Mentally ill and behind bars

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The measure of a country's greatness, Mahatma Gandhi said, should be based on how well it cares for its most vulnerable. Recently, I had the opportunity to work with members of a vulnerable population: men and women who have a mental illness and languish in jails and prisons around the country. My experience was eye-opening and heartbreaking.

Widespread incarceration of the mentally ill in a developed country such as the United States should be a national embarrassment. But this tragedy, which has reached an epidemic level, has been effectively shut out of the national conversation.

The problem has grown, and is enormous

By the estimate of the U.S. Department of Justice, more than one-half of people incarcerated in the United States are mentally ill and approximately 20% suffer from a serious mental illness.[1,2] In fact, there are now 3 times as many mentally ill people in jail and prison as there are occupying psychiatric beds in hospitals.[3] These numbers represent a considerable increase over the past 6 decades, and can be attributed to 2 major factors:

- A program of deinstitutionalization set in motion by the federal government in the 1950s called for shuttering of state psychiatric facilities around the country. This was a period of renewed national discourse on civil rights; for many people, the practice of institutionalization was considered a violation of civil rights. (Coincidentally, chlorpromazine was introduced about this time, and many experts believed that the drug would revolutionize outpatient management of psychiatric disorders.)
- More recently, heavy criminal penalties have been attached to convictions for possession and distribution of illegal substances—part of the government's "war on drugs."

As a consequence of these programs and policies, the United States has come full circle—routinely incarcerating the mentally ill as it did in the early 19th century, before reforms were initiated in response to the lobbying efforts of activist Dorothea Dix and her contemporaries.

My distressing, eye-opening experience

The time I spent with the incarcerated mentally ill was limited to a 6-month period at a county jail during residency. Yet the contrast between services provided to this population and those that are available to people in the community was immediately evident—and stark. The sheer number of adults in jails and prisons who require mental health care is such that the ratio of patients to psychiatrists, psychologists, and other mental health clinicians is shockingly skewed.

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It does not take years of experience to figure out that a brief interview with an 18-year-old who is being jailed for the first time, has never seen a psychiatrist, and suffers panic attacks (or hallucinations, or suicidal thoughts) is a less-than-ideal clinical situation. Making that situation even more hazardous is that inmates have a high risk of suicide, particularly in the first 24 to 48 hours of incarceration.[4]

Other ethical issues arose during my stint in the correctional system: My patients frequently would be charged with prison-rule violations (there is evidence that mentally ill inmates are more likely to be charged with such violations[2]); on many such occasions, they would be placed in solitary confinement ("the hole"), a practice the United Nations has called "cruel, inhuman, and degrading: for the mentally ill[5] and that, in turn, exacerbates the inmate's psychiatric illness.[6-11]

Last, there are restrictions on the types of formulations of medications that can be prescribed, involuntary treatment, and other critical aspects of care that make the experience of providing care in this system frustrating for mental health providers.

Are there solutions?

One way to tackle this crisis might be to insert more psychiatrists and psychologists into the correctional system. A more sensible approach, however, would be to tackle the root cause and divert the mentally ill away from incarceration and into treatment—moving from a model of retribution and incapacitation to one of rehabilitation. For example:

- Several counties nationwide have adopted diversion programs that include so-called mental health courts and drug courts, with encouraging results[12]
- Police departments are establishing Crisis Intervention Teams
- Assisted outpatient treatment programs are growing in popularity.

Far more needs to be done, however. In the absence of a national debate on the problem of the incarcerated mentally ill, there is real risk that this population will continue to be ignored and that our mental health care infrastructure will remain inadequate for meeting their need for services.

Clinical Point

There is real risk that the needs of the incarcerated mentally ill in this country will continued to be ignored

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