

Emptying the 'New Asylums'



A Beds Capacity Model to Reduce Mental Illness Behind Bars Executive Summary

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A BEDS CAPACITY MODEL TO REDUCE MENTAL ILLNESS BEHIND BARS

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EXECUTIVE SUMMARY

In 2016, nearly 400,000 inmates in US jails and prisons were estimated to have a mental health condition. Of those inmates, an estimated 90,000 were defendants who had been arrested and jailed but had not come to trial because they were too disordered to understand the charges on which they were detained.¹ All but three states authorize evaluating the mental competency of such offenders within the jails or in the community,² and some states authorize treatment to restore competency outside a hospital. Yet, America's state hospitals remain the default option for providing pretrial mental health services to criminal defendants.³

The term *mentally ill* is used to describe criminal detainees with serious mental illness in this study by design. Person-first usage would render these defendants inmates first, mentally ill second. In reality, the vast majority of pretrial offenders who require competency services become ill first, then inmates, a critical distinction we believe will not be addressed unless it is frankly recognized.

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Beds in these hospitals are in dire and chronic short supply. After climbing to a peak of 337 beds per 100,000 persons in 1955, the movement to “deinstitutionalize” mental illness drove the state hospital bed population to 11.7 per 100,000 by early 2016.⁴ Although community and private hospitals expand the total universe of inpatient options for psychiatric patients somewhat,* their beds are largely occupied by insured patients who have voluntarily sought care. Patients referred by the criminal justice system typically are not eligible to use them.

The most widely recognized direct result of bed shortages is the virtually universal phenomenon known as “boarding” — the practice of holding psychiatric patients for extended periods in hospital emergency departments (ED) until beds become available. Bed waits by mentally ill detainees in jails are the forensic equivalent, and they are nearly as widespread.

State hospitals dedicate an increasing percentage of their beds to the inmate population, but demand outstrips supply. As a result, the majority of state hospitals maintain bed-wait lists of inmates who have been court-ordered or otherwise referred for incompetent to stand trial (IST) services.⁵ In most states, these waits are around 30 days, but three states have reported forensic bed waits of six months to a year.⁶ In a sample of 25 states for its 2016 state hospital bed survey, the Treatment Advocacy Center found that 75% (18) of the states wait-listed pretrial detainees, and nearly 2,000 pretrial inmates were on waitlists in those states.⁷

Historically, state hospitals were called “asylums” because they were associated with long-term care and protection.^{8,9} Incarcerating pretrial and convicted criminal offenders with serious mental illness is so common today that jails and prisons are routinely called the “new asylums.” They are anything but protective.

Behind bars, inmates with mental illness are at heightened risk for victimization, including assault and sexual abuse. They are also more likely to attempt or complete suicide, which is the leading cause of death in US jails.¹⁰ And the number of inmates with mental illness is growing, particularly among those awaiting IST services. In 2016, the population of pretrial

* The US government does not report psychiatric bed data in a format that makes it possible to determine the complete and comprehensive population of private and public mental health beds in America.

detainees with mental illness was estimated to have grown 32.5% in Wisconsin, 76.3% in Washington, 90.0% in Oregon and 350% in Los Angeles County over varying stretches of the 21st century.¹¹ In 2015, Colorado reported a 500% increase in referrals to the state hospital for pretrial competency evaluations over a 10-year period. Many states report that the largest category of patients they serve in their hospitals are pretrial defendants who have been found IST.^{12,13}

Increasingly, the courts are ruling the waitlisting of these detainees to be illegal. Since January 1, 2014, public agencies and officials in more than a dozen states have been sued or threatened with legal action for violating the constitutional rights of pretrial prisoners (see Appendix A: Litigation Associated with Pretrial Forensic Bed Waits). In Alabama, for example, the American Civil Liberties Union is suing the state mental health commissioner over bed waits that average eight months for unconvicted detainees.¹⁴

All the while, the mentally ill inmates themselves languish, deteriorate further and sometimes die behind bars as they wait for a bed to open in the “old asylums.”

Emptying the ‘New Asylums’ was undertaken to apply queueing theory (the study of waiting) to the forensic bed emergency as a means of projecting the impact of changing specific public policies and practices on forensic bed waits in jails. Computer modeling offers a mathematical approach to examining systems as they exist and then projecting the results of introducing small changes into those systems. For this study, the Treatment Advocacy Center contracted with the University of North Carolina (UNC), where researchers had developed a discrete-event simulation model to project the number of civil beds needed to reduce hospital ED boarding in one region of the state. For *Emptying the ‘New Asylums,’* UNC developed a forensic bed-wait model based on queueing theory, a branch of mathematics that deals with the study of waiting lines or queues. The model was applied to forensic bed-wait data collected by the Treatment Advocacy Center from a five-state sample: Florida, Maine, New Jersey, Texas and Wisconsin.

The results of this undertaking show how forensic bed waits can be reduced to either three days or to 14 days by changing only one of three variables:

- Demand for beds represented by mentally ill inmates being added to waitlists
- Average lengths of stay for forensic patients receiving pretrial competency services
- Supply of staffed beds available to provide those services.

The model validates that relatively small changes to specific variables that are determined or influenced by public policy could significantly reduce forensic bed waits. The following examples illustrate the outcomes projected by modeling data from the sample states:[†]

- Diverting two mentally ill offenders per month from the criminal justice system in Florida reduced the average forensic bed wait in the state by 75%. From an average wait of 12 days in early 2016, the average wait fell to three days.
- Reducing the average length of stay for competency services by less than 2% in Texas — from 189 to 186 days — increased forensic bed capacity sufficiently to reduce bed waits from 61 to 14 days.
- Increasing the number of forensic beds by 11% in Wisconsin — from 70 beds to 78 beds — reduced IST bed waits from 57 days to 14 days.

[†] Projections are based on data collected from Florida, Maine, New Jersey and Texas in early 2016 and from Wisconsin current to September 1, 2016. They serve as examples but will not correlate with data that have changed in the interim or with more detailed data that were not included in this model.

This model demonstrates the direct and dramatic relationship between bed supply and forensic bed waits. Especially in states where psychiatric beds exist but are not occupied because they are not staffed, it suggests that merely opening existing beds could immediately reduce waitlists and their human and economic costs without expanding psychiatric facilities.

Assessing the net public costs associated with changes such as these was outside the scope of the study. Given the high cost of incarcerating offenders with mental illness,¹⁵ the direct and indirect costs that result from bed shortages, and the legal costs incurred by states defending themselves against constitutional challenges over forensic bed waits, such analysis would be useful. In the meantime, it does not require advanced economics to conclude that staffing existing beds is more economical than building new ones or that diverting people in psychiatric crisis out of the criminal justice system is cheaper than jailing them. The IST bed capacity model described in this paper not only validates that small changes to selected variables could reduce forensic bed waits, it suggests that these waits could be reduced for a relatively modest investment compared with the status quo.

Modeling is no road map for escaping the psychiatric bed shortage. Pretrial detainees with mental illness are just one of the populations affected by bed shortages. Reducing their need for beds still leaves untold numbers of convicted inmates with mental illness incarcerated without treatment, as well as countless nonforensic patients waiting in or turned away from hospital emergency rooms because of civil bed shortages.

Additionally, being hospitalized to restore legal competency is not to be confused with inpatient treatment to achieve long-term wellness, recovery from mental illness symptoms or successful re-entry into the community.¹⁶ Criminal defendants have an inalienable right to understand the proceedings against them and to assist in their own defense. IST services[‡] are designed to assess that capacity and, if lacking, restore it to the point that defendants understand why they are being tried and can participate in the proceedings against them. Legally unrelated to the defendant's mental condition at the time of the charged crime, "competency" in this context is a famously low bar. In many jurisdictions, a defendant's ability to answer "Yes" to the question, "Do you understand the charges against you?" is enough for a court to find a defendant competent, assuring that only individuals with the most profound illness are found incompetent and hospitalized for competency restoration.

Nonetheless, IST services are an urgent issue for the inmates whose criminal proceedings cannot move forward and for the state health care and criminal justice systems struggling to keep up with the growing tide of pretrial detainees with serious mental illness. Anecdotes abound of law enforcement using "mercy bookings" into jail to get people in psychiatric distress off the streets and of judges ordering IST services because no other treatment options are available.^{17,18} Being held behind bars while so disordered that IST services are needed is unhealthy for criminal detainees in psychiatric crisis, most of whom have been arrested for minor, nonviolent crimes.¹⁹⁻²¹ At the same time, turning jails into asylums requires corrections personnel who are not mental health professionals to perform mental health management activities,²² exacerbates jail overcrowding and mass incarceration,²³ and adds an arrest record to the already daunting obstacles individuals with serious mental illness face in finding housing and jobs.

[‡] Competency evaluation and restoration are also referred to in some states as not competent to stand trial (NCTST), incompetent to proceed to trial (IPT) or other terms. The more widely used IST is used in this study for all otherwise-named services with the purpose of evaluating or restoring competency to stand trial on criminal charges.

Boarding psychiatric patients in community hospital emergency rooms has been called “the canary in the coal mine” of America’s bed shortage.²⁴ Forensic bed waits are the canary’s mate.

There is no fast or easy fix for the mental health system failures that have taken half a century to develop. In an ideal world, individuals with acute or chronic psychiatric distress should not have to worry about wait times in jail for mental health beds because they would receive timely and effective treatment when they needed it and jail diversion when their symptoms led to criminal justice involvement. Under current less-than-ideal circumstances, reducing inmate bed waits and ED boarding will require implementing a combination of strategies that reduce forensic bed demand, increase bed supplies or both.

Computer modeling offers policymakers and mental health officials a mathematical tool for developing evidence-based policy and practice to break the logjam of inmates with mental illness who are unable to come to trial because they are too sick. Although it would not address the hospitalization needs of the other populations, this step alone could moderate the nation’s bed shortage, reduce mass incarceration of people with mental illness and make existing beds available to more patients.

That would be a start.

RECOMMENDATIONS AND CONCLUSION

Pretrial forensic bed waits are only one symptom of the nation's dysfunctional mental health system. Eliminating all the symptoms will require far more comprehensive changes than this study addresses. For example, evaluating legal competency and restoring it in the community, rather than in state hospitals, is a worthy goal, but half the counties in the United States have no mental health professionals to provide such services. The psychiatric personnel shortage thus exacerbates the psychiatric bed shortage. Telemedicine might address both shortages but remains to be licensed or tested. Elsewhere in the system, moving some chronically ill or ready-to-discharge patients from state hospitals to appropriate residential settings would relieve intensive-care bed shortages, but those settings are few and far between.

Nonetheless, by enacting the 21st Century Cures Act in 2016, Congress and the White House signaled that serious mental illness is, at last, a national priority. They need to follow through by moving swiftly to implement the bill's provisions. States and the federal government should build on this foundation with additional reforms to further improve treatment for serious mental illness and decrease its criminalization. Especially in today's cost-conscious environment, policies and practices of modest cost and enormous potential may offer an opportunity to improve lives and communities and ultimately save money doing it.

State Recommendations

To reduce forensic bed waits and the human and economic toll they take, the Treatment Advocacy Center makes the following recommendations to state policymakers.

- **Reduce forensic bed demand before and after arrest** by expanding the use of diversion practices that have proven effective in keeping at-risk individuals with serious mental illness out of the criminal justice system. These include but are not limited to the following:
 - *Pre-arrest practices*, such as assertive community treatment (ACT)/forensic assertive community treatment (FACT), assisted outpatient treatment (AOT), Crisis Intervention Team (CIT) training, mobile crisis teams and other interventions that diminish or de-escalate encounters between individuals with mental illness and law enforcement
 - *Post-arrest practices*, such as expanded use of community-based competency evaluation and restoration, the Miami-Dade model of diverting mentally ill offenders to dedicated recovery-oriented facilities and mental health courts for qualifying offenders
 - *Post-competency practices* that stop the practice of sending forensic patients deemed competent back to jail, where they are at risk to deteriorate and be rehospitalized — for example, by releasing misdemeanor and nonviolent offenders into the community to await trial with ACT/FACT and/or AOT support and by discharging patients to immediate trial rather than back to jail
- **Examine and reform length of stay and discharge policies and practices** that operate without regard for the clinical status or needs of patients, whether forensic or civil. These include but are not limited to the following:
 - State laws or regulations that mandate protracted competency hospitalization for administrative reasons

- State laws that mandate extended state hospital stays unrelated to mental health status (e.g., to house sexual offenders)
- State laws that delay hospital discharge for administrative purposes
- **Increase psychiatric bed supplies** to the point that mentally ill inmates wait no more than three days, on average, for competency services to be initiated and psychiatric patients wait no longer, on average, than nonpsychiatric patients for hospital admission from emergency departments. Steps should include the following:
 - Increasing the supply of nonhospital, residential beds in the community for patients who are ready to leave the hospital but have no place to be discharged and for long-stay patients who do not require the level of service and security that state hospitals provide
 - Budgeting sufficient funds to staff and open existing state and other public hospital beds
 - Opening new beds
- **Invest in and use mathematically based planning tools**, such as the IST capacity estimation model described in this report, to develop evidence-based strategies for reducing forensic bed waitlists and, in turn, jail overcrowding and the misery and costs that come with hospital admission delays.

Federal Recommendations

Congress and relevant federal agencies are urged to realize the potential of the 21st Century Cures Act by taking the following further actions:

- **Fund provisions in the Cures Act that expand criminal justice diversion programs**, such as AOT and FACT
- **Fund programs in the Cures Act designed to grow the mental health work force**, including mental and behavioral health education and training grants and minority fellowships
- **Repeal the discriminatory Institutions for Mental Disease exclusion**, which severely limits Medicaid reimbursement for psychiatric inpatient care, thus erecting an arbitrary financial barrier to states or private providers opening new beds
- **Promote the practice of pre-arrest jail diversion** by funding the implementation of evidence-based programs such as Miami-Dade County's in jurisdictions nationwide.

REFERENCES

- ¹ In 2015, the Prison Policy Initiative estimated there were 451,000 pretrial detainees in jails. (Wagner, P., & Rabuy, B. [2015]. *Mass incarceration: The whole pie*. Retrieved from <https://www.prisonpolicy.org/reports/pie2016.html>) Applying the generally accepted estimate that 20% of jail inmates have a serious mental health disorder yields an estimated total of 90,200 pretrial candidates for competency services.
- ² Fitch, W. L. (2014). *Assessment #3: Forensic mental health services in the United States: 2014*. Alexandria, VA: National Association of State Mental Health Program Directors. Retrieved from <http://www.nasmhpd.org/sites/default/files/Assessment%203%20%20Updated%20Forensic%20Mental%20Health%20Services.pdf>
- ³ Ibid.
- ⁴ Fuller, D. A., Sinclair, E., Geller, J., Quanbeck, C., & Snook, J. (2016). *Going, going, gone: Trends and consequences of eliminating state psychiatric beds, 2016*. Arlington, VA: Treatment Advocacy Center.
- ⁵ Ibid.
- ⁶ Fitch. *Assessment #3*.
- ⁷ Fuller et al. *Going, going, gone*.
- ⁸ Sisti, D. A., Segal, A. G., & Emanuel, E. J. (2015, January 20). Improving long-term psychiatric care: Bring back the asylum. *Journal of the American Medical Association*, 313(3), 243–244.
- ⁹ Lamb, H. R., & Weinberger, L. E. (2016). Rediscovering the concept of asylum for persons with serious mental illness. *Journal of the American Academy of Psychiatry and the Law*, 44, 106–110.
- ¹⁰ Noonan, M., Rohloff, H., & Ginder, S. (2015). *Mortality in local jails and state prisons, 2000–2013 – Statistical Tables*. Washington, DC: Bureau of Justice Statistics. Retrieved from <https://www.bjs.gov/content/pub/pdf/mljsp0013st.pdf>
- ¹¹ Katz, M. H., Kay, R., & Harding, C. A. (2016, September 19). *Examination of increase in mental competency cases*. Los Angeles: Los Angeles County Health Agency.
- ¹² Fitch. *Assessment #3*.
- ¹³ Sewell, A. (2016, March 8). L.A. County supervisors order report on unexplained surge in mental competency cases. *Los Angeles Times*. Retrieved from <http://www.latimes.com/local/lanow/la-me-ln-mental-competency-cases-20160308-story.html>
- ¹⁴ *ACLU v. Taylor Hardin*
- ¹⁵ Kim, K., Becker-Cohen, M., & Serakos, M. (2015). *The processing and treatment of mentally ill persons in the criminal justice system: A scan of practice and background analysis*. Washington, DC: Urban Institute.
- ¹⁶ Miami-Dade Forensic Alternative Center Pilot Program Status Report. (2016). Mental Health Association. Retrieved from <http://mha.ohio.gov/Portals/0/assets/Treatment/Criminal%20Justice/Steppingup/Miami-Dade-Forensic-Alternative-Center.pdf>
- ¹⁷ Rittiman, B. (2016, May 2). Debate rages over holding mentally ill patients. 9News Colorado. Retrieved from <http://www.9news.com/news/local/politics/debate-rages-over-holding-mentally-ill-patients/167367683>.
- ¹⁸ Fitch. *Assessment #3*.
- ¹⁹ Wagner & Rabuy. *Mass incarceration*.
- ²⁰ Holder, E. (2011, June 1). *National symposium on pretrial justice*. Washington, DC: Department of Justice.
- ²¹ James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates*. Washington, DC: Bureau of Justice Statistics. Retrieved from <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>
- ²² AbuDagga, A., Wolfe, S., Carome, M., Phatdouang, A., & Torrey, E. F. (2016). *Individuals with serious mental illnesses in county jails: A survey of jail staff's perspectives*. Public Citizen and the Treatment Advocacy Center.
- ²³ Fuller et al. *Going, going, gone*.
- ²⁴ Swartz, M. S. (2016). Emergency department boarding: Nowhere else to go. *Psychiatric Services*, 11, 1163. Retrieved from <http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.671102>



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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.