of the committee members may be involved in the inmate's current treatment. A majority of committee members must approve nonemergency involuntary treatment; the psychiatrist must be in the majority.

Jails

The West Virginia Regional Jail and Correctional Facility Authority (WV RJCFA) operates all jails in West Virginia. The WV RJCFA contracts with a private firm for mental health services. That firm is responsible for the treatment of inmates with severe mental illnesses. Medication is not administered involuntarily. Inmates who refuse medication and are in need of treatment are involuntarily committed to a state psychiatric hospital operated by the West Virginia Department of Health and Human Resources.

Wisconsin

Background

The largest remaining state psychiatric hospital in Wisconsin is the Mendota Mental Health Institute, with 234 beds. The largest state prison, at Oshkosh, holds 2,025 inmates; if 15 percent (304) of them are seriously mentally ill, that would make the state prison Wisconsin's largest "mental institution." The Milwaukee County Jail, with about 2,000 inmates, should also be considered for this dubious honor.

Wisconsin's county jails have been inundated with increasing numbers of mentally ill inmates as the state hospitals have been downsized. Many of these mentally ill prisoners receive no treatment. The consequences of failing to treat such individuals was illustrated by James Kruger, diagnosed with bipolar disorder, who was manic when he was arrested in Madison for obstructing a police officer. Despite notification of the jail staff that he needed his lithium, he was not treated during his five-day incarceration. Following his release, he committed 16

felonies in one week, including a stabbing, a robbery, a kidnapping, and a high-speed chase (*Portage Daily Register*, Sept. 19, 2013).

According to a 2012 report, "about a third of the men and two-thirds of the women in Wisconsin prisons have mental health conditions," and 23 percent of them (5,000 of 21,700) "are taking medications to treat mental illness" (*HNG News*, Jan. 10, 2014). Problems associated with mentally ill inmates in Wisconsin's prisons were highlighted by two lawsuits filed against the state by the U.S. Department of Justice and the American Civil Liberties Union alleging poor treatment at the Taycheedah Correctional Institution, the women's prison in Fond du Lac. It subsequently became clear these problems were system-wide, especially the use of isolation cells for mentally ill inmates: between 55 and 76 percent of the inmates in isolation were mentally ill (*The Real Cost of Prisons Weblog*, Feb. 24, 2010). Among prison suicides, 55 percent were mentally ill. And in a one-year period, there were "231 attacks on correctional officers caused by a mentally ill inmate" (*Madison Capital Times*, June 10, 2009).

Current Laws Governing Treatment in Prisons and Jails

Prisons

Wisconsin Department of Corrections (WI DOC) regulations allow for an inmate to be treated involuntarily with psychotropic medications in prison if one of the following applies:

(1) if the inmate is civilly committed as an outpatient to a correctional institution; or

(2) the court has found the inmate not competent to refuse psychotropic medication, and the inmate refuses to take the medication voluntarily.

A court may find an inmate incompetent if, after the advantages and disadvantages of and alternatives to accepting the particular psychotropic medication have been explained, the inmate is:

(1) incapable of expressing an understanding of the advantages and disadvantages of accepting treatment and the alternatives to accepting treatment; or

(2) substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to his or her condition in order to make an informed choice as to whether to accept or refuse psychotropic medication.

Jails

Wisconsin's civil commitment statute allows a court to commit an inmate on an outpatient basis to a jail. Based on survey information, jails in Wisconsin will administer involuntary medication if an order is issued by the court.

Wyoming

Background

Wyoming is one of the few states in which the state mental hospital, with about 100 beds, holds more seriously mentally ill people than any of the state's prisons or jails. The Natrona County Jail in Casper and the Laramie County Jail in Cheyenne have their share as well, as do the State Penitentiary in Rawlins and the Medium Correctional Institution in Torrington.

Delivering public psychiatric services in a state with very few psychiatrists and a population smaller than that of many counties in other states spread out over a vast area is very difficult. With the state hospital located in faraway Evanston, about as far away from the population centers as it could be, county jails become the logical holding place for seriously mentally ill people. As the father of a mentally ill daughter put it, "Wyoming is a terrible place to be sick," because of the lack of services. "The first stage is having some kind of place to hold people who are a danger to themselves that isn't jail" (*Casper Star-Tribune*, Sept. 22, 2005).

Current Laws Governing Treatment in Prisons and Jails

Prisons

Wyoming Department of Corrections (WY DOC) policy allows for nonemergency involuntary administration of medication if the following six conditions are met:

(1) the inmate is suffering from a mental illness and as a result of the illness:

(a) the inmate is gravely disabled; or

(b) the inmate's behavior creates a likelihood of serious harm to self or others.

(2) the inmate:

(a) is deemed not competent to give informed consent to administration of psychotropic medications as provided in the policy; or

(b) has refused to give informed consent to the administration of psychotropic medications.

(3) the use of psychotropic medications is clinically indicated for:

(a) restoring or preventing deterioration of the inmate's mental or physical health;

(b) alleviating extreme suffering; or

(c) saving or extending the inmate's life.

(4) psychotropic medications are the most appropriate treatment for the inmate's condition according to current clinical practice;

(5) other less intrusive procedures have been considered and the reasons for rejecting those procedures have been documented in the inmate's treatment record; and

(6) the treating psychiatrist attempted to first obtain the inmate's written informed consent.

Gravely disabled means:

a deterioration in routine functioning as evidenced by repeated and escalating loss of cognitive or volitional control over behavior that creates a danger of serious physical and/or psychological harm to the inmate and/or serious physical injury to others or property.

Authorization of nonemergency involuntary medication is determined through an administrative proceeding by a Special Committee consisting of a psychiatrist, a psychologist, and the associate/deputy warden of the correctional facility, none of whom may, at the time of the hearing, be involved in the inmate's treatment or diagnosis. The decision to medicate the inmate requires a majority vote of the committee; the psychiatrist must be in the majority.

Jails

Based on survey information, jails in Wyoming do not typically obtain a court order for involuntary administration of medication to inmates in jails. Jails either closely observe an inmate who has refused medication or petition for hospitalization. A hearing officer will conduct the hearing in the jail pursuant to the state's civil commitment statute. If a bed is not available at the state hospital, an inmate may have to be held in jail. According to the jail representative, it typically does not take more than a couple of weeks before the hospital can admit an inmate.

Chapter 4

Findings and Recommendations

In 1972, Marc Abramson, a young psychiatrist in San Mateo County, California, sounded the initial alarm for what he viewed as the "criminalization of mentally disordered behavior."[xliii] As California was emptying the state mental hospitals, Abramson was noting a rapid increase in the number of mentally ill inmates in the San Mateo County Jail. Reports from the California state prisons were describing a similar increase.

Forty-two years have elapsed since Abramson published his observations. The present study surveyed each state to ascertain what has happened to this trend during the intervening years.

Findings

1. **How many individuals with a serious mental illness are now in America's prisons and jails?** In 2011, there were 1,382,418 inmates in state prisons.[xliv] If 15 percent of them were seriously mentally ill, as discussed in Chapter 3, that would make a total of approximately 207,000 state prison inmates with serious mental illness. In 2012, there were 744,524 inmates in county and city jails.[xlv] If 20 percent of them were seriously mentally ill, as discussed in Chapter 3, that would make a total of approximately 149,000 jail inmates with serious psychiatric disease. *Thus, the total number of prison and jail inmates who were seriously mentally ill in 2012 would total approximately 356,000 inmates*. This is equivalent to the population of cities such as Anchorage, Alaska; Montgomery, Alabama; Peoria, Illinois; or Trenton, New Jersey.

   State mental hospitals were originally built for the protection and treatment of individuals with serious mental illness. At their maximum census in 1955, the state mental hospitals held 558,922 patients. Today, they hold approximately 35,000 patients, and states are continuing to close beds to reduce that number. Since there are 356,000 inmates with serious mental illness in prisons and jails and only 35,000 individuals with serious mental illness remaining in the state mental hospitals, *there are now 10 times more individuals with serious mental illness in prisons and jails than there are in state mental hospitals*.

   However, this situation is actually worse than it appears. Because of crowded prison conditions, a few states, such as Alaska and Hawaii, send some prisoners out of state to private prisons; such individuals are not counted in this survey among their state prison populations. Likewise, prisoners from the District of Columbia who previously were housed in the Lorton Reformatory Prison were dispersed within the federal prison service when Lorton closed and also are not counted in this survey. The situation is also worse than it appears because the majority of beds remaining in the state mental hospitals are not available for all the individuals with serious mental illness who need to

be hospitalized. The reason these beds are not available is because they are occupied by long-stay forensic patients and sex offenders who have been sent to the state hospital by court order. Thus, the 356,000 mentally ill inmates in prisons and jails are there by court order, and the majority of patients in state mental hospitals are there by court order. The trend toward the "criminalization of mentally disordered behavior," initially observed 42 years ago, is almost complete.

This is a far grimmer picture than the one that emerged from the Treatment Advocacy Center's 2008 report on the criminalization of mental illness, "More Mentally Ill Persons Are in Jails and Hospitals Than Prisons."[xlvi] That study utilized 2004 and 2005 hospital bed data and included the psychiatric beds not only in the state mental hospitals but also in private psychiatric hospitals and on the psychiatric units of general hospitals. In practice, most beds in private psychiatric hospitals and on psychiatric units of general hospitals are not available for individuals with serious mental illness, such as schizophrenia and bipolar disorder and almost certainly not available to patients charged or convicted of committing crimes. Such patients tend to be much more difficult and expensive to provide care for, including requiring more staffing and security. They also are less likely to have insurance coverage. The present study included only psychiatric beds in state mental hospitals, and thus the ratio of individuals with serious mental illness in prisons and jails compared to those in psychiatric hospitals is higher in the present study (10:1) than in the 2008 study (3:1).

In looking at the situation in individual states, this survey found that in 44 of the 50 states and the District of Columbia, at least one prison or jail in that state is holding more individuals with serious mental illness than is the largest remaining psychiatric hospital operated by the state. The only states for which this is not true are Kansas, New Jersey, North Dakota, South Dakota, Washington, and Wyoming. Indeed, the Polk County Jail in Iowa, the Cook County Jail in Illinois, and the Shelby County Jail in Tennessee each have more seriously mentally ill inmates than *all* the remaining state psychiatric hospitals in that state combined. In Ohio, 10 state prisons and two county jails each hold as many inmates with serious mental illness as does the largest remaining state hospital. In Michigan, nine state prisons each hold more inmates with serious mental illness than does the largest remaining state psychiatric hospital. Although the placement of mentally ill individuals into prisons is not the only cause, it is a significant contributing factor to the nationwide prison overcrowding problem. To illustrate, half a century ago in Michigan, there were 20,000 individuals in the state psychiatric hospitals and 10,000 individuals in the state prisons. Today, there are 1,000 in the state mental hospitals and 51,000 in the state prisons.[xlvii]

2. **What is it like to be seriously mentally ill and in prison or jail?** Previous studies have reported many adverse aspects of incarceration for an individual with serious mental illness. Such individuals are often raped or otherwise victimized, disproportionately held in solitary confinement, and frequently attempt suicide. Because treatment of mental illness is often not available behind bars, symptoms often get worse, sometimes leading to self-mutilation.

Prior to the introduction of effective medication in the 1950s, conditions for patients in state mental hospitals were often abysmal. Exposés of these conditions provided a major impetus for the deinstitutionalization of the patients and the closings of hospitals. However, by shifting the venue of these mentally ill individuals from the hospitals to prisons and jails, we have succeeded in replicating the abysmal conditions of the past but in a nonclinical setting whose fundamental purpose is not medical in nature. The present survey identified many examples of such conditions. In New York, a man with schizophrenia was in prison for 15 years, 13 years of which were spent in solitary confinement. In a Minnesota county jail, a man with schizophrenia blinded himself with a pencil while "standing naked in his cell, standing in his own feces, screaming gibberish." In a Mississippi prison specially designed for mentally ill inmates, "rats climb over the prisoners' beds, and some prisoners capture the rats, put them on makeshift leashes, and sell them as pets to other inmates." President John Kennedy, as part of his proposal to close state psychiatric hospitals, promised that "the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability." This unquestionably is not what he meant.

3. **How can prison and jail inmates be treated for their serious mental illness?** The availability of psychiatric treatment for inmates with serious mental illness varies widely from state to state and also among prisons and jails within a state. Despite many legal and other impediments to providing such treatment, this survey found that the administrators of many prisons and jails have undertaken impressive efforts to provide appropriate psychiatric treatment. Treating mentally ill inmates who are aware of their illness and will voluntarily accept treatment is comparatively easy. The real problems come from mentally ill inmates who refuse treatment because they believe they have no awareness of their illness and believe they are not sick (i.e., suffer co-occurring anosognosia).

Prison treatment. This study found that, in 31 states, a seriously mentally ill inmate can be involuntarily treated when the inmate's mental illness meets state-specific criteria and a small treatment review committee of prison officials, including a medical professional, is convened to review the case. This procedure is authorized by a legal case originating in Washington State (*Washington v. Harper*), as described in Chapter 2 and upheld by the U.S. Supreme Court. The states in which a *Washington v. Harper* committee can authorize involuntary treatment are the following:

Alabama	Kentucky	Oklahoma
Alaska	Michigan	Oregon
Arizona	Mississippi	South Dakota
Colorado	Missouri	Tennessee
Connecticut	Montana	Texas
Delaware	Nebraska	Utah
Georgia	Nevada	Washington
Idaho	New Jersey	West Virginia
Illinois	North Carolina	Wyoming
Indiana	North Dakota	
Kansas	Ohio	

In addition to these 31 states, available public information suggests Arkansas may also use this committee procedure. Because Arkansas was the only state that refused to provide information to the survey, this could not be verified. It is important to add, however, that even though a state *authorizes* the use of a treatment review committee, state prisons may not actually *use* this procedure.

States that authorize the use of a treatment review committee provide at least a theoretically reasonable approach for the use of involuntary treatment for seriously mentally ill inmates who meet specific criteria. For the other 18 states and the District of Columbia that do not authorize the use of a treatment review committee, the involuntary treatment of mentally ill inmates in state prisons is more difficult. These include the following:

California	Maryland	Rhode Island
District of Columbia	Massachusetts	South Carolina
Florida	Minnesota	Vermont
Hawaii	New Hampshire	Virginia
Iowa	New Mexico	Wisconsin
Louisiana	New York	
Maine	Pennsylvania	

Of these, in five states and the District of Columbia, the involuntary treatment of mentally ill prisoners can take place only by court order, by the court appointment of a guardian, or by the transfer of the mentally ill inmate to a state mental hospital. The last is especially problematic because most state mental hospitals are continuously full, so no beds are available. Thus, such individuals languish in prison for weeks or months, untreated. Those states in which involuntary treatment of inmates is most difficult are the following:

District of Columbia	Maryland	Pennsylvania
Iowa	New York	South Carolina

County jails. Procedures vary widely by county and are often applied ad hoc without any formal policy or procedure. South Dakota is the only state that has authorized the use of a treatment *Washington v. Harper*-type review committee for the county jails in that state. One or more individual counties in Utah and Washington also authorize the use of treatment review committees. In the majority of states, there appears to be no legislation to prohibit the use of treatment review committees by jails, making this mechanism one that could be developed and utilized by counties. However, a majority of counties specify that seriously mentally ill jail inmates must be transferred to state mental hospitals before involuntary treatment can take place; this, of course, means that such treatment rarely occurs, and inmates continue to be seriously mentally ill in jail, often with worsening symptoms over time.

Given the many legal difficulties in providing adequate treatment for individuals with serious mental illness in prisons and jails, it is not surprising many of them, including those who are most severely ill receive no treatment whatsoever. This leaves corrections officers with few

options for controlling the mentally ill inmates' psychotic, often violent behavior. One option is to use seclusion, which often makes the inmate's mental illness worse. Changes to restrict the use of seclusion for mentally ill prisoners was recently introduced in Colorado and New York State as well as in New York City.An alternative approach to controlling inmates experiencing psychiatric symptoms that make them violent is to use pepper spray on them. This tactic, too, has come under fire, and authorities in California in 2013 drafted new rules to limit its use. Some prisons and jails have resorted to restraining devices, but their use has been less common since a mentally ill inmate in the Utah State Prison died after being confined in a restraining chair for 16 hours.

In summary, we have placed more than 300,000 severely mentally ill individuals in prisons and jails that are neither equipped nor staffed to handle such problems. We subsequently have made it very difficult to treat the mentally ill inmates, put restriction on other options for controlling their behavior, and then blamed the prison and jail administrators when they fail. It is a situation that is grossly unfair to both the inmates and the corrections officials and should be the subject of public outrage and official action.

The survey thus demonstrates that the transinstitutionalization of seriously mentally ill individuals from state psychiatric hospitals to state prisons and county jails is almost complete. From the 1830s to the 1960s, we confined such individuals in hospitals, in large part because there were no effective treatments available. Now that we have effective treatments available, we continue to confine these individuals but in prisons and jails where the treatments are largely not available. We characterize seriously mentally ill individuals as having a thinking disorder, but surely it is no worse than our own.

Recommendations

All recommendations for improving the situation begin with the general premise that individuals with severe mental disorders who are in need of treatment belong in hospitals, not in prisons and jails. The present situation suggests that the public mental illness treatment system is broken. Thus, the ultimate solutions to the problems presented in this report include having an adequate number of public psychiatric beds for the stabilization of mentally ill individuals and involve a fundamental realignment of the public mental illness treatment system in which public mental health officials at the state and county level are held responsible for any failure of the treatment system. Until that is done, the following are some interim recommendations.

1. **Provide appropriate treatment for prison and jail inmates with serious mental illness:** Decisions by the U.S. Supreme Court have affirmed that prisons and jails have a duty to provide medical care to individuals in their custody. Just as inmates should be treated for tuberculosis, diabetes, and hypertension, so also should they be treated for schizophrenia, bipolar disorder, and major depression.

   The capacity to provide appropriate treatment will vary widely. Treatment issues for a state prison with several hundred long-term prisoners with schizophrenia are obviously very different from those for a small, rural county jail that is asked to hold an individual who is acutely psychotic while awaiting transportation to a state hospital.

To lay the foundation for appropriate treatment existing state laws need to be amended, as necessary, to require provide for such treatment. Providing a centralized, comprehensive source of information about the state of existing laws for each state is a major goal of this report and its publication on the TACReports.org website. A model law (below) is also provided to inform changes to state laws as needed.

Another aspect of providing appropriate treatment is the administration of psychiatric medication. This can be done by a nurse or other healthcare professional, and the issues are thus similar as for the administration of medication for other diseases. Some states have provisions in their laws stating that involuntary medication can be given only in a hospital setting, but this is not necessary.

A major issue is the availability of specific psychiatric medications, many of which are expensive. In many cases for individuals who have just been incarcerated, the family of the mentally ill inmate will bring the medication he/she is on to the jail. Some jails refuse to accept such medication because of fears of legal liability. Laws should be written in such a way that corrections officials are legally protected under a "good faith" provision. The officials may reject the medications, however, if they are stimulants, benzodiazepines, or the antipsychotic quetiapine (Seroquel), all of which can be used as drugs of abuse, or if the officials suspect that the drugs being offered may be street drugs.

2. **Implement and promote jail diversion programs:** The use of mental health courts and crisis intervention team (CIT) policing has proven to be effective in diverting mentally ill persons from incarceration, but their use by the states varies widely. In states such as Utah, Arizona, New Mexico, and Connecticut, these programs are comparatively widespread, whereas in states such as Iowa, Mississippi, West Virginia, and Arkansas, they are virtually nonexistent. If we want to reduce the criminalization of mental illness, utilizing these proven diversion techniques is an obvious place to start. For an assessment of program availability in all the states, see "Prevalence of Mental Health Diversion Practices: A Survey of the states" published by the Treatment Advocacy Center in 2013.[xlviii]

3. **Promote the use of assisted outpatient treatment (AOT):** Assisted outpatient treatment (AOT) to assure treatment delivery to at risk individuals with mental illness while they continue living in the community is available in 45 states and the District of Columbia but is markedly underutilized. The Department of Justice has deemed AOT an effective and evidence-based practice for reducing crime and violence and where it has been actively implemented, AOT has proven to be very effective in reducing the time mentally ill individuals spend in jail. In North Carolina, a randomized study reported that patients "with a prior history of multiple hospitalizations combined with prior arrests and/or violent behavior" had a reduction in arrests from 45 percent to 12 percent in one year while participating in AOT.[xlix] In New York, the percentage of mentally ill individuals arrested decreased from 30 percent prior to receiving AOT to five percent while in the state's "Kendra's Law" program, and the percentage of those incarcerated decreased from 23 percent to three percent while on AOT.[l] In both studies, court-ordered outpatient treatment was also accompanied by a major reduction in alcohol and drug

abuse. And in a small pilot study in Nevada County, California, the use of AOT reduced jail time for the seriously mentally ill persons in the program from 521 days to 17 days, a 97 percent reduction.[li] In these contexts, AOT can be regarded as another type of jail diversion.

4. **Encourage cost studies:** One of the driving forces behind the closure of state mental hospitals and subsequent transinstitutionalization of mentally ill individuals from hospitals to prisons and jails has been a belief that it saves money. The daily cost of care for jail and prison inmates can appear to significantly less expensive than the daily cost of care in a state mental hospital. However, such comparisons omit many costs, including the higher costs of mentally ill inmates; the longer incarcerations of inmates with mental illness because of the time often required to restore their sanity sufficiently to try them in a court of law; the higher rate of recidivism among mentally ill inmates; and the high cost of settlements and awards resulting lawsuits following inmate suicides and self-mutilation. Cost assessments that identify the comprehensive expense of incarcerating mentally ill individuals would provide public officials with a more accurate basis for making mental illness treatment policy and unmask cost savings that are illusory.

   The least expensive option of all, of course, is to make sure seriously mentally ill individuals receive proper psychiatric care in the community so they do not end up in jails or prisons. For example, a study in Florida followed 4,056 individuals with schizophrenia or bipolar disorder for seven years following their discharge from psychiatric hospitalization. Those who remained on medication were significantly less likely to be arrested and cost the state 40 percent less in total care costs over the seven-year period.[lii]

5. **Establish careful intake screening:** One of the most effective ways to minimize problems associated with mentally ill individuals in prisons and jails is to identify the potential problems at the time the individual enters prison or jail. A variety of screening techniques are available; all should include an assessment of suicide potential and the person's medication history. The American Psychiatric Association has established guidelines for serving mentally ill individuals in prisons and jails that describe some alternatives.[liii,liv]

6. **Mandate release planning:** For all mentally ill inmates being released from prison or jail, a written plan for psychiatric follow-up should be developed. Studies have suggested this presently happens in only a small percentage of cases.[lv] One recent study reported that inmates with serious mental illness who were released from prison without follow-up treatment were almost four times more likely to commit another violent crime compared to mentally ill inmates who were given treatment after their release.[lvi] Included in the plan should be identification of the organization specifically responsible for the person's psychiatric care. This responsibility could be assigned, for example, to the mental health center or to the prison or jail system along with funding to discharge this responsibility. The important point is that some agency or organization must be specifically assigned responsibility for psychiatric follow-up and then held accountable.

A Model Law

Absent conflicting state law or statute, it is not necessary that there be a state law authorizing jails to use the *Washington v. Harper* type of administrative proceeding, because the U.S. Supreme Court decided in 1990 that the procedure and criteria (gravely disabled and likelihood of serious harm) are constitutional. The procedure is thus being used in prisons and some jails across the country without statutory authority. Nonetheless, a Model Law for medication over objection for jail inmates in need of treatment is provided below for advocates to use in their states.

SECTION I. DEFINITIONS

As used in this act:

A. "Mental illness" means a substantial impairment of a person's thought processes (e.g., delusions), sensory input (e.g., hallucinations), mood balance (e.g., mania or severe depression), memory (e.g., dementia), or ability to reason that substantially interferes with a person's ability to meet the ordinary demands of living.

B. "Gravely disabled" means in danger of serious physical harm resulting from the inmate's failure to provide for his or her essential human needs of health or safety.

C. "Severe deterioration" means a substantial decline in routine functioning evidenced by the inmate's repeated and escalating loss of cognitive or volitional control over his or her actions, while not receiving such care as is essential for the inmate's health or safety.

D. "Likelihood of serious harm" means:
1. a substantial risk that the inmate will inflict physical harm upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on self;
2. a substantial risk that the inmate will inflict physical harm upon another, as evidenced by behavior which has caused such harm or which places any person in reasonable fear of sustaining such harm; or
3. a substantial risk that the inmate will inflict physical harm upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others.

E. "Competent lay advisor" means a person appointed by the warden or administrator of a jail to advise inmates during medication review hearings. To be eligible for appointment as a competent lay advisor, a person shall:
1. have completed a course of training in mental health;
2. demonstrate knowledge of the psychiatric issues raised in medication review hearings; and
3. have no current involvement in the inmate's treatment.

SECTION II. RIGHT TO REFUSE TREATMENT

A. An inmate in a local jail has the right to refuse psychotropic medication unless, as a result of a mental illness, the inmate:
   1. is gravely disabled;
   2. manifests severe deterioration; or
   3. poses a likelihood of serious harm to self or others.

B. Psychotropic medication may not be involuntarily administered to an inmate unless authorized by a medication review panel pursuant to this act or required in an emergency. Prior to the initiation of an involuntary medication hearing pursuant to this act, an inmate's treating psychiatrist shall make reasonable efforts to obtain the inmate's informed consent.

SECTION III. 21-DAY INVOLUNTARY MEDICATION HEARING

A. Upon failing to obtain an inmate's informed consent for the administration of psychotropic medication, the inmate's treating psychiatrist may request a 21-day involuntary medication hearing. Pending the decision of the medication review committee, the treating physician may continue to administer or supervise the administration of emergency involuntary psychotropic medication.

B. The request shall be assigned to a medication review committee, which shall include:
   1. a chairperson,
   2. a non-treating medical professional, and
   3. a non-treating psychiatrist.

C. The treating psychiatrist shall submit a report to the committee which shall include:
   1. the inmate's mental illness diagnosis, symptoms, and treatment status;
   2. the psychotropic medications recommended for the inmate;
   3. the inmate's voluntary and involuntary medication history, to the extent known;
   4. a description of the efforts made to obtain the inmate's informed consent to the recommended medications; and
   5. a description of any less intrusive appropriate treatment alternatives considered or attempted.

SECTION IV. HEARING AND NOTICE

A. The chairperson shall schedule a hearing as soon as possible but no later than seven calendar days following the request.

B. The inmate shall receive written notice at least twenty-four hours prior to the hearing.

The notice shall include:
1. the date and time of the hearing;
2. the inmate's current mental illness diagnosis;
3. the recommended antipsychotic medications and the clinical basis for the each such recommendation; and
4. a statement of the patient's rights under Section V of this Act.

SECTION V. INMATE RIGHTS AT THE HEARING

A. At the hearing, the inmate shall have the right to:
   1. attend, be heard, and present relevant evidence;
   2. refuse to attend or participate;
   3. cross-examine adverse witnesses; and
   4. receive the advice of a competent lay advisor.

B. An inmate's rights under subsection A of this section shall be limited only upon a finding of good cause by a majority of the medication review committee. An inmate may only be excluded from the hearing for safety or security reasons, or if he or she is so disruptive that it is unreasonably difficult to conduct the hearing with the inmate present.

C. The chairperson shall document in writing any refusal of the inmate to attend or participate in the hearing and any determination pursuant to subsection B of this section to limit the inmate's rights under subsection A of this section.

SECTION VI. DECISION OF THE MEDICATION REVIEW COMMITTEE

A. The decision of the medication review committee to authorize or deny the involuntary administration of psychotropic medication for a period of twenty-one days shall be made by majority vote, provided that the non-treating psychiatrist must vote in favor of any involuntary administration of psychotropic medication.

B. The medication review committee shall issue its decision in writing, stating the basis of the decision including the finding as to whether the inmate is gravely disabled, manifests severe deterioration or poses a likelihood of serious harm to self or others, and any recommended psychotropic medications. Copies of the written decision shall be provided to the inmate and the treating psychiatrist.

C. Upon receipt of the medication review committee's written decision, the treating psychiatrist shall administer or supervise administration of the medication according to the accepted medical standard of care in the community.

SECTION VII. 180 DAY INVOLUNTARY MEDICATION HEARING

A. If the treating psychiatrist determines that an inmate currently subject to a 21-day involuntary medication order requires psychotropic medication for a longer period, and reasonable efforts to obtain the inmate's informed consent have failed, the treating psychiatrist may request a 180-day involuntary medication hearing. Such hearing shall occur prior to the termination of the 21-day involuntary medication order and shall follow all procedures provided in this chapter for the 21-day involuntary medication hearing.

B. Prior to the expiration of a 180-day involuntary medication order, the treating psychiatrist may follow the procedures of subsection A of this section to seek an involuntary medication order for an additional period of 180 days.

SECTION VII. APPEAL

A. Within 24 hours of receipt of the written decision of the medication review committee, excluding holidays and weekends, the inmate may file an appeal to the warden or administrator of the jail, alleging that a procedure required by this act was not followed.

B. Within 24 hours of receipt of an appeal, excluding holidays and weekends, the warden or administrator shall review, investigate and decide the appeal. If the warden or administrator finds merit in the inmate's allegation that a procedure required by this act was not followed, the warden or administrator shall re-convene the medication review committee, or, if appropriate, convene a new medication review committee, to conduct a new involuntary medication hearing pursuant to the requirements of this act.

C. Nothing in this section shall be construed to prevent an inmate from seeking judicial review of an involuntary medication order after the remedy provided herein has been exhausted.

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