AMERICAN IGNOMINY:
THE INCARCERATION OF THE MENTALLY ILL

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ABSTRACT

Prisons and jails have become the *de facto* psychiatric hospitals of the twenty-first century. In the wake of deinstitutionalization, as mental healthcare transitioned to a community-based model, many patients with mental illness found themselves incarcerated rather than hospitalized. Strict drug laws combined with the current opioid epidemic are now forcing the government to consider treatment over punishment, lest the prison populations continue to swell. It is time to strongly consider using the involuntary commitment for severe cases of substance abuse if the patient is unwilling to undergo rehabilitation. Refusing to wait for the federal government to act, cities and states around the nation have begun to experiment with novel solutions to these issues, working within the framework of the prison system to achieve better outcomes.

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To my friends and family: you have suffered my insufferableness with aplomb.

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CHAPTER 1

INTRODUCTION

The United States has a long and tortuous history regarding its approach to mental illness. Beginning with the construction of state hospitals in the early nineteenth century and up to the present day, the United States has never mounted an appropriate response to dealing with its ever-present mentally ill population. This includes substance abuse, and the opioid epidemic is the public health crisis of our time. With deaths from opioids reaching 42,249 in 2016, a rate five times higher than in 1999, the media and government have begun to pay closer attention to substance use disorder (SUD) and what can be done to combat it (CDC, 2017).

The current state of psychiatric care in the United States can be better understood in terms of its historical context. The nineteenth century saw the construction of public psychiatric hospitals, and with each one that was built the patient population increased in a linear fashion. This continued through the twentieth century, peaking around 1955, until antipsychotic medications were introduced and community-based clinics increased in number. Thus the paradigm of treatment shifted from state mental hospitals to the community. The response has never been adequate, however, as mentally ill persons now have much higher rates of homelessness, drug abuse, and incarceration (Pow, Baumeister, Hawkins, Cohen & Garand, 2015).

Prisons and jails are the *de facto* state hospitals of the twenty-first century. Resources for mental health treatment in prisons are not up to par with the standard of care a person would otherwise receive. Therefore, despite the country's best intentions in

closing state hospitals, the number of mentally ill persons incarcerated today shows that there is still a need for long-term state-run facilities, as well as a reformation of our laws as they pertain to drug abuse.

Data from 2008 showed that at that time there were roughly 316,000 severely mentally ill inmates in our prisons and jails, compared to only 60,000 in inpatient psychiatric facilities. For the first part of the twentieth century, mental hospital inpatient numbers greatly exceeded those that were incarcerated. Beginning in the mid 1970s, however, this trend reversed, and throughout the 1980s the incarcerated population experienced a fivefold increase as the inpatient population went through a rapid decline (Raphael & Stoll, 2013).

I propose that this trend was multifactorial, stemming initially from deinstitutionalization but continuing until today. American society has largely been ignorant of this issue due to desensitization from expanding social media and macroeconomic issues like income inequality. The war on drugs and the current opioid epidemic have only exacerbated the problem of swelling prison populations. Some have called for the use of the involuntary commitment for cases of substance abuse in the hopes of directing more people into treatment rather than incarceration. Cities and states around the nation have begun implementing novel solutions, working within the predefined structures of the prison system to mount an appropriate response to the needs of incarcerated mentally ill persons. This paper will highlight some of the issues surrounding the delivery of mental healthcare to incarcerated populations, their etiologies, and current projects that address them.

CHAPTER 2

DEINSTITUTIONALIZATION AND ITS AFTERMATH

It is well known that psychiatric care has primarily moved from the asylum into the community. This paper will not delve into the specifics of deinstitutionalization, as many others have already discussed that at length. Thus I will focus on the problem that society most urgently needs to address, namely, that mentally ill individuals are unfairly targeted by the criminal justice system. Perhaps this was an inevitable consequence of deinstitutionalization, given that so many patients who would have once remained in asylums are now living in our communities, and the laws regarding their care have not been properly updated to reflect this.

There are concrete examples of legislation that can be attributed to this trend. These include the 1963 Community Mental Health Service Act, which established community mental health centers to provide outpatient, emergency, and partial hospitalization services for the mentally ill. Another is the Supreme Court case *O'Connor v. Donaldson* (1975), which found that mental illness alone is not sufficient grounds for involuntary commitment, and that the patient must be a clear and present danger to himself or to others (Raphael & Stoll, 2013).

The prevalence of mental illness among inmates greatly exceeds that of the general population, with 50-60% of inmates reporting having a mental health problem or symptoms indicative of mental illness. For severe mental illness, the relative prevalence is about five times that of the general population (Raphael & Stoll, 2013). As prison populations have soared in recent decades, it should be determined what proportion of

this increase is attributable to changing attitudes towards the mentally ill. Raphael & Stoll (2013) suggest that 4-7% of the growth in the incarcerated population can be attributed to deinstitutionalization. In a different era many of these inmates would have been found within the mental healthcare system rather than incarcerated. Other studies claim that an individual with serious mental illness was ten times more likely to be found in a psychiatric bed for treatment in 1955 than in 2004. The number of psychiatric beds per capita went from 1:300 at that time to around 1:3000 presently (Torrey, Kennard, Eslinger, Lamb, Pavle, 2010).

Ethical and clinical issues abound with treating mentally ill persons in prison. Sisti, Segal & Emanuel (2015) write, "Mentally ill inmates live in an environment anathema to the goals of psychiatric recovery; it is often unsafe, violent, and designed to both control and punish." For a prison psychiatrist, this can prove a daunting task. The concept of a therapeutic milieu, used by most psychiatric hospitals, is lost.

Another challenge is the difficulty of maintaining continuity of care. When patients are in and out of the corrections system, they are likely to receive care from multiple providers, and this presents many challenges to appropriately managing their illnesses. It is easy to imagine a scenario in which a person has an outpatient psychiatrist, is incarcerated and lost to follow up, receives differing levels of care while incarcerated, and then upon release finds another new psychiatrist. This constant shuffle does not allow for the development of a strong patient/physician relationship, and can lead to other medical issues such as polypharmacy. Prescription drug monitoring programs have helped alleviate some of this in recent years, but the problem still remains. Additionally,

psychiatric patients often require ancillary support, such as a caseworker, and even this can be hard to maintain for a person whose living situation is constantly in flux.

There is also a financial cost associated with housing mentally ill persons in prisons and providing them care. Not surprisingly, mentally ill inmates cost more than those without a mental health condition. In Texas this discrepancy can range from $8,000-$28,000 more per year. Data also show that mentally ill inmates stay incarcerated longer, such as in New York's Rikers Island, where the average stay times for all inmates and mentally ill inmates show a disparity of 173 days (Torrey et al., 2010). The mentally ill find often find it more difficult to adapt to the rules and expected behaviors of the prison system, which may partially explain the longer stays that these inmates experience. Increased costs can be attributed to the price of psychiatric care itself, including assessments and medications, as well as incidents that can be attributed to poor behavior on the inmates' parts and potential abuse that they may suffer while incarcerated. Costs will continue to increase as improvements in care are tried and implemented in the wake of *Brown v Plata* (2011), which ruled that the quality of treatment offered to mentally ill inmates by prisons and jails amounts to cruel and unusual punishment.

The transinstitutionalization of the mentally ill from asylums to prisons may be seen as a natural consequence of deinstitutionalization, but the United States government has also taken an active role in worsening the situation. To this day, the government continues to reduce the number of available psychiatric beds without accounting for the effects of such an action. It is not likely that a perfectly linear relationship can be drawn between decreases in psychiatric beds and increases in prison populations, as there are numerous variables involved, including economics. For example, in countries with higher

income inequality, there is an association with increased violent crime and larger prison populations. Inversely, those countries with fewer psychiatric beds tend to have greater income inequality. Thus it is no surprise that the United States, a country whose prison population is over 2.2 million, has worsening income inequality, ever lowering psychiatric bed numbers, and an inadequate allocation of resources for community mental health services (Allison et al., 2017). The problem is self-perpetuating and involves much more than simply converting prison beds to psychiatric beds.

Properly analyzing the relevant data can paint a clear picture of the problem for the federal government. As ever, the motivating factor for change is probably going to be financial, and thus it is paramount that a case be made for solutions that are more cost effective than the current model. The medical community must also become more vocal in demanding a more appropriate level of care for these inmates.

CHAPTER 3

A CULTURAL ACCEPTANCE OF UNDULY HARSH SENTENCES

The expansion of the prison-industrial complex can be explained through decades of policy changes that have gradually decreased the number of psychiatric beds, while simultaneously creating a prison population that is the largest in the world. Egregious as this may sound, a more sinister question lingers: why do we tolerate this? For perspective, I offer some statistics published by the Institute for Criminal Policy Research. The total prison population of the U.S. currently hovers around 2.2 million, by far the largest in the world in terms of absolute numbers. Second is China, with around 1.65 million, and after that no other country breaks the one million mark. In terms of the imprisoned population per 100,000, the U.S. comes in second at 698 incarcerated per 100,000 people, bested only by the Seychelles at 799. To compare, Cuba has 510, Russia 445, and Rwanda 434. Around 21% of the U.S. prison population is un-sentenced (Walmsley 2016). Can it be that the land of the free and the home of the brave stands on the backs of the disenfranchised?

Politicians and parties come and go, and political movements all have their times. The U.S. has a rich history of social justice movements and generational protests, even a civil war that was fought in the name of equality. Yet American society in 2018 has grown complacent, turning a blind eye to the injustices of our time, including the incarceration and subpar treatment of the mentally ill. Silence on these matters is complicity, and we are all as guilty as our politicians. Two factors that greatly influence this alarming trend are income inequality and social media.

Though talk of socialism in the United States may feel taboo, most people would agree with this twofold statement: societal wealth should not be disproportionately held by a small group of the elite, nor should it be equally distributed among all citizens. In a sense, Americans are comfortable with a range of incomes existing in society. This only becomes a problem when extremes are reached, either by the wealthy accumulating too much of the economy's growth, the poor losing too much of it, or both. In 2018, it appears that both are happening. I offer a graphic published by Piketty, Saez & Zucman (2017) that shows the distribution of economic growth in the United States from 1980-2014 based on income percentile.

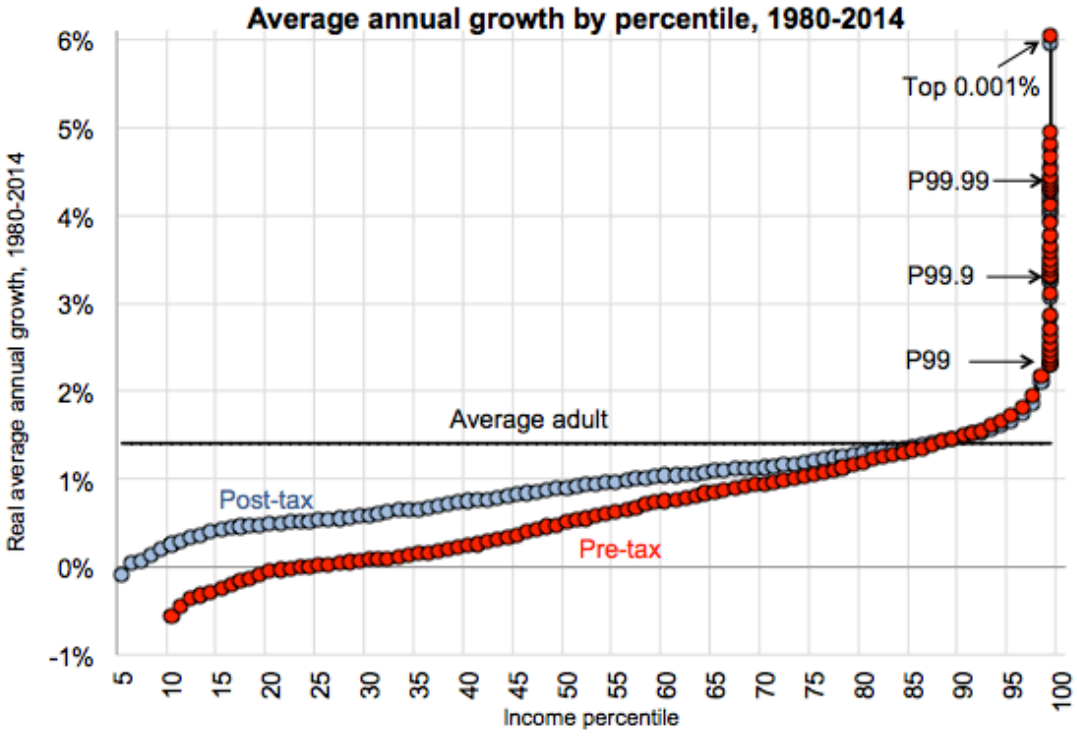

Figure 1: The Distribution of Economic Growth in the United States

Breaking this graph down into three parts will elucidate this issue. The largest section is in the middle, with post-tax income for the vast majority of income percentiles experiencing modest growth, though not more than 2% annually. Note that on the whole, the lower the income percentile, the lower the real annual average growth a person was likely to have experienced. At the extremes, an even more alarming picture is seen. For those in the 5% income percentile bracket, growth was actually net negative for the period from 1980-2014. For those in the top 99%, and especially those in the top 99.999%, income growth was astronomically higher than the vast majority of income earners. Based on these trends, the problem is only worsening.

These trends may be related to increased prison populations. As income inequality worsens, society becomes increasingly stratified based on one's income percentile. Issues that affect one subgroup may be of little concern to those in another. After all, why would people in the top 0.01% be concerned that those at the opposite end of the spectrum lose out with every "win" they experience? Likewise, why would those at the lowest end of the income spectrum be concerned by laws that concern only top tier earners? Of course this is an oversimplification, but this division only serves to isolate and make the problem worse. With money comes political power, and so as the wealthiest among us consolidate their wealth and political influence, the poorest among us lose theirs. It should come as no surprise that laws that disproportionately disenfranchise poor people, notably via incarceration, would be of little concern to the wealthy.

Still, the vast majority of American society does not fall into either category. The middle class has been largely unaffected by these matters, though middle class growth is certainly not what it once was in the middle of the 20th century. Their incomes have still

grown, albeit modestly, and unemployment has even decreased in recent years, following the slump of the 2008 recession (Pew Research Center, 2015). Sadly, it appears as though this is still enough to keep the middle class complacent, as there have been few protests or social movements combatting this. The "Occupy Wall Street" movement is a notable exception, though it has never gained wide, mainstream appeal. This may be a case of willful ignorance, and a response may only be seen when income inequality reaches an undetermined "critical mass," affecting more than just the extremes of the income spectrum.

Social media plays a major role as the means through which this apathy disseminates. Once thought of as a quaint way to keep in touch with old friends and relatives, the 2016 presidential election taught us that social media is a potent societal force. Questions of Russian meddling in the election have led to the conclusion that a significant portion of this crime took place via Facebook and Twitter. The initial response to this conclusion was that there could be no way for social media users to influence an American election. After all, if they did not actually hack voting machines and ballots, how could they have had any real impact? The answer lies in the fundamental design of social media, one that preys upon our basest instincts and biases, sometimes leading to the dissemination of toxic ideas and distracting us from the real issues.

For a Facebook user who is politically left leaning, he may find that his newsfeed is full of posts and articles that seemingly bolster and support his predispositions. These posts aim to stir emotions like anger, shock, and outrage. As expected, the user then interacts more with these posts, and the Facebook algorithms learn that the user is more likely to use the site if their newsfeed is full of these "triggering" posts. Thus the

"Facebook bubble" is created: the illusion that everyone else on the Internet agrees with your political positions.

Political activism in 2018 goes hand in hand with social media. Rallies are organized through it, often effectively, and petitions routinely circulate, which are less likely to have any real effect. Users simply sign a petition that they came across in their newsfeed, probably there because Facebook predicted that it would interest the user, and then continue scrolling along. Regardless of the method used, the ability to "like," "share," or post opinions gives people a false sense of activism. To sum the effect up, if an article on incarceration appears on someone's newsfeed detailing the United States' abysmal standing among the developed world, all that is likely to result is a digital condemnation, a whisper in an echo chamber, and the reader will go on with his day.

Articles, issues, and petitions constantly bombard social media users, so much so that they become dilute and ineffective. Long gone are the days of civil unrest and large-scale grassroots movements that were once the norm in the middle of the last century. If the public were more actively aware and engaged by the issues surrounding mental health and incarceration, perhaps greater change would be on the horizon. We may be witnessing the beginnings of this now, in early 2018, in the wake of the school shooting in Parkland, FL. Survivors of the massacre, all high school students, have taken to social media in demanding legislation, refusing to accept their tragedy as inevitable. President Trump has now weighed in on the discussion, saying, "We're going to be talking seriously about opening mental-health institutions again," referring to reopening the mental asylums of decades past (Khazan, 2018). Time will tell if these students' efforts on social media will have any lasting impact on mental healthcare in this country. They

have already organized one large-scale protest in Florida's capital, however, and hopefully this will continue. Real activism of this kind, in conjunction with social media, must be part of the solution to the incarceration and mistreatment of the mentally ill.

CHAPTER 4

DRUGS, MENTAL ILLNESS, AND INCARCERATION

Much of the research on this topic involves the treatment of patients holding a primary psychiatric diagnosis, such as depression or schizophrenia, but the reality is that most prison psychiatric care is dual-diagnosis in nature. Laws criminalizing drug possession and abuse lead to the incarceration of these individuals, and many mentally ill citizens find themselves using illicit substances all too often. Put together, this toxic combination has led to a massive prevalence of drug abuse and addiction within the prison system.

It should be noted that there is no clearly defined relationship between prison populations and psychiatric bed numbers. Though numerous studies have shown that as psychiatric bed numbers have declined in the U.S., prison populations have grown, there are many covariates that make this relationship hard to define. Some of these variables include macroeconomic conditions, such as income inequality, and investments in community based mental healthcare, which have often been inadequate (Allison et al., 2017). Correlation does not imply causation, but it is clear that prisons have, in more ways than one, supplanted the psychiatric hospitals of decades past.

A large part of the blame for these skyrocketing prison populations is what is known as the "war on drugs." This began in the 1980s, when high crime rates led to increasingly harsher sentences for convicted criminals. The "war on drugs" refers to the introduction of stricter sentencing guidelines for drug-related offences, thus limiting the

discretion of judges and parole boards, who may have been more lenient otherwise (W.W., 2015). Sentencing for other crimes increased as well:

> Between 1984 and 2009, the time typically served in state prisons increased by roughly five years for murder, three years for sexual assault, eighteen months for robbery and six months for burglary. A significant reduction in the incarceration rate will require rolling back prison terms for these crimes, too. (Raphael & Stoll, 2013)

Being that our incarceration rates are now in a league of their own among the developed world, it seems likely that our sentencing is now too harsh, rather than it being too lenient in the past.

When this trend started in the 1980s, the drug at the forefront of the discussion was crack cocaine. The epidemic of addiction was hardly treated as such, being seen as an issue of public safety and personal accountability rather than one of public health. Today the United States struggles with opioids. This includes both legal prescription drugs, like morphine and oxycodone, and illicit ones, like heroin and fentanyl. In recent years a new synthetic opioid called carfentanil has made an appearance, and is said to be 10,000 times more potent than morphine and 100 times more potent than fentanyl, a drug already lethal to humans in extremely small doses. Carfentanil can be lethal even if a small speck of it is accidentally absorbed, which unfortunately does happen, as drug dealers are forced to "cut" their product with increasingly potent compounds to satisfy demand for the drug. Its immediate potency seems to make animate the dire situation in which we now find ourselves.

The medical community is in large part to blame for the creation of the opioid epidemic. Overprescribing opioid pain medications has led to millions of Americans who are now addicted to a substance that they may have never encountered otherwise. In 2001, the Joint Commission and the Centers for Medicare & Medicaid Services (CMS) presented their Pain Management Standards, which codified the idea of pain as the "fifth vital sign" (Fiore, 2016). A generation of unwitting or irresponsible physicians thus set the stage for a generation of Americans ripe for developing substance use disorder.

As the medical community began to realize what was happening, some physicians became more judicious with their prescribing habits, but the damage was done. Many people who were once on prescription narcotics have since found themselves either unable to afford them or unable to find a physician willing to continue prescribing them. Sadly, many of these people turned to the much cheaper and more readily available drug heroin. The development of any epidemic is multifactorial, but the first step that the medical community needs to take is to admit our ethical failure to maintain the principle of non-maleficence. I do believe that this process has begun, but is only now in its infancy.

Having discussed how the war on drugs and an epidemic of addiction have led to mass incarceration of Americans, more questions remain. Does the prison system offer adequate treatment for these addictions to the same degree that a person could find outside the prison, or does it only serve to punish and not to rehabilitate? Is incarceration the best solution to an epidemic of addiction that grows more each day? How many of those convicted have a comorbid psychiatric condition that predisposed them to their

addiction, rather than merely a failure of personal accountability, and how does the prison system address this issue? To begin answering these questions, we will first define Substance Use Disorder (SUD) and discuss its epidemiology.

The DSM-5, a manual that defines and classifies mental disorders, defines SUD as such:

> A problematic pattern of use leading to clinically significant impairment or distress is manifested by two or more of the following within a 12-month period:
>
> 1. Often taken in larger amounts or over a longer period than was intended.
> 2. A persistent desire or unsuccessful efforts to cut down or control use.
> 3. A great deal of time is spent in activities necessary to obtain, use, or recover from the substance's effects.
> 4. Craving or a strong desire or urge to use the substance.
> 5. Recurrent use resulting in a failure to fulfill major role obligations at work, school, or home.
> 6. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by its effects.
> 7. Important social, occupational, or recreational activities are given up or reduced because of use.
> 8. Recurrent use in situations in which it is physically hazardous.
> 9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
> 10. Tolerance.

11. Withdrawal. (Dugosh & Cacciola, 2017)

SUD is therefore multifaceted, and comprises much more than just repetitive abuse of a substance. The social, psychological, and physical impacts are all included in these diagnostic criteria, as they must be when considering treatment.

For a non-incarcerated patient, there are many treatment options available, provided that the patient is willing to seek and accept treatment. These include outpatient care, intensive outpatient programs, partial hospital programs, residential services, and medically managed intensive inpatient services. The options range in intensity depending on the severity of the illness. Additionally, comorbid psychiatric disorders and social issues, such as homelessness and disability, must be taken into account. There is no one standard of care for a person with SUD, but these options exist and the patient has the freedom to choose from among them as able. Within the prison system, that is not always the case.

For context, a 2006 study by the U.S. Department of Justice showed that among inmates with a mental health problem, local jail inmates had a rate of comorbid dependence or abuse of alcohol or drugs of 76%, followed by state prisoners at 74%, and federal prisoners at 64%. Among those without another mental health problem, the rates of dependence or abuse were 53% in local jails, 56% in state prisons, and 49% in federal prisons. The rates of treatment since admission for those with a mental health problem were 17% in local jails, 34% in state prisons, and 24% in federal prisons (James & Glaze, 2006).[i] It should be noted that the data do not exclude those who had mental health

[i] Note that this study used criteria from the DSM-IV, which has since been supplanted by the DSM-5.

symptomology stemming from substance abuse versus a primary mental health disorder, nor do they break down the figures among those who received treatment by individual diseases.

Given that the rates of comorbidity of SUD and other serious mental health issues are so high, attention should be given to the treatment that inmates receive for these other conditions as well. After all, a patient with a serious mental illness is much more likely than someone without one to develop SUD, or to self-medicate with drugs or alcohol instead of taking his prescribed psychiatric medications (Kessler, Chiu, Demler, Merikangas & Walters, 2005). Ideally, treatment in the prison system should be at least up to par with the treatment modalities available outside of it, and theoretically even better, since the lives of prisoners are so well regulated while incarcerated. Unfortunately, this is not the case.

According to one study, between 40% and 50% of inmates who were taking a psychiatric medication at the time of incarceration did not receive any medication in prison. In this same sample, 90% of the respondents were screened at intake, which correlated strongly with being seen by a medical professional, thus increasing medical continuity. The authors posit that the overall lack of treatment continuity is multifactorial, stemming from an increase in prison population without a corresponding increase in prison staff, as well as an incentive for prison administrators to keep mental health classification levels low to save costs related to healthcare (Reingle Gonzalez & Connell, 2014). An increase in funding for these matters by federal and state governments could serve to alleviate the situation, allowing prison staff to base decisions on proper medical recommendations rather than cost considerations.

There are concrete programs that can be implemented right now, provided that the funding and willpower are available, to better address the needs of inmates who struggle with substance abuse. The criminal justice system can offer treatment programs as an alternative to incarceration in appropriate cases, something that is already happening in locales around the nation and that will be discussed later in more detail. Prisons and jails could also provide opioid agonist therapy, such as methadone or buprenorphine, to inmates addicted to opioids (Kolodny & Frieden, 2017). Currently the barriers to prescribing these medications are too burdensome to make this an easy task, which is ironic given the ease with which prescription opioids are prescribed to the public at large. Legislation that counters the actions of the pharmaceutical lobby is the best way to expedite this process.

In addition to their obvious therapeutic effects for the patient, studies have shown that the use of opioid agonist therapy substantially reduces crime-related costs when compared to addicts who are not in treatment (NIDA, 2017). Initiating and continuing opioid agonist therapy for addicted inmates will set them up for greater success upon reentry into society, and likely translate into lower rates of recidivism as well.

This discussion has focused mainly on opioids as the most problematic drugs, and this is indeed the case. Alcohol and benzodiazepines, lethal in both overdose and withdrawal, are also prominent substances. Other street drugs, like PCP, K2, and cocaine, are no less worrisome. Marijuana, less dangerous than the others, is still problematic in terms of the prison population. Federal law still classifies it as an illicit substance, though many states and cities have either legalized or decriminalized it. Still, a person may be found to be in violation of their parole because of possession of marijuana, or arrested

because of it. Neither scenario helps the greater problem at hand. Legislation, increased funding, and adherence to medical guidelines for treatment, rather than cost considerations or moral obligations, are the best ways to ensure proper treatment is delivered to inmates with SUD and other psychiatric diagnoses.

CHAPTER 5

COERCED TREATMENT FOR SUBSTANCE ABUSE DISORDERS

As the opioid epidemic ravages the nation, some have begun to discuss extending the use of the involuntary commitment, which gives the court the power to commit someone to a mandatory stay in a psychiatric facility, to encompass cases of substance abuse as well. The scale of such an undertaking would be enormous, and would surely overwhelm the system, which already cannot keep up with demand. For the sake of discussion, we will assume a scenario in which the government miraculously funds this endeavor, opening up enough new beds for it to be feasible. The ethicality and efficacy of the involuntary commitment for substance abuse would still be in question, even though it would likely remove a large burden from the prison system.

The main ethical dilemma that comes with any involuntary commitment is that of *capacity*. One definition of capacity reads:

> …a person's ability to make a decision. In a medical context, capacity refers to the ability to utilize information about an illness and proposed treatment options to make a choice that is congruent with one's own values and preferences. (Karlawish, 2018)

An important point is that mental illness does not preclude capacity. For example, a person with florid schizophrenia can still have capacity if he is able to provide sound reasoning for his decisions. That same man can be said to not have capacity, however, should he attribute his decisions to command auditory hallucinations. These lines are blurred in the context of substance abuse.

If a person is intoxicated or in acute withdrawal, then his capacity cannot be determined. For a person with a chronic addiction, capacity becomes more difficult to assess. Returning to the definition of SUD, we see that the very nature of the disease is such that a person will often direct his actions towards the ends of obtaining more of the addictive substance, and that this frequently disrupts social and personal obligations. Neurobiological research informs this notion, as the dopaminergic pathways of the brain that involve learning, memory, and reward are "rewired" through substance abuse. Walton and Hall (2017) write,

> Taken cumulatively, these findings describe a pathogenic process by which sustained drug use moves from hedonic to compulsive as the motivation to use shifts from volitional pleasure-seeking behavior to reflexive withdrawal aversion. (p. 389)

Therefore, if a person is thought to be in need of rehabilitation, but refuses, it may be that the courts have the authority to order an involuntary commitment for treatment if that person is unable to provide sufficient reasoning for the refusal, or if it is thought that the refusal is based solely on the grounds of wanting to continue seeking out the addictive substance.

The World Health Organization's consensus view on legally coerced treatment was that it was legally and ethically justified, so long as the patient was given "due process" and effective and humane treatment was provided. Their logic was that without due process, treatment could be considered another form of imprisonment, but without judicial oversight. Without effective and humane treatment, the law could be abused as simply a means of reducing prison populations (Hall & Lucke, 2010).

The physician's obligation to public health is also part of the discussion. Infectious diseases often go hand in hand with intravenous drug use, and stopping the spread of these diseases must involve stopping the routes of their transmission. Diseases like HIV, hepatitis C, and bacterial endocarditis are much more prevalent within the subpopulation of IV drug users than in the general population. Still, patient autonomy must be weighed against these greater goods. Programs such as clean needle exchanges have successfully straddled the gray area between the two, preventing disease transmission while refraining from infringing upon a person's autonomy.

Were coerced treatment the reality today, undoubtedly many more individuals would be in treatment facilities rather than in prisons or jails. Barring ethical questions, the issue of efficacy still looms. Within the psychiatric community, there is still a divide over whether or not coerced treatment is effective in the setting of substance abuse. Some feel that a willingness to accept treatment is a *sine qua non* of true rehabilitation; others disagree. There is some evidence to suggest that coerced treatment does not lessen its effectiveness, and that legal pressure may improve admission and retention rates (Hills, Siegfried, & Ickowitz, 2004). Another study showed that both voluntary and coerced admissions to inpatient rehabilitation facilities were associated with reduced mental distress. At their six-month follow-up, however, the coerced group had mental distress levels comparable to the levels seen before treatment. Active substance abuse was strongly associated with increased mental distress, highlighting the importance of active follow-up after treatment, especially for those who are admitted involuntarily (Pasareanu, Vederhus, Opsal, Kristensen & Clausen, 2017).

Interestingly, the U.S. began experimenting with coerced treatment as early as the 1930s, when the Public Health Service created two hospitals for just that purpose in Lexington, KY and Fort Worth, TX. These programs were specifically aimed at opioid dependence. In the 1960s, trials were also established in California and New York. The trials in the 1930s were largely unsuccessful, and can be mostly ignored today due to advancements in treatment modalities that were not available at that time. The California program did show positive results, however, with reductions in drug use and crime shown to be quicker than with imprisonment alone. The key to their approach was close community follow up after treatment, including frequent urinalysis (Hall & Lucke, 2010).

Coercive treatment for substance abuse would not be without precedent in this country, and with a whole host of treatment modalities, including group therapy and opioid agonist therapy, it offers an appealing gaze into the future of the opioid epidemic. It should be noted that this discussion has focused on coerced treatment in terms of persons who are brought into the criminal justice system only, not in terms of an involuntary commitment petitioned by family members, which is currently a legal option for persons with serious mental illness. Though ethically questionable to some, these concerns can be alleviated by offering convicts the option of choosing treatment over incarceration, and by instilling a fear of being incarcerated for failing to comply with treatment in the future. Perhaps a more appropriate term for this is "semi-coercive." Without funding for such an endeavor, however, this topic will remain largely theoretical.

CHAPTER 6

ALLOCATION OF RESOURCES AND MODELS OF CARE

It has been common knowledge for decades that as deinstitutionalization progressed, the number of mentally ill inmates steadily increased. Though the prison industrial system seems more than willing to accommodate these numbers, which is unsurprising for a largely for-profit industry, it has failed to adequately match the mental health needs of these inmates. Perhaps the prisons are not fully culpable; after all, the prison system in the United States has always leaned towards punishment rather than rehabilitation. It is therefore the government's job to make available the funds and resources needed to respond to the mental health needs of inmates. So much of their freedom is stripped upon intake, and perhaps not always without reason, but to also take away a person's right to adequate healthcare only serves to add an additional injustice to the one initially committed by the criminal. Failing to rehabilitate those inmates who are willing and able, as well as inadequately stabilizing their mental health as necessary, does a great detriment to society. Ideally, prisoners upon release would be more capable than previously of living a proper civic life. High rates of recidivism and a lack of mental health care paint a different picture.

In the Los Angeles County Jail, an estimated 90% of mentally ill inmates are repeat offenders, with 31% having been incarcerated 10 or more times. Inmates with a mental illness also stay longer and cost more. Governments are aware of these problems, but most seem at a loss for solutions to them (Torrey et al., 2010). Florida has been exemplary in this regard. The state government implemented the Criminal Mental Health

Project (CMHP), which aims to divert people out of the criminal justice system and into community mental health treatment. The impetus for this was the soaring costs of housing mentally ill inmates in the prison system. The bill also grants judges the authority to order defendants with a mental illness into treatment, and about 80% of those who are offered this option accept it (Chang, 2016). The CMHP, part of what has become known as the "Miami Model," has gained national attention as an example of what can be done to solve the problem of mentally ill persons getting trapped in the revolving door of the criminal justice system.

The CMHP further breaks down its initiative into pre-booking and post-booking programs, referring to their temporal relation to an arrest. The former includes the Crisis Intervention Team, which is comprised of officers who have received 40 hours of training in recognizing the signs and symptoms of someone who may have a mental illness or be in distress. These persons are then diverted into crisis treatment centers rather than arrested and brought to jail. The New England Journal of Medicine published a piece on the program, writing,

> In 5 years, officers from the two largest police departments have responded to about 50,000 mental health crisis calls that resulted in 9000 diversions to crisis units and only 109 arrests. The average daily census in the county jail system has dropped from 7200 to 4000, one jail facility has been closed, and fatal shootings and injuries of mentally ill people by police officers have been dramatically reduced. (Iglehart, 2016, p. 1702)

The post-booking program allows inmates who show signs of acute psychiatric distress to be transferred to a crisis treatment center (Iglehart, 2016). These initiatives

show that it is possible to work within the existing framework of the prison system to improve outcomes and treatment accessibility for inmates and persons with mental illness who come in contact with the criminal justice system. This is in contrast to a reversion back to the system of asylums and state hospitals that was once the norm.

The American Psychiatric Association Foundation has recognized this as well through its creation of the Step Up Initiative, which seeks "to reduce the number of people with mental illness in U.S. jails" (American Psychiatric Association Foundation, 2016). The initiative is a collaboration of state and local governments that share this common goal. Their website exhibits many of the innovative approaches that these governments are implementing around the nation.

The city of Philadelphia has its own responses in the works as well, funded by a grant from the MacArthur Foundation. The program seeks to divert people with mental health issues and minor parole violations into community based treatment centers, rather than jails. Another program aims to divert people with probation detainers into substance abuse treatment, if needed. A third aspect is a "prescription bridge" that will deliver prescription medications to newly admitted inmates who were either recently prescribed a medication in the community, or who received a medication in the jail previously. The goal of this initiative is to not only provide proper treatment, but to reduce incident rates that can lead to further distress or inmate isolation (Melamed, 2017). Dozens of similar programs can be found all around the nation, and hopefully with the support of the Step Up Initiative, they will continue to grow and serve as examples to other municipalities looking for solutions.

Still, funding for such programs is a barrier to their success. Medicaid is a major source of funding, but in a state like Florida, which declined to expand its Medicaid program under the Affordable Care Act, finding the funds can be tricky. In regards to Miami's CMHP, Iglehart (2016) writes,

> In addition to grappling with inadequate funding, the local mental health system is hampered by fragmented service delivery and poor coordination, which make it difficult to navigate. Some additional funding has been secured from governmental and private sources, but the initiative's success is largely attributable to an effort to structure patterns of service delivery and deploy existing resources in ways that are better aligned with the needs of people coming out of the justice system. (p. 1702)

Barring a major piece of legislation passing into law, which seems unlikely given the current polarized state of the federal government, it seems that reallocation of existing resources and working within previously existing structures is the most pragmatic way of moving forward. Still, the federal government would do well to take note of these smaller scale initiatives and increase funding for them, if they are unwilling to attempt one on their own.

CHAPTER 7

CONCLUSION

Recent decades have borne witness to an expanding prison-industrial complex and an epidemic of addiction, both of which continue to feed into the other. In the wake of deinstitutionalization, our prisons have assumed the role that state hospitals held in generations past, without the adequate funding or resources to accommodate the needs of the mentally ill. Americans have grown used to this problem, and the ever-increasing stratification of society has led to a large portion of the population feeling as though they are unaffected by it. This is of course not the case, as more and more people are swept into the criminal justice system each day, stripping them of their liberties and possibly preventing them from accessing proper mental healthcare. A large-scale shift in public opinion is necessary to remedy this, and may already be in progress.

Cities and states across the nation have begun mounting their own responses to the situation, reallocating resources and working within previously defined institutional structures, rather than waiting for the federal government to act. A major step that can be taken is the implementation of semi-coercive treatment for substance abuse, which would both decrease prison populations and respond to the opioid epidemic at the same time. This would require an enormous amount of funding, however, and does not seem realistic at this point in time. For now, programs such as the “Miami Model” are at the forefront of innovation and can serve as exemplars for the rest of the nation. These initiatives, along with input from the medical community, can begin to reverse the disheartening

trend of punishing citizens who suffer from a mental illness, rather than treating them with the dignity and respect that any patient deserves.

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