

# **Jails Have Become the Poor Person's Mental Hospital: The Intersection Between Drug Use and Mental Illness**

By Abigail Parolise

## **I. Introduction**

Most countries have laws criminalizing drug use and the United States is no exception. Because of the social costs of drug abuse, legislation aimed at deterring drug use through criminal sanctions may be appropriate on public health grounds. However, mere criminalization of drug use, when combined with the closure of mental health institutions has led to the imprisonment of many whose drug use is linked to mental illness. Understanding the co-occurrence of mental illness and drug use is necessary to understand how many of this country's mentally ill are funneled into the criminal justice system initially, and to provide the mental health services and drug treatment necessary to end recidivism.

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## **II. The War on Drugs in the Context of Deinstitutionalization of the Mentally Ill**

### **A. Brief History of Mental Health Hospitals**

As the number of people in cities increased, the need for mental health institutions also increased.<sup>1</sup> In rural areas, local support for the mentally ill was much more prevalent due to the lower chance of disturbance caused by the mentally ill in these areas.<sup>2</sup> Bethlehem Royal Hospital, also known as "Bedlam," is the first known psychiatric hospital in England.<sup>3</sup> Bethlehem Royal began admitting mental patients in London in 1403 and acted as a repository for the poverty-stricken mentally ill.<sup>4</sup> By the Eighteenth Century, Bethlehem Royal also provided amusement for visitors who would pay a penny to witness the tortures inflicted upon

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<sup>1</sup> Nolan, Peter. A History of Mental Health Nurses.

<sup>2</sup> *Id.*

<sup>3</sup> Encyclopedia Britannica: Bedlam.

<sup>4</sup> *Id.*

the patients.<sup>5</sup> The trend of imprisoning poor people with mental illness extended to the United States in about 1800 and was initially considered a humane alternative to housing the mentally ill in jail.<sup>6</sup> Over time, as psychiatric doctors began to understand more about mental illness, treatment developed from the use of torture and restraints, to the lack of restraints in the 1860s, to electroshock, insulin, and frontal lobotomy “therapies” in the 1940s, and finally, to medication in the 1950s.

### B. Deinstitutionalization of the Mentally Ill and the Rise of Prisons

In the early 1960s public opinion turned against the psychiatric hospital because of its inhumane history and its economic costs to the state.<sup>7</sup> The development of medication to treat mental illness allowed previously institutionalized individuals the ability to return to their normal lives.<sup>8</sup> Doctors began prescribing antidepressants and muscle relaxants to treat depression.<sup>9</sup>

The negative view of mental health institutions combined with the political movement against social welfare programs in the 1980s continued to add strength to the deinstitutionalization movement.<sup>10</sup> Deinstitutionalization refers to “a range of procedural, statutory, and ideological changes that attempt to transfer the care of the chronically mentally ill from institutional to community settings.”<sup>11</sup> Unfortunately, the dismantling of state mental health apparatus did not correspond with the formation of effective community treatment alternatives.

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<sup>5</sup> *Id.*

<sup>6</sup> Nolan

<sup>7</sup> Bacharach, *A Conceptual Approach to Deinstitutionalization*, 29 HOSP. COMMUNITY PSYCHIATRY 573 (1978); Morrissey, *Deinstitutionalizing the Mentally Ill: Processes, Outcomes, and New Directions*, in DEVIANCE AND MENTAL ILLNESS (W. Gove ed. 1982).

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

A 1939 study of several European countries found that "as a general rule, if the prison services are extensive, the asylum population is relatively small and the reverse also tends to be true."<sup>12</sup> At the end of 1968, there were 399,000 patients in state mental hospitals and 168,000 inmates in state prisons.<sup>13</sup> The confinement of persons with mental illness in state mental hospitals was at its highest in 1955 at 559,000 persons.<sup>14</sup> Within a decade, the hospital population fell 64%, to 147,000, while the prison population rose 65%, to 277,000.<sup>15</sup> By 2000, the number of individuals in public mental health hospitals has dwindled to 70,000; an 85% reduction.<sup>16</sup>

The Department of Justice estimates that 16% of the prison population is mentally ill,<sup>17</sup> but "this figure does not take into consideration the number of individuals who were not clinically diagnosed with a mental illness at the time of incarceration."<sup>18</sup> These are staggering figures when compared to the incidence of mental illness in the United States at large which is 5.4%.<sup>19</sup> According to the Office of Juvenile Justice and Delinquency Prevention, more than 20 percent of those in the juvenile justice system have serious mental health problems.<sup>20</sup> The National Alliance for the Mentally Ill estimates that, "25 to 40 percent of America's mentally ill

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<sup>12</sup> Penrose, *Mental Disease and Crime: Outline of a Comparative Study of European Statistics*, 18 BRIT. J. MED. PSYCHOLOGY 1 (1939).

<sup>13</sup> Goldman, Adams & Taube, *Deinstitutionalization: The Data Demythologized*, 34 HOSP. COMMUNITY PSYCHIATRY 129 (1983).

<sup>14</sup> Richard Lamb, M.D. and Linda E. Weinberger, Ph.D., Persons with Severe Mental Illness in Jails and Prisons: A Review, 49 (4) Psychiatric Services 423 (April 1998).

<sup>15</sup>

<sup>16</sup> *Id.*

<sup>17</sup> DOJ

<sup>18</sup> CRIMINALIZATION OF THE MENTALLY ILL: THE CHALLENGING ROLE OF THE DEFENSE ATTORNEY IN THE MENTAL HEALTH COURT SYSTEM. Christin E. Keele. Fall, 2002. 71 UMKC L. Rev. 193.

<sup>19</sup> Ronald C. Kessler, et. al., A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness, in *Mental Health, United States 1999* 99-109 (Ronald W. Manderscheid & Marilyn J. Henderson eds., 1998).

<sup>20</sup> Durham

will come into contact with the criminal justice system" at some point in their lives.<sup>21</sup> On any given day, between 300,000 and 400,000 people with mental illnesses are incarcerated in jails and prisons across the United States and another 500,000 people with mental illnesses are on probation in the community.<sup>22</sup>

There are many explanations for the over-imprisonment of the mentally ill. For instance, many of these mentally ill become homeless when forced out of the psychiatric institutions and unable to participate in mainstream society. Police often arrest the homeless for minor infractions to get them off of the street either for magnanimous or discriminatory reasons. Also, the challenges associated with representing the mentally ill can also compromise the efficacy of the representation making it much more likely that they will be incarcerated or receive these harsher punishments. Efficacy of representation is especially a concern for indigent defendants where the public defenders assigned to their cases are often overworked, and less experienced. In addition, when arrested for more serious offenses, the insanity defense's incredibly high burden is another mechanism that funnels the mentally ill away from hospitals into prison. Less than 1% of all criminal cases raise the insanity defense and within that group only 1 out of 100 is successful.<sup>23</sup> Furthermore, courts often mete out harsher sentences for the mentally ill without exploring the connection between the defendant's mental illness and the severity of the crime. However an often overlooked and under-examined contributor to the increase in the percentage of mentally ill in prisons is the increased criminalization of drug use.

### C. The War on Drugs, Increased Criminalization for Drug Offenses, and the Re-institutionalization of the Mentally Ill

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<sup>21</sup> LeRoy L. Kondo, Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders, 28 *Am. J. Crim. L.* 255, 272 (2001).

<sup>22</sup> Testimony

<sup>23</sup> *Id.*

Deinstitutionalization along with increased punishment for drug offenses leads to increased criminalization of the mentally ill. The modern War on Drugs has led to arrest of more than one million Americans per year as reported in 1994.<sup>24</sup> In the 1980s, “while the number of arrests for all crimes was rising 28 percent, the number of arrests for drug offenses rose 126 percent.”<sup>25</sup> The number of inmates in the United States tripled from 1980 until 1998 from 501,866 inmates to 1,825,000.<sup>26</sup> America incarcerates a higher proportion of its population than any other nation in the world.<sup>27</sup> Several states, such as California, divert funds from the education budget and siphon them to the prison budget.<sup>28</sup> This practice occurs despite the fact that “spending more money on education and social programs would provide greater long-term socioeconomic benefits to states.”<sup>29</sup>

The National GAINS Center estimates that “nationwide over one million people with acute mental illnesses are arrested and booked into jails annually. Roughly 72% of these individuals also meet criteria for co-occurring substance use disorders.”<sup>30</sup> The linkage between mental illness, drug abuse, and incarceration is especially prevalent in the female prison population. The majority of illegal acts that women commit are drug offenses.<sup>31</sup> Up to 75% of the women convicted of drug trafficking or possession have been physically or sexually

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<sup>24</sup> Lester Grinspoon, M.D. & James B. Bakalar, J.D. (February 3, 1994). "The War on Drugs -- A Peace Proposal": 357-360.

<sup>25</sup> Austin J. McVey AD. The 1989 NCCD prison population forecast: the impact of the war on drugs. San Francisco: National Council on Crime and Delinquency, 1989.

<sup>26</sup> Steven Belenko, *The Challenges of Integrating Drug Treatment Into the Criminal Justice Process*. 63 Alb. L. Rev. 833, 834 (2000); see Jodi M. Brown, et al, U.S. Dep't of Justice, *Correctional Populations in the United States*, 1994, at 7 (1996); see also, Allen J. Beck & Christopher J. Mumola, U.S. Dep't of Justice, *Prisoners in 1998*, at 1 (1999).

<sup>27</sup>

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

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<sup>31</sup> Lawrence A. Greenfield & Tract Snell, U.S. Dep't of Justice, *Office of Justice Programs, Special Report on Women Offenders*, NCJ 175688, at note 4 at 5.

abused.<sup>32</sup> Women who have been abused are more likely to suffer from depression and are more likely to abuse drugs.<sup>33</sup>

#### D. Social and Economic Effects of the War on Drugs

The economic and social costs of the War on Drugs are extensive. Due to the higher number of arrests and conviction for drug offenses, the needs of state and federal prisons have grown as well. Federal and state prisons need 1,600 new beds each week.<sup>34</sup> Accordingly, new prisons are being built to meet this demand. The fixed costs of building a new prison is \$60,000 to \$75,000 per inmate.<sup>35</sup> Operating costs average \$60 per day per inmate which adds up to \$22,000 annually per inmate.<sup>36</sup> The federal prison budget is one billion dollars per year as is the combined prison budgets of California, Florida, Michigan, New York, and Texas.<sup>37</sup>

Increased incarceration also has social and economic effects on the African American community specifically. African-Americans are incarcerated at disproportionate rates. “One in three African American males between the ages of twenty and twenty-nine is involved in the criminal justice system.”<sup>38</sup> This phenomenon has effected the public’s perception of African Americans, has exacted a toll on African American families, and has affected African American dating and marriage patterns.

There is an increasing number of African American fathers incarcerated for drug-related crimes.<sup>39</sup> Mandatory minimums have taken their toll by leading to the increased incarceration of

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<sup>32</sup> *Id.* at note 4, 3-5.

<sup>33</sup> Mark I. Singer et al., *They Psychosocial Issues of Women Serving Time in Jail*, 40 Soc. Work: The Nat’l Ass’n Soc. Workers 103, 103-14 (Jan. 1995).

<sup>34</sup> Bureau of Justice Statistics, U.S. Dep’t of Justice, *Prisoners in 1998* at 1 (1999).

<sup>35</sup> Jeff Potts, *American Penal Institutions and Two Alternative Proposals for Punishment*, 34 S. Tex. L. Rev. 443, 453 (1993).

<sup>36</sup> Belenko at 1487

<sup>37</sup> *Id.* at 1487-8.

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

African American mothers for non-violent drug offenses.<sup>40</sup> This impedes the formation of the black, two parent family which is significant in the development of African American children.<sup>41</sup> The absence of one or both parents has the “potential to impair child development, behavior, discipline, and emotional growth,”<sup>42</sup> Financially, this phenomenon also harms the African American family in terms of the opportunity costs of spending years in prison not accumulating any work experience and the inability of many to find adequate employment after prison. The War on Drugs has imposed heavy burden on the state and on African Americans specifically, and has led to the disproportionate incarceration of the mentally ill. To fully understand this phenomenon, it is important to examine the connection between mental illness and drug abuse.

### **III. Mental Illness and Drug Abuse as Co-Occurring Conditions**

As previously stated, the Department of Justice estimates that 16% of the prison population suffers from mental illness. With the rate of mental illness in society at large estimated at 5.4%; the fact that at least 16% of the prison population is mentally ill means that the mentally ill are being incarcerated at rates three times the rate of the population not suffering from mental illness. One 2002 study, entitled “Prevalence Estimates of Psychiatric Disorders in Correctional Settings,” attempts to show the incidence of certain mental disorders endemic in the prison population compared to the rates in the population as a whole.

Table 1 shows the prevalence for mental illness in the U.S. population at large, in the U.S. population living in poverty (called “Distressed 1” by the authors), and in the U.S. population of drug users living in poverty (called “Distressed 2” by the authors). The authors of

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<sup>40</sup> *Id.*

<sup>41</sup> Haskins, Ron. *Work Over Welfare: The Inside Story of the 1996 Welfare Reform Law*. Washington, D.C.: The Brookings Institute (2006).

<sup>42</sup> Belenko at 1488

the study delineated these groups in order to have segments of the population in the U.S. that better socio-economically matched the populations in federal and state prisons and community corrections.<sup>43</sup> Because jail and state prison populations tend to have higher rates of poverty and drug use, the authors of this study applied Distressed 2 to this population.<sup>44</sup> Federal and community corrections populations tend to be better off socio-economically, and so, the authors applied Distressed 1 to this population.<sup>45</sup> Six month prevalence estimates were used for the jail populations due to their shorter duration and lifetime prevalence estimates were used for the other criminal justice populations.<sup>46</sup>

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<sup>43</sup> Community corrections is comprised of the community-based correctional programs the subcontract from the Bureau of Prisons. These programs include (1) privately-owned facilities for juvenile and adult offender, (2) residential reentry centers also known as “halfway houses,” (3) comprehensive sanction centers which offer a structured and gradual reentry into the community, and (4) home confinement.

<sup>44</sup> n62. Veysey & Bichler-Robertson, Prevalence Estimates, *supra* note 38, at 59.

<sup>45</sup> *Id.*

<sup>46</sup> *Id.*



Table 1. Prevalence Estimates of Select Mental Disorders in the U.S. Population<sup>47</sup>

Disorder	Community Sample (U.S.)	6 Month Rates	
		Distressed 1 (Poverty Subsample)	Distressed 2 (Poverty/ <b>Drug</b> Use Subsample)
	%	%	%
Schizophrenia	0.4	0.9	0.8
Major depression	8.4	11.6	20.6
Bipolar	1	1.5	3.6
Dysthymia	2	3.5	7.3
Post-traumatic	3.4	6.7	10.5
Anxiety	14.6	18.5	28.3
Antisocial	-	-	-

  

Disorder	Community Sample (U.S.)	Lifetime Rates	
		Distressed 1 (Poverty Subsample)	Distressed 2 (Poverty/ <b>Drug</b> Use Subsample)
	%	%	%
Schizophrenia	0.8	1.6	1.6
Major depression	18.1	20.1	33.6
Bipolar	1.7	2	5.3
Dysthymia	7.1	8.5	15.8
Post-traumatic	7.2	11	18.2
Anxiety	24.6	28.9	41.3
Antisocial	14.8	20.7	45.3

The authors applied the rates of Table 1 to the rates of Table 2 weighted by the age, race, and gender of each population.<sup>48</sup> Table 2 summarizes the results of this study. The authors of this study created different samples in order to create a high and a low estimate of the incidence of mental illness.

<sup>47</sup> Bonita M. Veysey & Gisela Bichler-Robertson, Prevalence Estimates of Psychiatric Disorders in Correctional Settings, in 2 Nat'l Comm'n on Corr. Health Care 63, table 7 (Apr. 2002), available at [http://www.ncchc.org/pubs/pubs\\_stbr.vol2.html](http://www.ncchc.org/pubs/pubs_stbr.vol2.html) (last visited April 6, 2007); see also Nat'l Comm'n on Corr. Health Care, U.S. Dep't of Just., 1 The Health Status of Soon-to-be-Released Inmates 24 (Mar. 2002), available at [http://www.ncchc.org/pubs/pubs\\_stbr.vol1.html](http://www.ncchc.org/pubs/pubs_stbr.vol1.html) (last visited April 6, 2007), (describing each of the listed mental disorders).

<sup>48</sup> *Id.* at 62-63.

Table 2. Prevalence Estimates of Select Mental Disorders Among Criminal Justice System Populations<sup>49</sup>

Disorder	Comparison	Jails	Comparison	State
	Rates (U.S.)		Rates (U.S.)	
	%	%	%	%
Schizophrenia	0.9 - 0.8	1.0 - 1.1	1.6 - 1.6	2.3 - 3.9
Major depression	11.6 - 20.6	7.9 - 15.2	20.1 - 33.6	13.1 - 18.6
Bipolar	1.5 - 3.6	1.5 - 2.6	2.0 - 5.3	2.1 - 4.3
Dysthymia	3.5 - 7.3	2.7 - 4.2	8.5 - 15.8	8.4 - 13.4
Post-traumatic	6.7 - 10.5	4.0 - 8.3	11.0 - 18.2	6.2 - 11.7
Anxiety	18.5 - 28.3	14.1 - 20.0	28.9 - 41.3	22.0 - 30.1
Antisocial	-	26.3 - 46.2	20.7 - 45.3	26.0 - 44.5
		n=500,483		N=1,010,228
Disorder	Comparison	Federal	Comparison	Community
	Rates (U.S.)	Prisons	Rates (U.S.)	Corrections
	%	%	%	%
Schizophrenia	0.8 - 1.6	0.8 - 2.5	0.8 - 1.6	0.8 - 2.1
Major depression	18.1 - 20.1	13.5 - 15.7	18.1 - 20.1	15.2 - 19.3
Bipolar	1.7 - 2.0	1.5 - 2.7	1.7 - 2.0	1.4 - 2.4
Dysthymia	7.1 - 8.5	6.8 - 11.6	7.1 - 8.5	6.7 - 11.7
Post-traumatic	7.2 - 11.0	4.9 - 6.8	7.2 - 11.0	5.9 - 9.3
Anxiety	24.6 - 28.9	18.2 - 23.0	24.6 - 28.9	22.4 - 27.1
Antisocial	14.8 - 20.7	21.3 - 28.2	14.8 - 20.7	16.6 - 25.5
		n=91,506		N=3,269,481

Despite the fact that this study did not attempt to prove the correlation between drug use and mental illness, it did just that. This study details the most common mental health illnesses affecting the prison population and shows the increased incidence of mental illness among the poor and poor drug abusers. Table 1 has lists of disorders in the U.S. population. If you look across the rows you can see that each disorder increases when poverty and drug use is factored in. However, the utility of this study is limited. The authors of the study attempted to adjust for

<sup>49</sup> *Id.*

socio-economic status, drug use, race and gender, but did not take into account access to health care and perhaps racism as a skewing factor.<sup>50</sup>

The Department of Justice maintains that the occurrence of certain psychiatric disorders is accompanied by the increased risk of drug abuse. The disorders linked to an increased risk of drug abuse are listed below along with their corresponding increased percentage of risk.<sup>51</sup>

**Disorders With Increased Risk of Drug Abuse<sup>52</sup>**

<b>Disorder</b>	<b>Risk</b>
Antisocial personality disorder	15.5%
Manic episode	14.5%
Schizophrenia	10.1%
Panic disorder	04. 3%
Major depressive episode	04.1%
Obsessive-compulsive disorder	03.4%
Phobias	02.1%

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 Source: National Institute of Mental Health.

<sup>50</sup> Women, for example, have "higher rates of major depression, dysthymia, post-traumatic stress disorder, and anxiety disorders," and "whites have higher lifetime rates of major depression." This study site white women as being the largest group diagnosed with depression; an assertion that becomes less significant when other figures are taken into account. African American make up 12% of the population of the United States, half of the prison population, 40% of the homeless population, and 40% of the juvenile correction population. Generally speaking, the health care crisis has hit the African American community particularly hard. Additionally, African Americans are more likely to be treated in inpatient facilities versus outpatient facilities. Without adequate health care, African Americans are less able to seek help for more minor mental health issues, such as depression, which would be most likely be treated in an outpatient facility. That means, that the African Americans that have received mental health services are more likely to have done so through governmental intervention. While receiving services "when compared to whites who exhibit the same symptoms, African Americans tend to be diagnosed more frequently with schizophrenia and less frequently with affective disorders. In addition, one study found that 27% of blacks compared to 44% of whites received antidepressant medication."

Another great weakness in this study is that the figures in Table 1 do not account for the fact that some of the people with mental illness may have previously gone or may one day go to jail. The data in Table 1 is like a snapshot and for that reason is inconclusive as to rates of mental illness in the population at larger. According to the National Alliance on Mental Illness, "roughly 40% of adults who suffer from serious mental illnesses (SMI) will come into contact with the criminal justice system at some point in their lives. Unfortunately, these contacts result in the arrest and incarceration of people with SMI at a rate vastly disproportionate to that of people without mental illnesses."

<sup>51</sup> <http://www.usdoj.gov/ndic/pubs7/7343/index.htm#What>

<sup>52</sup> <http://www.usdoj.gov/ndic/pubs7/7343/index.htm#What>

Substance use disorders often occur in relation to other mental health disorders, especially mood and anxiety disorders and antisocial personality disorders.<sup>53</sup> Persons:

with mental illness have a higher rate of alcohol and substance abuse problems than the general public...persons with mental illness often use alcohol and illegal drugs as self-medication to relieve the symptoms of their illnesses. Self-medication is more apt to occur among persons who are indigent and, therefore, less knowledgeable about health care and less connected to the health care system.<sup>54</sup>

Between 50% and 75% of general psychiatric population have alcohol and drug disorders.<sup>55</sup> Almost 60% of patients diagnosed with a personality disorder specifically also suffer from a substance use disorder.<sup>56</sup>

Does mental illness lead to chronic drug abuse or does chronic drug abuse lead to mental illness? The answer to this question is “both.” The practice referred to as “self-medicating” refers to a seriously mentally ill individual taking illegal drugs in an effort to alleviate symptoms of his or her disorder.<sup>57</sup> For example, schizophrenics often use marijuana to counteract negative symptoms like “depression, apathy, and social withdrawal,” and side effects associated with prescribed medication.<sup>58</sup> Alternatively, abuse of the drug known as ecstasy can produce “long-term deficits in serotonin function in the brain, leading to mental disorders such as depression and anxiety. Chronic drug abuse by adolescents during formative years is a particular concern because it can interfere with normal socialization and cognitive development and thus frequently contributes to the development of mental disorders.”<sup>59</sup>

Additionally, mental health professionals have begun considered addiction itself as a disease that requires treatment. “Drug abuse is a decision, a voluntary decision, someone makes and,

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<sup>53</sup> Axis II Comorbidity of Substance Use Disorder And Patients Referred for Treatment of Personality Disorder. Skodol, Andrew E. *Am. J. Psychiatry* 1999

<sup>54</sup> 7 U Chi L. Sch Roundtable 113

<sup>55</sup> Miller and Gold. *Dual Diagnosis: Psychiatric syndromes in Alcoholism and Drug Abuse.* (1991).

<sup>56</sup> Skodol.

<sup>57</sup> <http://www.usdoj.gov/ndic/pubs7/7343/index.htm#What>

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

therefore, it is a voluntary, preventable behavior. At the same time addiction is a qualitatively different state. It is, in fact, a disease, and it is a treatable disease.”<sup>60</sup>:

What is believed to occur in addiction is that an individual voluntarily begins to use drugs and then, at some point, something happens. A metaphorical "switch" flips, in reality a cascade of biochemical events at the molecular, cellular, and systems levels, at different times for different people based on biological and other factors, and an individual moves from a state of voluntary drug use to become a compulsive drug user. Compulsive drug use is the essence of addiction: compulsive, often uncontrollable, drug craving, seeking, and use in the face of negative consequences. It is this compulsion that is responsible for the disruption, crime, and other negative correlates of drug use that follow in its wake. Because addiction comes about as a result of what drugs do to the brain, and causes these long-lasting changes, at its core, addiction is a brain disease. It is, however, not that simple. Drug addiction is not just a brain disease. There are contributions of biology, behavior, and environment.<sup>61</sup>

The complicated relationship between mental illness and drug abuse lead to misunderstanding on the part of the criminal justice system. The increased criminalization of drug use has diverted the mentally ill with co-occurring substance abuse conditions away from treatment and into prison where symptoms of mental illness are exacerbated.

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#### **IV. Mental Health and Drug Treatment Crisis in Prisons**

##### **A. Prisons and the Mentally Ill**

The current prison system, as it stands now, is perhaps the worst place to put a drug addict who is also mentally ill. The prison system is fraught with misunderstanding, neglect and abuse. The seven main problems associated with the confinement of the mentally ill in prison are (1) inadequate screening procedures at intake,<sup>62</sup> (2) inadequate numbers of qualified mental health staff, (3) inadequate training for prison guards, (4) excessive use of solitary confinement,

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<sup>60</sup> Richard A. Millstein, J.D. \* and Alan I. Leshner, Ph.D. SYMPOSIUM: "SUBSTANCE ABUSE, FAMILIES AND THE COURTS: LEGAL AND PUBLIC HEALTH CHALLENGES": ARTICLE: The Science of Addiction: Research and Public Health Perspectives. 3 J. Health Care L. & Pol'y 151

<sup>61</sup> *Id.*

<sup>62</sup> *Woodward v. Correctional Medical Servs.*, 368 F.3d 917 (7<sup>th</sup> Cir. 2004); *Gibson v. County of Washoe*, 290 F.3d 1175, 1189 (9<sup>th</sup> Cir. 2002), *cert. denied*, 537 U.S. 1106 (2003).

and improper use of restraints (5) sleep deprivation, (6) suicide, and (7) harassment and abuse by other inmates.<sup>63</sup>

Timothy Souder, “a mentally ill 21-year-old Michigan prisoner, died of thirst after spending four days shackled to a cement slab as punishment for flooding his segregation cell during a heat wave in August 2006. Souder suffered from manic depression.<sup>64</sup> The circumstances that led to Souder’s arrest and conviction are as follows: while attempting to steal two paintball guns, he was caught, threatened employees with a pocket knife and then when police arrived, begged them to end his life.<sup>65</sup> A video record shows he ate and drank little and received no meaningful medical care.”<sup>66</sup> While in jail, Souder tried to kill himself on three different occasions.<sup>67</sup> The state psychologist that saw him after he stabbed himself seven times in the stomach decided that psychiatric intervention would not be necessary because he determined that Souder was merely trying to manipulate staff with his suicide attempt.<sup>68</sup> A social worker thought he should be moved to a mental hospital, but the paperwork was never completed.<sup>69</sup> The prison had only one psychiatrist on staff and at this time he was on a seven week leave and had not been replaced and so when Souder took a shower without permission and ended up in solitary confinement, no mental health professional was consulted.<sup>70</sup> When Souder broke a stool and flooded his cell the prison guards restrained him to his bed, again, no mental health professional was consulted.<sup>71</sup> Souder was supposed to be allowed up to walk around every two hours while in restraints, but video tape shows that he was restrained for up to

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<sup>63</sup> Rivera, Ralph M. *The Mentally Ill Offender: A Brighter Tomorrow Through the Eyes of the Mentally Ill Offender Treatment and Crime Reduction Act of 2004*. 19 J.L. & Health 107 (2004).

<sup>64</sup> 60 Minutes, February 11, 2007.

<sup>65</sup> *Id.*

<sup>66</sup> <http://www.aclu.org/prison/index.html> (last visited April 6, 2007)

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

seventeen hours at a time.<sup>72</sup> During the four days of punishment, Souder clearly began to weaken. He collapsed while taking a shower. The guards did not take him to the infirmary. Instead, they put him in a wheel chair and chained him up again.<sup>73</sup>

Timothy Souder tragic death illustrates six out of seven distinct problems associated with the prison system's handling of the mentally ill. First, this prison had inadequate screening procedures. It is clear that Souder was not found to be mentally ill while in prison despite the overwhelming evidence to the contrary. Even after his suicide attempt, a mental health professional failed to diagnose Souder's mental illness. This failure also implicates the second problem with the prison system's handling of the mentally ill: the lack of adequately trained mental health staff. Adequately trained mental health staff is considered the "single most important factor in providing good mental health services."<sup>74</sup> Prompt diagnosis and treatment could have saved Souder's life. Third, there was an inability of guards to deal with the mentally ill. Guards used punishment to try and modify Souder's behavior, and they failed to see that their punishments were too severe. The prison guards also used two types of punishment that tend to exacerbate the symptoms of the mentally ill: isolation and sleep deprivation. It was the solitary confinement for the shower incident that caused Souder to act out in the way that led to his final punishment. Additionally, being chained down for stretches of seventeen hours without water would certainly interfere with sleep patterns. Suicide is the sixth problem the mentally ill face in prison. Souder made three different suicide attempts before the events that ended his life. Prison guards are ill-equipped to anticipate suicide attempts.

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<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> Rivera, Ralph M. *The Mentally Ill Offender: A Brighter Tomorrow Through the Eyes of the Mentally Ill Offender Treatment and Crime Reduction Act of 2004*. 19 J.L. & Health 107 (2004).

The final problem with confining the mentally ill to prisons is that they often become targets of abuse by other inmates. This peer ridicule is the only factor for which there is no evidence in the Souder story, but it is clearly a problem. Abuse will certainly exacerbate mental health issues and sometimes leads to death for either the abuser or the abused. The population discussed in this paper has co-existing substance abuse disorders and distinct difficulties in prison unique to substance abuse.

### B. The Drug-Addicted and Prisons

There is a major problem in the criminal justice system with pretrial detention of drug addicts. Inadequate assessment and treatment of alcohol and drug withdrawal leads to depression, sleep disturbance, “needless pain and suffering, medical morbidity, and in some instances, death.”<sup>75</sup> The “nature and intensity of withdrawal symptoms vary depending on the substance, duration, and quantity of use.”<sup>76</sup> Experts agree that detoxification is necessary to transition a drug-addicted individual to a drug-free state. Detoxification is “a medically supervised procedure intended to insure a safe, effective, and humane transition to a drug or alcohol free state.”<sup>77</sup> After an arrest, an individual can be held for 48 hours without being charged. After arraignment, the individual can be held for much longer whether or not bail has been set. Failure to go through an adequate detoxification process during this time period can lead to serious consequences.

For example, in January 23, 2005, in Jacksonville, Florida, Eric L. Freeman died of “withdrawal from a drug used to treat heroin addiction.”<sup>78</sup> Chronic methadone withdrawal is a

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<sup>75</sup> Kevin Fiscella, et al. *Benign Neglect or Neglected Abuse: Drug and Alcohol Withdrawal in U.S. Jails*, 32 J.L. Med. & Ethics 129 (2004).

<sup>76</sup> *Id.*

<sup>77</sup> *Id.*

<sup>78</sup> Gordon Jackson. *Inquest: Drug craving killed inmate; Camden jury cites "chronic methadone withdrawal" in death*. 2005 The Florida Times-Union. June 8, 2005



treatable condition. Despite this fact, after three days of chronic pain and seizures, Freeman succumbed.<sup>79</sup> Correctional officers called paramedics three times and Freeman was taken to the emergency room two times, where neither treating physician completed a diagnosis before Freeman was returned to jail.<sup>80</sup> Perhaps the fact that Freeman was argumentative made the diagnosis difficult, but the argumentativeness may have also been a symptom.<sup>81</sup>

“A major task for treatment is to either change the brain back or compensate in some way for that brain change.<sup>82</sup> As drug addiction is a biobehavioral disorder, the best treatments will attend to all aspects of the addiction: the biological, the behavioral, and the social context aspects simultaneously.”<sup>83</sup> Only “28% of prisons have substance abuse programs, and only 7% of those programs provide a comprehensive level of services that include drug counseling, treatment, and transitional planning.”<sup>84</sup> Fewer than 1% of prisons offer ten hours or more of drug treatment services per week.<sup>85</sup> There is a disturbing deficit of treatment for the mentally ill and/or substance abusers in prison despite the fact that treatment can lower recidivism.<sup>86</sup> Courts have struggled with establishing the Constitutional minimum for medical treatment of prison inmates but this is only a Constitutional minimum and does not cover the range of treatment that should be given to the mentally ill and drug-addicted in prison.

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<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> Millstein

<sup>83</sup> *Id.*

<sup>84</sup> Inciardi, James A., ed, *A Response to the War on Drugs, in Drug Treatment and Criminal Justice*. (1993)

<sup>85</sup> *Winning the War on Drugs: A “Second Chance” for Nonviolent Drug Offenders*. 113 Harv. L. Rev. 1485 (April 2000).

<sup>86</sup> *Id.*

V. **Judicial Response to the Mental Health Crisis in Prisons: The Government's Duty to Provide Adequate Medical Care for Prison Inmates**

**A. Origins of Prisoner's Right to Adequate Medical Care**

At common law, private hospitals had no affirmative duty to provide health care, even in the event of an emergency.<sup>87</sup> Courts carved out an exception where there exists a special relationship between the person in need of medical attention and the person who can provide it. For example, a physician did not have to accept a patient, but once the doctor accepted that person as patient, a special relationship was established and the doctor has an affirmative duty to provide his patient with adequate medical attention. Likewise, generally, the government has no affirmative duty to provide medical care to individuals in the absence of a special relationship.<sup>88</sup>

However, in *Youngberg v. Romeo*,<sup>89</sup> the Supreme Court recognized that when an individual is completely dependent on the state through his involuntary confinement in the state mental institution, an affirmative duty is then created for the State to provide certain necessary services. "The right to personal security constitutes a 'historic liberty interest' protected substantively by the Due Process Clause. And that right is not extinguished by lawful confinement, even for penal purposes."<sup>90</sup> Adequate food, shelter, clothing, and medical care are the essentials of care that the State must provide to an institutionalized individual.<sup>91</sup>

Due Process claims, where there exists a custodial relationship, are based on a state restriction on life or personal liberty. In the context of prison inmates, the Eighth Amendment is implicated in addition to the Fourteenth Amendment because prisoners are in the custody of the

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<sup>87</sup> *Hill v. Ohio County*, 468 S.W.2d 306, 308 (Ky. 1970).

<sup>88</sup> *See, Hams v. McRae*, 448 U.S. 297, 319 (1980). *See also, Maher v. Roe*, 432 U.S. 464, 469 (1977).

<sup>89</sup> *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982).

<sup>90</sup> *Id.* at

<sup>91</sup> *Id.* at

government and prisoners are being punished. The Eighth Amendment, which bars “cruel and unusual punishment,” is only available to prisoners. The body of case law concerning prisoners’ rights to medical care primarily employs the Eighth Amendment. However, in situations that end with a prisoner’s death, at least one court has suggested that the denial of adequate medical care could rise to a deprivation of life under the Fourteenth Amendment’s Due Process Clause.<sup>92</sup>

The Eighth Amendment holds that: “Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”<sup>93</sup> The Supreme Court has ruled that only the “unnecessary and wanton infliction of pain” implicates the Eighth Amendment,<sup>94</sup> however, the Court has also ruled that “there is no merit to [the] contention that that standard should be applied only in cases involving personal, physical injury.”<sup>95</sup>

#### B. Prisoner’s Right to Adequate Medical Care and the Deliberate Indifference Standard

In *Estelle v. Gamble*, the Supreme Court established the test under which courts determine whether an inmate’s medical care or lack thereof rises to the level of a violation of the Eighth Amendment. “The Court ruled that inmates must prove that prisons exhibited “deliberate indifference” to their medical needs in order to maintain a claim under the Eighth Amendment.<sup>96</sup>

In *Farmer v. Brennan*,<sup>97</sup> the Supreme Court narrowed the deliberate indifference standard of *Estelle*. A prison official violates the Eighth Amendment only when two requirements are met:

First, the deprivation alleged must be, objectively, sufficiently serious. For a claim based on a failure to prevent harm, the inmate must show that he is incarcerated under conditions posing a substantial risk of serious harm. The second requirement follows from the principle that only the unnecessary and wanton infliction of pain implicates the

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<sup>92</sup> *Bowring v. Godwin*, 551 F.2d 44 (1977).

<sup>93</sup> U.S. Constitution. 8<sup>th</sup> Amendment

<sup>94</sup> *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)

<sup>95</sup> *Id.*

<sup>96</sup> 429 U.S. 97 (1976).

<sup>97</sup> *Farmer v. Brennan*, 511 U.S. 825

Eighth Amendment. To violate the Cruel and Unusual Punishments Clause, a prison official must have a sufficiently culpable state of mind. In prison-conditions cases that state of mind is one of deliberate indifference to inmate health or safety.<sup>98</sup>

The first prong of the test requires a showing that the prisoner has an objectively serious medical need. The Second Circuit ruled that some factors to be considered in this determination are: “(1) whether a reasonable doctor or patient would perceive the medical need in question as important or worthy of treatment; (2) whether the medical condition significantly affects daily activities; and (3) the existence of chronic or substantial pain.”<sup>99</sup> The Eleventh Circuit held that it would be likely to find a “serious medical need” where there is a condition the “has been diagnosed by a physician as mandating treatment or...is so obvious that even a lay person would easily recognize the necessity of a doctor’s attention.”<sup>100</sup> The Ninth Circuit determined that “a serious medical need is present whenever the failure to treat the prisoner’s condition could result in further significant injury or the unnecessary and wanton infliction of pain.”<sup>101</sup> The Second, Seventh, Eighth and Ninth Circuits held that a “serious medical need” did not have to be life threatening.<sup>102</sup>

The second prong of this test provides a significant barrier to recovery by inmates because of the difficulty in proving the “deliberate indifference” to the inmates’ health. The term “deliberate indifference” requires a showing that the official was subjectively aware of the risk.”<sup>103</sup> Eighth Amendment liability “requires more than ordinary lack of due care for the prisoner's interests or safety.”<sup>104</sup> Mere negligence is not enough to prove deliberate indifference,

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<sup>98</sup> *Id.* at 843.

<sup>99</sup> *Brock v. Wright*, 315 F. 3d 158, 162 (2<sup>nd</sup> Cir. 2003).

<sup>100</sup> *Hill v. DeKalb Reg’l Youth Detention Ctr.*, 40 F.3d 1176, 1187 (11<sup>th</sup> Cir. 1994).

<sup>101</sup> *Clement v. Gomez*, 298 F. 3d 898, 904 (9<sup>th</sup> Cir. 2002).

<sup>102</sup> *Greeno v. Daley*, 414, F. 3d 645; *see also Brock, Clement, and Ellis v. Butler*, 890 F. 2d 1001.

<sup>103</sup> *Id.*

<sup>104</sup> *Farmer* at 843.

but the prisoner does not need to show that the prison official knew of the specific risk to the prisoner from a specific source.<sup>105</sup>

### C. Prisoner's Right to Adequate Mental Health Treatment

Mental health care falls under the same two pronged test as other medical treatment. The court must find (1) a “severe” mental illness and (2) deliberate indifference on the part of a prison official. A “severe” mental illness one “that has caused significant disruption in an inmate’s everyday life and which prevents his functioning in the general population without disturbing or endangering others or himself.”<sup>106</sup>

In *Bowring v. Godwin*,<sup>107</sup> the Fourth Circuit employs a different analysis holding that any prison inmate was entitled to psychological or psychiatric treatment if a health care provider, exercising ordinary skill and care at the time of observation, concluded with reasonable medical certainty: “(1) that the prisoner's symptoms evidenced a serious disease or injury; (2) that such disease or injury was curable or could be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial.”<sup>108</sup> This duty does not arise merely because the inmate desires mental health services or deems them necessary. The requirement of potential harm begs the question of whether this would mean only physical harm to oneself or to others and whether mental harm would qualify. Since there is a deficit of adequately trained staff the determination that a state official knew of a mental health condition, and that the condition could result in harm for the prisoner would be very difficult to prove.

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<sup>105</sup> *Id.*; see also *Bradley v. Puckett*, 157 F.3d 1022, 1025 (5<sup>th</sup> Cir. 1998).

<sup>106</sup> *Tillery v. Owens*, 719 F. Supp. 1256, 1286 (W.D. Pa. 1989), *aff'd*, 907 F.2d 418 (3<sup>rd</sup> Cir. 1990).

<sup>107</sup> *Bowring v. Godwin*, 551 F.2d 44 (1977).

<sup>108</sup> *Id.*

It is clear that Souder's condition met the tests under both *Farmer* and *Bowring*. He was unable to function in general population as evidenced by his stint in restraints in solitary confinement and was certainly a danger to himself. Souder was entitled to medical care commensurate with his condition. Deliberate indifference can be found in the mental health professional that failed to diagnose him, the social worker who failed to complete the paperwork for his transfer, and the prison guards who returned him to his restraints despite his deteriorating condition and his collapse in the shower.

The Ninth Circuit, in *Jordan v. Gardner*, found a "deliberate indifference" to the "psychological trauma of cross-gender body searches male guards perform on female inmates when 1) the staff urged the superintendent of the facility to suspend the policy and 2) the court order issued to prevent the searches was instituted after the policy banning such searches was violated."<sup>109</sup> The superintendent did all this knowing of the female inmates' history of physical and sexual abuse and knew that the searches required physical touching of the female inmate's genitalia.<sup>110</sup> This illustrates the need for both subjective knowledge and the severity of the neglect needed to rise to the level of an Eighth Amendment violation. Both factors make Eighth Amendment claims in the area of mental illness particularly difficult.

Inadequate mental health care has been found when the court finds (1) inadequate screening procedures at intake,<sup>111</sup> (2) failure to follow up with prisoners known or suspected to have a mental illness,<sup>112</sup> (3) inadequate numbers of qualified mental health staff,<sup>113</sup> (4) excessive

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<sup>109</sup> *Jordan v. Gardner*, 986 F.2d 1521, 1528-29 (9<sup>th</sup> Cir. 1993)

<sup>110</sup> *Id.*

<sup>111</sup> *Woodward v. Correctional Medical Servs.*, 368 F.3d 917 (7<sup>th</sup> Cir. 2004); *Gibson v. County of Washoe*, 290 F.3d 1175, 1189 (9<sup>th</sup> Cir. 2002), *cert. denied*, 537 U.S. 1106 (2003).

<sup>112</sup> *Woodward, supra*; *De'Lonta v. Anelone*, 330 F.3d 630 (4<sup>th</sup> Cir. 2003).

<sup>113</sup> *Cabrales v. County of Los Angeles*, 864 F.2d 1454, 1461 (9<sup>th</sup> Cir. 1988), *vacated*, 490 U.S. 1087 (1989), *reinstated* 886 F.2d 235 (9<sup>th</sup> Cir. 1989); *Ramos v. Lamm*, 639 F. 2d 559, 577078 (10<sup>th</sup> Cir. 1980).

use of solitary confinement,<sup>114</sup> (4) improper use of restraints,<sup>115</sup> (5) excessive force by prison personnel,<sup>116</sup> and (6) inadequate training for prison guards.<sup>117</sup> This is hardly a comprehensive list of the problems that the mentally ill face in prison, there lacks uniformity across jurisdictions as to which are recognized by courts. It also does not apply to drug treatment. Some circuits have led the way in the area of adequate mental health treatment for prisoners, but as of today the Supreme Court has been silent on this issue and that has led to disparate treatment of prisoners.

There are two main problem with using the courts to improve mental health treatment in prisons. First, law is reactionary in nature. A court cannot change the law unless a prisoner brings a claim, which means that the court must wait for a case where the facts rise to the very high level of a Eighth Amendment violation before it may act. Second, the Eighth Amendment can only vindicate egregious wrongs and has little utility for bringing truly adequate mental health and drug treatment into the prisons. For this reason, the legislature has a greater ability to bring reform.

## **VI. Legislative Response to Mental Health Crisis in Prisons: The Mentally Ill Offender Treatment and Crime Reduction Act of 2004**

The Mentally Ill Offender Treatment and Crime Reduction Act, passed by Congress in 2004, sets aside fifty million dollars for grants aimed at addressing the disproportionate numbers of mentally ill in prison. The bill “provides incentives such as grants to the criminal justice, juvenile justice, mental health and substance abuse treatment systems to provide treatment”<sup>118</sup>

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<sup>114</sup> *Gates v. Cook*, 376 F.3d 323, 343 (5<sup>th</sup> Cir. 2004).

<sup>115</sup> *Campbell v. MacGruder*, 580 F.2d 521, 551 (D.C. Cir. 1978).

<sup>116</sup> *Coleman v. Wilson*, 912 F.Supp. 1282, 1298 (E.D. Cal. 1995).

<sup>117</sup> *Olsen v. Layton Hills Mall*, 312 F.3d 1304, 1319-20 (10<sup>th</sup> Cir. 2002).

<sup>118</sup> States News Service. THREE OHIO COURTS RECEIVE MENTALLY ILL OFFENDERS GRANTS THROUGH DEWINE BILL (September 1, 2006).

only to “non-violent mentally ill offenders.”<sup>119</sup> The grants, “which are available to state, tribal, and local governments, may be used to develop and implement a variety of programs designed to improve outcomes for individuals with mental illness involved in the criminal justice system.”<sup>120</sup> The purpose of the grant is to provide more money for such things as more trained staff to serve this population and for the training for police officers who represent the first interaction between the state and the mentally ill person on the street. In Ohio, three courts have been awarded grants:

(1) “Hamilton County Juvenile Court -- \$250,000 to establish a diversion model program for youth with serious emotional disturbances who are at risk for on-going criminal behavior, but do not have a history of extensive contact with the juvenile justice system. The program will divert youth to services before their trial to assess and address emotional and behavioral issues for treatment.

(2) Columbiana County Juvenile Court -- \$50,000 to design a collaborative plan for the identification and treatment of juveniles with mental illness in order to ensure earlier identification and treatment to prevent youth from becoming involved in the juvenile justice system and/or reduce recidivism and the length of time youth are involved with the juvenile justice system.

(3) Mansfield Municipal Mental Health Court -- \$199,981 to accept referrals from entities in which potential participants meet the criteria of severe mental illness and have exhibited criminal behavior problems which are manageable in an outpatient, non-jail setting.<sup>121</sup>

Similarly, in Durham, North Carolina, “local authorities including the Durham Center, law enforcement, Duke University, Triangle Empowerment Center and Housing for New Hope will use the [planning] grant to spend a year designing a program to promote the cross-training of criminal justice and mental health personnel, plus better communication and sharing of resources.”<sup>122</sup>

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<sup>119</sup> *Id.*

<sup>120</sup> *Id.*

<sup>121</sup> *Id.*

<sup>122</sup> \$50,000 grant a boon for mentally ill; Money will improve services within criminal justice system. The Herald-Sun. October 15, 2006.



This is a step in the right direction but there is much that needs to be done. Mentally ill drug abusers should not be put in prison at all. First, this population should be diverted out of the traditional criminal justice system in the first place. If that is not possible, the state should provide mental health services and drug treatment for prisoners. In order to accomplish this there is a great need for adequately trained mental health staff. Courts have called this factor the “single most important factor in providing good mental health services.”<sup>123</sup>

The main problem with this act is one of impact. The Act only authorizes 50 million dollars for the entire country, and the grants cannot be for more than \$75,000 and are nonrenewable. First, if one million mentally ill are arrested and booked each year, this only authorizes \$5 per individual. Second, if only 7% of prison provide adequate drug treatment for prisoners, 50 million dollars total will not even scratch the surface of the problem. Third, the non-renewable nature of the grants discourages states from starting these programs. If a state were to implement such a program the state would run the risk of having to shoulder the complete cost of the program within five years. Perhaps this accounts for the fact that not many state agencies have applied for grants thus far. If Congress is serious about ending this mental health care crisis it will have to divert more funds toward these programs and mandate state action instead of waiting for the states to do so on their own initiative.

## **VII. Conclusion**

The deinstitutionalization of mental health facilities when combined with the increased criminalization of drug offenses during the War on Drugs has led to the imprisonment of many mentally ill drug users. The economic and social costs of these policies have been great. It is important to understand the connection between mental illness and drug use in order to truly end

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<sup>123</sup> *Ramos v. Lamm; Wellman v. Faulkner; Cody v. Hillard*, 599 F. Supp. 1025, 1044 (D.S.D. 1982).

the cycle of the mentally ill being caught up in the criminal justice system again and again. The Mentally Ill Offender Treatment and Crime Reduction Act of 2004 is a step in the right direction, but it is not enough. Diversion is necessary in order to keep this population out of the prisons that exasperate their conditions. Treatment is necessary to ensure that the mentally ill are able to become more productive members of society. Drug treatment is needed to lower recidivism. Congress has a long way to go in order to reverse the trend that jails have become the poor man's mental health institution.

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