The Bill Blackwood
Law Enforcement Management Institute of Texas

County Jails: The New Generation of Mental Hospitals

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ABSTRACT

The process of de-institutionalizing the mentally ill merely redefined the role of caretaker and protector. Once the mental hospitals began disgorging patients to the streets, the law enforcement community was forced to assume the position of monitor and guardian for an exploding population of people with very different wiring. Many mentally ill individuals run afoul of the law and end up in jails or prisons, which for all practical purposes, has replaced the mental hospital as the primary caregiver to this segment of the population. This is not the role of law enforcement, but it is one that has been thrust upon the profession.

As of midyear 2005, 64% of inmates housed in local jails nationwide have a diagnosable mental health problem (United States Department of Justice, 2006). This figure has been rising steadily since the mental hospital began the process of attrition, and the largest jails in the country are now the largest mental hospitals. The focus of this paper centers on the ability of the county jail and corrections personnel to effectively manage the needs and safety of the severely and marginally mentally ill. The county jail should not be the locus of treatment for these unfortunate people, but it is often the only safe alternative available.

The method of inquiry included a review of pertinent literature and a survey of five jails with varying inmate population. Results of the research completely supported the premise that law enforcement should not be the primary venue for managing the mentally ill, but there is little else available. The fate of the mentally ill should rest in the hands of those most qualified to help them; however, the opportunities are exceedingly limited. Community based partnerships consisting of law enforcement, psychiatrists,

and medical personnel have met with success in areas of the country willing to spend the necessary dollars for proper housing, qualified staff, post incident care, and follow-up. Mental health courts and crisis intervention training have proven successful in communities where the programs have been implemented (Texas Department of State Health Services, 2006).

In areas where these services are not available, the mentally ill are predominantly subject to incarceration first and mental assessment later. Jails are overcrowded, corrections officers are not properly trained to interact with inmates that have mental health issues, and mentally ill inmates are victimized by other inmates due to lack of special needs housing. While the numbers of beds in psychiatric hospitals continues to dwindle, the number of prisons being built is on the rise. Many county jails are considering expansion, and several have completed significant additions to increase available bed space. According to Faust (2003), “Failure to treat people before they enter the criminal justice system is a major reason for the increase in jail populations” (p. 2). In order to cope with the population increase, many county jails must consider expansion. In essence, the state has simply traded one institution for another: a psychiatric facility for a jail, a state prison for a state hospital.

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INTRODUCTION

History will most certainly judge each generation as to how well it cared for those who are unable to care for themselves. One of the issues plaguing society for centuries concerns the humane care and proper medical treatment of the seriously mentally ill. In 1955 and 1965, two significant events occurred that forever changed the fate of hundreds of thousands of seriously mentally ill (SMI) in this country. In addition to the effects on the mentally ill, these events had a profound impact on local law enforcement agencies and detention facilities. In 1955, the first effective antipsychotic drug, Thorazine, was introduced on a large scale with more than satisfactory results. In 1965, the federal government enacted the Medicaid and Medicare programs, which facilitated the availability of medical care for anyone not able to afford it. These two events provided the leverage the federal government needed to pursue what they believed to be more humane and community based care of the mentally impaired members of society. The policy that evolved from these events is known as *deinstitutionalization* (Torrey, 1997). Torrey (1997) defined deinstitutionalization as the "name given to the policy of moving severely mentally ill people out of large institutions and then closing part or all of these institutions; it has been a major contributing factor to the mental illness crisis" (p. 8).

This "crisis" not only placed an inordinate amount of strain on social service agencies, but it significantly impacted community law enforcement as well. Many of these people lacking other caretakers or means of financial support migrated from hospitals into the streets without medication or psychiatric help, and for various reasons, they found themselves in trouble with the law. Forty-two years later, the criminal justice

system is still struggling with the aftermath of deinstitutionalization. Police officers deal with the mentally ill daily. Frequently the extent of impairment is obvious, but it is often clouded by alcohol and/or drugs. It is not always immediately evident whether the offender is simply intoxicated or has more debilitating issues. The officer on the street must establish whether or not the individual is a danger to themselves or others. Once the officer confirms the criteria, the individual is taken into custody and usually transported to the local jail facility.

Once in the jail setting, the offender is now thrust into a totally alien environment where they are rarely emotionally capable of responding to the requirements of uniform and compliant behavior. Corrections officers typically lack the level of training needed to effectively evaluate the mentally ill during the intake process. This often places the offender in jeopardy when they are mixed with general population inmates. Many jail facilities do not have proper observation or assessment housing designed to protect the offender while medical and psychological evaluations are being conducted. In addition, many jails do not have the space available to safely house the mentally ill once they are evaluated and a treatment protocol is in place (Sowers, Thompson, & Mullins, 1999).

The burden of the mentally ill places a mandated and underfunded strain on law enforcement and detention facilities. The cost is high, not only in dollars, and it significantly affects manning requirements. The offender who suffers from mental illness must be handled carefully, both on the street and in the jail. This requires time, patience, and the ability to establish a communication process with the offender on a level they comprehend and perceive as non-threatening. Although law enforcement and detention has inherited the role abandoned by the state hospitals, this is not the

role the police or corrections officer was trained for (Texas Department of State Health Services, 2006).

The focus of this paper will center on the inability of county jails and corrections personnel to effectively manage the needs and safety of the severely mentally ill during incarceration. For the purpose of this paper, SMI is stipulated as any diagnosable psychiatric disorder such as schizophrenia, bipolar disorder, severe depression, mental retardation, or any form of developmental disability that interferes with the ability to function independently in society. This will require examining several issues and defining the risks associated with intake procedures, medication administration, staff training, and special needs housing. The methodology employed to examine this issue included a review of the literature and a survey instrument of various sized jail facilities.

The conclusions reached will no doubt support the premise that law enforcement is not the instrument of choice for handling the problems of the mentally ill. This is not the mission of law enforcement or corrections and should not be the primary venue for solving this problem. The fate of the mentally ill should be in the hands of those most qualified to help them. Community partnerships need to be established and funded to generate appropriate interventions and long-term housing for the mentally ill. The criminal justice community and mental health professionals need to evaluate the need to either expand or increase specialized incarceration facilities for this population or revamp the mental hospital environment.

REVIEW OF LITERATURE

In September of 2006, the United States Department of Justice published startling statistics regarding prison and jail inmate populations. The report stated that as

of midyear 2005, over half of all inmates in federal, state, and local detention centers had a diagnosable mental health problem. According to the study, a staggering 64%, or 479,900, of these individuals are housed in local jails across the country (United States Department of Justice, 2006).

These numbers come as no surprise to corrections personnel who must ultimately manage this problem population. Since the process of deinstitutionalization began in 1955, the county jail has become the local mental health facility, and the corrections officer has been forced into the role of ward attendant. The influx of the mentally ill into jails is directly proportional to the decrease in available bed space in state hospitals. In Texas today, there are only 2,477 beds for the mentally ill. Of that total, there are 738 forensic beds, which are beds allotted for patients ordered there by the criminal courts. This leaves a total of 1,739 beds for the remaining mentally ill patients statewide (Padilla, 2007). The crisis is nationwide, and according to Faust (2003), “In virtually every county in the nation, the county jail holds more people with severe psychiatric illness than any psychiatric facility in that county” (p. 1). The fact that the mentally ill are creeping back into the corrections environment at an alarming rate is causing county facilities to look for other alternatives to incarceration, but little progress has been made due to lack of funding and other resource limitations (Texas Department of State Health Services, 2006).

In recent years, the impetus to de-criminalize the mentally ill has focused on crisis intervention training for police officers and mental health deputies and mental health courts designed to move the SMI pre-trial detainee into a health care protocol rather than jail (Texas Department of State Health Services, 2006). These programs

evolved in part from concerns that if police officers were spending countless hours dealing with the mentally ill, they would not be able to effectively protect the lives and property of others. Litigation and public outcry elicited by violent encounters between the seriously mentally ill and police officers also played a pivotal role in re-evaluating how law enforcement dealt with this group of people. Crisis intervention training provides police officers with a different set of tools needed to effectively manage interaction with these "consumers," since the process taught in the academy may not be the best approach for this segment of the population. All of these programs have merit and a certain level of effectiveness, but none address the underlying problem that mandates treating these people before they run afoul of the law (Faust, 2003).

The majority of mentally ill offenders find their way into the criminal justice system for misdemeanor offenses like public intoxication, criminal mischief, or trespassing. More often than not, the arrest is the result of a family member being repeatedly plagued by the offender's behavior and not having the means or skills to cope. Occasionally, the offender's behavior becomes extremely violent, and the police are called to protect the family member (Faust, 2003). In many cases, the offender serves a minimal sentence and is either discharged with a personal recognizance bond or serves the time. This is the beginning of a cycle that often generates multiple arrests, repeated exposure to law enforcement, and frustration for the police having to handle this offender on a routine basis. With each arrest, it becomes easier to transport the offender to jail than to initiate the lengthy process of obtaining a mental health assessment. It is also safer than leaving the individual to the mercy of the street. Many

of the transient mentally ill feel secure in jail where they have warmth, food, and company (Torrey, 1997).

Once in jail, the mentally ill offender faces and creates numerous serious problems. Because of their condition, they are less able to comprehend the unspoken politics of inmate life. One thing is certain; they will be at the bottom of the established pecking order. Issues like self-control, diplomacy, and tact are not typically high on their level of skills, and they soon become victims of ridicule, bullying, and assault, both physical and sexual. If the mentally ill are left in general population, food, hygiene supplies, and medication may be confiscated by other inmates, which creates additional management problems for corrections officers.

Medicating the mentally ill inmate presents a different and multi-faceted set of problems. The medical staff must ensure the inmate is taking the prescribed medication, and the corrections officers must be able to tell if the inmate is off his or her medication. Often, the other inmates in the unit coerce the mentally ill inmate to give up the medication, and they will ingest the drug. This alone may have devastating effects such as overdose, allergic reactions, or dangerous drug interactions. Special care is needed to ensure the inmate prescribed the drug is not hoarding quantities for a possible suicide attempt. Another concern arises when inmates refuse to take medication prescribed to stabilize behavior. When the mentally ill inmate refuses to take his or her medication, demeanor and behavior may go from placid to extremely violent, forcing the staff to intervene in dangerous confrontations. The behavior of the SMI offender may be so disruptive or offensive that cell members may attack the irritating inmate, believing brute force to be the best form of behavior modification. This is seldom successful, and

the SMI offender often continues with the unwelcome behavior until he or she can be relocated.

This type of unstable atmosphere puts additional burdens on the corrections officers who must maintain control of the jail population at all times. Corrections officers also have a duty to be concerned regarding inmate safety and to act when an inmate is being mistreated by cellmates. Corrections officers are typically hired with little experience and are usually trained on the job by senior officers. Emphasis is usually placed on the rules and regulations inmates are expected to follow as well as facility policy and procedures. Corrections officers do receive more formal classroom training, but the bulk of it focuses on dealing with the typical rather than atypical inmate. Input from the medical staff is limited, and, often, there is little transfer of information regarding diagnostic or treatment issues of the SMI due to privacy issues. Consequently, inexperienced and insufficiently trained officers are handling some extremely difficult behavioral situations (United States Department of Health and Human Services, 2006.)

Most jails are not physically designed for housing the SMI. The jail, by its very nature, is constructed to house as many inmates as is feasible and safe for all concerned. It was not designed for medical or psychiatric purposes, but rather for detention. A crisis develops when a mentally ill inmate must be isolated for his or her safety and the safety of the other inmates. Placing a severely mentally ill or developmentally disabled inmate in segregation is not only dangerous, it can be counterproductive to stabilizing behavior. Segregation often exacerbates depression and can lead to suicide. Segregation cells are not safe or therapeutically sound for the

mentally ill inmate. Unfortunately, this is the only option many jails have due to bed limitations in infirmaries or lack of specialized housing just for the mentally ill (National Mental Health Association, 2005.)

The county jail housing anywhere from 48 to 500 inmates does not typically have the asset base to provide medical and psychiatric personnel to perform intake evaluations on inmates. Corrections officers usually complete these assessments during the booking process. Consequently, an inexperienced or untrained officer may not recognize behaviors that trained personnel may pick up on immediately. Having corrections officers conducting these evaluations is dangerous for the inmate and the jail administration. It is a liability disaster waiting to happen (United States Department of Health and Human Services, 2006.)

The literature on the plight of the mentally ill and developmentally disabled in the criminal justice system is extensive. The consensus of opinion confirms that it is not beneficial to the individual or the system to keep running the mentally ill through the criminal justice system. Incarceration is not synonymous with treatment and therapy. Corrections personnel are not sufficiently trained to interact effectively with mentally ill inmates. Jails and prisons are not conducive to healing the fractured mind or the tortured soul (Faust, 2003).

METHODOLOGY

The research question to be examined considers whether or not county jails are appropriate environments for housing and effectively stabilizing the seriously mentally ill. There is an enormous repository of published information related specifically to this topic. The consensus of these publications, both from a law enforcement and

psychiatric management perspective, affirm that jails and prisons are definitely not the place for the seriously mentally ill. Several significant works on this topic will be included in the research.

The researcher hypothesizes that the county jail is an inadequate venue for effectively managing the seriously mentally ill for several reasons. Corrections officers in general are not adequately trained in effective interaction and management of the seriously mentally ill. Many jails are not able to provide separate and specialized housing for this type of offender due to budgetary restraints, manpower issues, and space limitations. Those jails that have a qualified medical and psychiatric intake staff are not the norm, especially in facilities of less than 1,000 beds. Local communities are hesitant to commit money, manpower, and time to establishing a holistic approach to taking the mentally ill off the street and keeping them out of jail.

The method of inquiry will include a review of the literature on the topic of the incarcerated mentally ill. Research methods relating to the topic will also incorporate various journal articles, studies, bulletins, and statistical evaluation documents available through electronic media sources. Supplemental data will be provided via a telephone survey employed to garner data from county jails of various inmate populations across the state.

The instrument to be used to obtain a sampling of data in support of the research hypothesis that the county jail is an inadequate environment for the seriously mentally ill is a basic telephone opinion survey. The survey will be given to five jail facilities ranging in maximum inmate population from 150 to 1,106. The target interview will be with medical personnel who typically have a broader perspective of the problems affecting

mentally ill inmates. In the event medical personnel are unavailable, those involved with corrections officer training will be interviewed.

The size of the survey will consist of eight questions designed to support or contradict the review of literature and anecdotal information assembled by the researcher. The respondents will be selected based on jail population and location across the state of Texas. The survey questions will address institutional size, housing design, training, and community involvement. The questions will be designed to establish a response comparison between small and large jails, which the researcher believes has a proportional relationship to positive or negative answers regarding the ability to manage SMI inmates.

The response rate to the survey instrument resulted in a unanimous but not unexpected concern for the plight of the SMI being held in county jails and the effect on corrections personnel. All five agencies queried were eager to provide the requested information and share anecdotal information regarding some of their cases. Surprisingly, the “proportional relationship” referred to in the last paragraph did not materialize. There was no difference in responses regardless of how large or small the facility.

The information obtained from the survey will be analyzed by assessing the respondents’ answers and comparing the results to the literature reviewed. The information obtained will be used to either validate or contradict the argument that jails are not appropriate detention centers for the seriously mentally ill. The information gleaned from the survey and associated literature will be used to further strengthen a

course of action to better serve the needs of the seriously mentally ill in communities across the state.

FINDINGS

The purpose of the survey was to attempt to validate anecdotal information and data obtained from the review of literature regarding the research hypothesis. The questions posed were designed to ascertain if jail personnel, regardless of agency size, felt a certain inadequacy in providing proper care to SMI inmates. The first question established the population of the jails included in the study. The five respondents housed 150, 190, 337, 598, and 1,106 inmates respectively. The sample was taken from jails scattered across the state of Texas and targeted a variety of demographics. In addition, all respondents interviewed were medical personnel.

The second question posed to the respondents determined if the facility had special or separate pre-housing detention for the mentally ill. Regardless of facility size, none of the five respondents had a separate detention area to detain the mentally ill offender during the intake evaluation process. The mentally ill offenders were isolated from others in holding cells whenever possible, but due to space restrictions, they were often relegated to violent criminal cells for overall safety concerns.

The third question inquired as to whether or not the facility offers special or separate housing for the mentally ill. Again, all five respondents stated that they had no special housing units designated specifically for the mentally ill inmate. Two of the five responding agencies stated that, occasionally, regular infirmary beds have been utilized for the mentally ill. The medical personnel were not comfortable with this arrangement

because there is no way to completely isolate the mentally ill inmate from other inmates requiring the use of the infirmary.

Question number four addressed the availability of specially trained officers or mental health professionals on staff to evaluate the mentally ill offender at intake. Only one of the five jails had a full time medical staff whose job it is to assess all incoming offenders for medical and or psychological issues. The other four jails utilize corrections officers and pre-printed assessment forms for this purpose.

When asked if they believed their corrections officers are adequately trained to deal with mentally ill inmates, all five respondents stated their officers were not adequately trained and often experienced difficulty communicating with this inmate group. The majority of respondents felt that many corrections officers were afraid to have any contact at all with mentally ill inmates. The respondents believed this fear stemmed from lack of previous exposure to this group as well as a lack of specialized training on how to interface with the mentally ill.

Question number six posed a hypothetical query regarding specialized training. Police officers are required to complete crisis intervention training as mandated by the Texas Commission on Law Enforcement Officer Education and Standards. This is to better prepare the street officer to interface with the mentally ill offender. By contrast, corrections officers who deal with the mentally ill for longer periods of time, and on a more intense level, are not required to have any specialized training. When asked if the respondents would support development of an intermediate level core course or any course specific to working with mentally ill inmates for corrections personnel, the response was a unanimous “yes.”

All five respondents agreed that jails and prisons where not appropriate environments for housing the mentally ill offender for either long or short term. All five respondents agreed that the recidivism rate with some of the better known consumers in their areas was frustrating and discouraging. The same offenders continue to present with progressively more serious offenses until they are again released or moved to state prisons.

The last question addressed the existence of any local programs in place to divert the mentally ill from jails into a community based intervention program. All respondents stated that they relied on local mental health and retardation chapters but had no specific intervention or diversion programs. All respondents were aware of jail diversion programs in other areas of the state and expressed the desire to have one implemented in his or her respective area.

DISCUSSION/CONCLUSIONS

The problem or issue examined by the researcher considered whether or not county jails were adequately equipped to manage the continued influx of seriously mentally ill inmates. Based on the volume of available literature covering this subject, the research established that funneling the SMI through the criminal justice system remains a significant problem in society today. Seriously mentally ill inmates housed in county jails and state prison systems continue to rise at alarming rates. The number of successful jail diversions and community intervention programs are slowly increasing, but the need is still far greater than available assets.

The purpose of this research was to support the argument that jails and corrections officers are indeed not appropriate venues or caretakers for the housing and

supervision of mentally ill inmates. The review of literature and survey instrument confirmed that jails are a poor choice for housing mentally ill offenders. Specific reference was made to the lack of proper training for corrections officers, poorly designed jail facilities, predatory inmates, lack of full time medical and psychiatric staff, and the very nature of the regimented jail environment.

The research question that was examined focused on the practicality of law enforcement to continue to manage the behavior and care of the mentally ill offender in lieu of an alternative custodial environment. It is quite possible that jails and prisons will continue evolving into the new generation of mental hospitals. In light of this possibility, it is important to consider issues that can negatively impact the mentally ill in traditional detention facilities. Presently, the jail environment is not therapeutically appropriate for these special needs offenders and can be detrimental to the inmate's well being. Many jails may not be physically designed for safe management of the mentally ill offender. There may not be an adequate number of trained medical and psychiatric personnel available for proper management of the mentally ill offenders. Finally, and perhaps most critically, there is a need for corrections officers to be properly briefed and trained on managing this type of inmate population.

The researcher hypothesized that the problems faced by the mentally ill offender in jails and prisons posses a commonality regardless of facility size or location. In addition, the corrections officers charged with the care, custody, and control of this population are often lacking proper training that would facilitate better management of this inmate population. The researcher also believed that jails and prisons have become

an ever increasing repository for the nation's mentally ill for lack of any other appropriate custodial environment.

The researcher concluded from the findings that the number of seriously mentally ill inmates is steadily increasing and will continue to grow if alternative placements are not developed. The literature, survey, and anecdotal research reflected significant concern nationwide by law enforcement leaders that the profession is not equipped to assume the responsibility of psychiatric management of offenders. It is agreed that this role has been thrust upon them, and adjustments must be made for the protection of police officers, corrections officers, the public, and the mentally ill offender as well.

The findings of the research did support the hypothesis. The reason why the findings did support the hypothesis is probably due to the constant entry and re-entry of seriously mentally ill into the corrections environment. Despite the establishment of mental health courts, community intervention, and jail diversion programs, the mentally ill still slip through the cracks and become a law enforcement problem. The issue of what law enforcement needs to do with the mentally ill began developing in the mid 1960s, but it has been recently exacerbated by the increase in homelessness, unemployment, and general economic downturn.

The size of the research sample (five jails) may be considered a limitation since there are many jails and prisons in the state of Texas. However, the researcher tried to access a variety of jails based on location in the state and size of the inmate population. Due to the highly publicized nature of this topic, there were no other apparent limitations that might have hindered this study as all survey responses supported cited literature.

All survey respondents where extremely cooperative and qualified answers with multiple examples of issues encountered in his or her facility.

The study of jails evolving into the new generation of mental hospitals is relevant to contemporary law enforcement because it is an ongoing problem with no immediate solution. The number of mentally ill offenders continues to grow significantly and alternative custodial environments are extremely limited. The corrections facilities will continue to see an increase in inmates with mental impairments due to the economic crisis the country is now experiencing. The mentally ill rendered homeless and jobless will be on the streets, and this will raise the probability of law enforcement encounters. This, in turn, will increase the number of arrests for misdemeanor offenses, which will initiate the revolving recidivism that so often plagues the mentally ill offender.

Law enforcement and corrections management would stand to benefit by exploring the results of this research. The research paints a rather bleak picture of a problem that will continue to grow and mushroom, but there are solutions that can be applied on several levels. When jail administrators have the option of building or re-modeling a facility, special care should be given to designing separate housing areas appropriate for the mentally ill or developmentally disabled. The space need not be large, but it should be designed for the safety of the special needs population. Whenever possible, medical and psychiatric personnel should be available for inmate intake assessments. This important task of assessing medical and mental health should not be relegated to floor or booking officers. Corrections officers must have more extensive training in dealing with the mentally ill offender. Mental health officer training is available to jailers, and it should be pursued by as many corrections personnel as is

practical. Corrections supervisors must monitor staff to evaluate interactions among officers and mentally ill offenders. It is imperative that the floor officer be vigilant and prevent, at all costs, the abuse of the mentally ill or developmentally disabled by other inmates. Supervision of medication disbursement must be reinforced constantly. Medical and floor staff should work together to ensure that medication for the mentally ill is disbursed and consumed properly.

In addition, physicians, governmental agencies, mental health professionals, and law enforcement must continue to develop crisis intervention and jail diversion programs in communities. This requires professionals from all affected agencies to evaluate and seek available assets to dedicate to this cause. Most importantly, communities must recognize that the plight of the mentally ill is not the responsibility of just one group. The responsibility must be shared and distributed to those who can properly care for the seriously mentally ill. Historical research has demonstrated that the crisis of the mentally ill cannot and should not be the burden of the law enforcement profession alone.

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APPENDIX

Survey Instrument from Sgt. Margaret Smith
Comal County Corrections division
County Jails: The New Generation of Mental Hospitals
Results to be used for inclusion in Law Enforcement Management Institute
Leadership Command College ARP

Agency: _____
Contact: _____

1) What is the total number of beds in your facility?
_____

2) Do you have special or separate pre-housing detention for mentally ill?
_____

3) Do you have special or separate housing for mentally ill?
_____

4) Do you have specially trained officers or mental health professional on staff to evaluate inmates that exhibit mental illness?
_____

5) Do you believe your corrections officers are adequately trained to deal with mentally ill inmates?
_____

6) Would you support a TCLOESE mandated intermediate core course for C.O.s to better manage mentally ill inmates?
_____

7) Do you believe jail or prison is the appropriate place for housing the mentally ill?
_____

8) Do you have any local programs used to divert mentally ill offenders from jail to facilities designed to help the mentally ill?
_____