The Asylum, The Prison and the Future of Community Mental Health

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Introduction

There are ten times as many individuals with serious mental illness behind bars as there are in state and V.A. psychiatric hospitals (Torrey et al, 2014). This reality requires a reassessment of deinstitutionalization and community mental health, a widespread conclusion being that deinstitutionalization and public mental health in general have failed, and that is why so many individuals who would have been consigned to state mental hospitals, the asylums, have become non-adherent with community mental health treatment, involved in substance abuse (dual diagnosis) and homeless, and then inevitably a large number find their way into the criminal justice system (Kupers, 1999). The jails and prisons have become the new asylums. The question is what we want to do about that. While some commentators call for the re-institutionalization of dysfunctional individuals with serious mental illness, I argue that the first issue is not where mental health treatment is to occur – the asylum, in the community or behind bars – it is whether there are sufficient resources to fund adequate mental health care. Because it is near impossible to provide adequate mental health care in the context of the culture of punishment that prevails in jails and prisons, I argue that most of the care should occur in the community, but with adequate resources. This means the asylums should remain shuttered, the prison population should be reduced by quite a lot, a community mental health model should be utilized in correctional facilities with the small number of prisoners who need to remain there, but the main focus of clinicians needs to be diversion and quality mental health care in the community.

Comparing Asylums and Prisons
Asylums of the 1940s and 1950s produced two riveting images of the person with serious mental illness, one involving angry and bizarre acting out and the other involving zombies who have been pacified with strong tranquilizers, electro-convulsive therapy (ECT) and lobotomies. The films *Snakepit* (1948), starring Olivia de Havilland, and *One Flew Over the Cuckoo’s Nest* (1975), based on Ken Kesey’s 1962 novel and starring Jack Nicholson and Louise Fletcher, frame the asylum world of those years. In the latter film, Nicholson’s character, Mac McMurphy, makes trouble on the psychiatric ward by organizing patients to defy authority, but then Fletcher’s character, Nurse Ratched, forces Mac to undergo several ECT treatments and then a lobotomy, which takes the defiance out of him. *One Flew Over the Cuckoo’s Nest* was iconic for R.D. Laing and the anti-psychiatry movement of the late 1960s and 1970s. In those years, deinstitutionalization was being proposed by advocates of community mental health, and meanwhile the anti-psychiatry movement was loudly decrying the dangers of over-medicating, shocking and lobotomizing mental patients. There was both the image of the out-of-control and bizarre lunatic of the early asylum, and then, once Thorazine and other neuroleptics came on the market in the mid-fifties, the overmedicated chronic mental patient of the sixties asylum world. The anti-psychiatrists claimed that disability was caused by institutionalizing and over-medicating the patients, not by the psychotic condition itself (Rissmiller et al, 2006).

In the asylum era, when individuals suffering from serious mental illness were confined in large public psychiatric hospitals, institutional dynamics came under the spotlight. Erving Goffman, Thomas Scheff and other “sociologists of deviance” hypothesized that institutional dynamics had a big part in driving patients to regress into impotent and bizarre aggressive behaviors while clinicians were side-tracked into self-fulfilling biases in diagnostics (Goffman, 1962; Scheff, 1966).

Consider this hypothetical example of their theory: A young man is brought to the asylum by family members who consider him “crazy,” he protests loudly that he is not crazy and in fact it is his parents who want him locked up who are actually the crazy ones; the psychiatrist interprets his increasingly loud protests as signs of the very mental illness being ascribed to him; he is involuntarily admitted to the asylum; as he realizes he is being deprived of his freedom his protests become louder and more desperate; the staff take his emotional protests as further evidence confirming the diagnosis of psychosis; he is placed on a locked ward and deprived of most familiar means of expressing himself; he does something irrational
such as throwing a chair through a window in order to express his outrage over being deprived of his freedom; the staff are even more convinced of his “madness” and lock him in an isolation room with no clothes and no pens or writing materials; being even more incensed and more desperate to express himself he smears feces on the wall of the isolation room and begins to write messages with his finger in the smears on the wall. Of course, Goffman was very concerned about the self-fulfilling-prophecy in the patient’s escalation and the staff’s diagnostic process, and they warned poignantly that incremental denial of freedom to individuals within “total institutions” (this term from sociology includes both asylums and prisons), whether they actually suffer from a bona fide mental illness or not, leads them inexorably into increasingly irrational and desperate attempts to maintain their dignity and express themselves.

Besides the self-fulfilling prophecy involved in the ongoing diagnostic process, Goffman pointed out other realities of total institutions that do not bode well for the prognoses of individuals with mental illness. There is the anonymity of the patient, the many rules that must be followed passively, the dwindling initiative on the part of patients who are constantly being ordered about, the loss of contact with the outside world which causes patients to stop thinking about and planning for their future in the community, and so forth. We call it institutionalization. The “good patient” stops questioning authority and in the process becomes weaker, more passive and more lacking in initiative and vitality the longer he or she remains in the asylum. Then there is the medicating, often simply an attempt to maintain peace and quiet, and just as often the reason why patients lack vitality and initiative. The term that came into use was “chronic mental patient,” where the chronicity bred of the treatment became the obstacle to human functioning more than any disabling illness. That was the theory espoused by R.D. Laing, the anti-psychiatrists and the radical therapists of the seventies (Laing, 1967; Talbot, 1974; Agel, 1971).

Switching to jail and prison, we can explore similarities in what has evolved as more individuals with serious mental illness have found their way into correctional facilities. Donald Clemmer (1940/1958) coined the term prisonization for the very huge effect of incarceration where a prisoner takes “on in greater or less degree the folkways, mores, customs and general culture of the penitentiary.” Craig Haney (2003) describes prisonization: “The process of prisonization involves the incorporation of the norms of prison life into one’s habits of thinking, feeling and acting… the longer persons are incarcerated, the more significant is the nature of
their institutional transformation” (pp. 33-65). Prisoners tell me, “You don’t want to get your head into prison, and you don’t want to get prison into your head.” They are talking about the potential destructive effects of prisonization on their eventual adjustment in the community. If an individual can sustain a sense of being part of the larger community to which he or she will eventually return, then he or she will be motivated to take advantage of every opportunity in prison to undergo needed treatment, learn skills and maintain healthy relationships after release. On the other hand, if the prisoner starts to think of himself or herself as “merely a prisoner,” his or her options become constricted, dealing drugs or joining in fights and criminal activities in prison becomes an expected part of the role, and his or her prospects for success after release dwindle significantly.

Prisonization includes the same phenomena sociologists of deviance describe as institutionalization, where the institution is the prison. There is loss of the idiosyncratic identity one had in the community as one becomes an anonymous prisoner known by a number. One’s clothing choices are vastly restricted, one’s grooming is proscribed, there are rules governing just about every aspect of one’s existence and there are officers who surveil, give orders, control one’s life and mete punishments on a regular basis. Then, for men at least, there are the unwritten rules, the “prison code” that requires men to act tough, not show feelings, definitely hide weakness and neediness, not talk to officers, and never “snitch.” I have written about the way the prison code in men’s facilities and the institutional dynamics reinforce the most toxic aspects of masculinity, and ill-prepare individuals for successful reintegration into family and community upon release (Kupers, 2005). There are unwritten rules for women prisoners as well. For example, according to Barbara Owen (1998), “Respect appears to be based on personal behavior and known history, typically in terms of offense and interaction with staff and prisoners alike…. Being able to stand your ground and maintain a positive reputation in dealing with other prisoners seems to be a key to respect in the women’s prison” (p. 170).

When the prisoner suffers from serious mental illness, and somewhere between 30% and 56% of prisoners do suffer from mental illness depending on which statistics one believes (Bureau of Justice Statistics, 2015), the effects of prisonization look dreadfully similar to the institutionalization and chronicity that asylums fostered. In very many cases, the prisoner with mental illness winds up in segregation, often in a supermax solitary confinement unit (Kupers, 2013b). There are two basic reasons for that. One is the way individuals with serious mental illness have trouble controlling
their emotions and following rules, and uncontrolled emotions (especially anger) and rule-breaking can get one into deep trouble in prison. The other reason is that custody officers do not have much training managing prisoners with serious mental illness. Too often, when they are frustrated with the disturbed prisoner’s behavior, they write a disciplinary ticket which causes the prisoner to spend time in segregation. There are mental health assessments, of course. Most states, on account of past class action litigation, require that mental health staff assess prisoners who are consigned to segregation. But the assessments are typically quite flawed, the clinician more interested in identifying malingering or psychopathy than in protecting a prisoner with *bona fide* mental illness from the harsh and damaging conditions of solitary confinement. Once staff decide the prisoner is “bad” and not “mad,” a series of further punishments are in store when he or she breaks more rules in the isolation unit (Toch, 1982). And prisoners with serious mental illness are very prone to break rules in solitary confinement, the isolation and idleness cause significant behavioral dyscontrol. For example, where a “take-down” would occur in an asylum, in prison there is the “cell extraction.” A rule-breaking or recalcitrant prisoner with mental illness in SHU (Security Housing Unit, the acronym from California that signifies supermax solitary confinement) is ordered to comply with an officer’s orders, and if he or she refuses immobilizing gas (pepper spray) is sprayed and a group of four or five officers in riot gear and gas masks barge into the cell and take the prisoner down. There are often pretty serious injuries.

The following is a case vignette right out of a report I wrote for the court in a class action lawsuit about the quality of prison mental health care in a large northeastern state:

Lige (not his real name) is a 24 year old African American man who has been in prison for 8 years. He is interviewed while in SHU (solitary confinement), where he has been for four months. Just prior to our interview he learned a disciplinary hearing decision was reversed because there was no consideration given to his mental health status, and now there will be a new hearing. He says he has had ‘mental problems’ all of his life, and is currently taking Zyprexa, 10 mg. per day. He has been admitted to the psychiatric hospital connected to the department of corrections. He complains about mental health treatment in prison, “any time you have a mental problem you get stripped and searched.” About SHU he says, “The mental health staff come around the SHU, but
merely talk to you through your food slot.” He reports he has been hearing voices his whole life, and with the right medications ‘I can deal with it.’ He complains that other prisoners in the SHU suffer from mental illness to such an extent that they bang on their doors, or scream, or otherwise cause a nearly constant commotion, ‘especially at night so nobody gets any sleep.’ He complains that the officers ‘hold onto your food and play with you.’ He gets headaches, and the voices get louder, when he is alone in a cell in SHU. He gets desperate to get out because ‘it’s upsetting to be cut off from the world.’ He gets paranoid in SHU. ‘Officers control mail and everything, and when they cut off the radio, you don’t know what’s going on.’ When the officers come by and ask him how his food tasted, he worries lest they be putting something in it. Officers do not respond when a prisoner calls them. On the swing shift, the officers come around only 2 times in 8 hours. He loses sleep in SHU, and that makes his mental illness worse. He is unable to concentrate, his memory is so impaired he cannot remember what he read the page before, so he cannot read nearly as well as usual – which depresses him. An officer walks around with the nurse who passes out medications, and that officer ‘messes with people.’ The night prior to our interview he paced in his cell for 4 or 5 hours. While he told the police in the community he’d done more drugs, he actually only smoked marijuana. He finished the 10th grade, and never received a GED in prison because he spent so much time in the solitary confinement. He has received 50 disciplinary tickets in prison, most of them involving command hallucinations telling him to do the illegal acts, usually fighting. He reports he has told mental health staff about that, but they ignore him, so he has stopped telling them. And the psychiatrist told him, ‘if you pull this psychotic routine again we’re going to strip you down.’ When he was in Suicide Observation, he smeared and threw excrement in response to voices telling him to do so. On mental status exam there is flatness, concreteness, history of hallucinations and delusions, and very strong First Rank Symptoms of acute psychosis.

As an expert witness in many class action lawsuits challenging the constitutionality of prison conditions and correctional mental health care, I have had an opportunity to interview hundreds of prisoners in segregation or supermax solitary confinement. I find many cases, and Lige is one, where I am convinced there is serious mental illness but the symptoms have been dismissed as “malingering,”
“manipulations” or “antisocial personality disorder” (Kupers, 2004). The mental health staff then leave the prisoner in the hands of custody staff, who proceed to invoke ever harsher punishments the more the prisoner fails to comply with the rules and their orders. In other words, the more staff disbelieve that a prisoner with mental illness is in fact suffering from mental illness, the more impatient they become with the prisoner and the worse the brutalization.

Once a culture of punishment takes hold and the staff feel they need to respond to each new unacceptable behavior on the part of prisoners with further punishments, the punishments become more severe and the effect too many times is more emotional harm to the prisoners, in many cases including suicide. But to the extent it is the conditions of confinement, the almost total idleness and isolation in the supermax unit, that drive much of the prisoners’ unacceptable or symptomatic behavior, the successive punishments serve merely to exacerbate the problem.

Unfortunately, the modern prison is an environment that can too easily foster hateful tendencies. Both prisoners and staff are subject to the effects of the prison environment, an environment where one group (the officers) exercise total control over the lives of another group (the prisoners), just as in the Stanford Mock Prison Experiment (Haney & Zimbardo, 1973; Zimbardo, 2007). Prisons are designed to maintain a huge power imbalance, which is built into our society’s notion of punishment. Trends of recent decades - including prison crowding, cuts in rehabilitation programs, downsizing of mental health treatment programs and the consignment of an unprecedented proportion of prisoners to supermax solitary confinement - exacerbate the problem. Prisoners often feel they have no rights and no recourse to appeal what they consider unfair or abusive treatment by staff. They feel disrespected. Staff, meanwhile, feel that their job has relatively low status in society, and that they risk their safety and security by working in correctional facilities, especially as crowding and violence mount (Liebling, 2011).

In a power imbalance of such severe proportions, there is a heightened risk that the group that has control will, however inadvertently, act out some degree of hatred, often based on race or sexual orientation, toward the group that is without power and most ill-equipped to stand up for their rights. The pressure placed on correctional staff not to inform on fellow staff members (“The Blue Code”) constitutes another institutional dynamic in correctional settings that makes the expression of
hatred toward subpopulations of prisoners more pervasive and difficult to suppress. Unfortunately, prisoners with serious mental illness bear the brunt of the malice (Fellner, 2015).

Comparing asylums and prisons, the number of similar practices and phenomena is remarkable. Michel Foucault wrote a book about madness and another about prisons, both covering the period between the mid-seventeenth Century and the beginning of the Nineteenth, termed the “Classical Age” (Fourcault, 1965 & 1977). In both books he explains how the external constraints of the asylum as well as the public spectacle of drawing andquartering could be jettisoned only after sane and law-abiding citizens had fully internalized the rules of the reigning social arrangements. In the asylum there is the bizarre and sometimes aggressive acting out on the part of patients, and in the prison individuals with mental illness are either victimized, which can precipitate breakdowns replete with bizarre symptoms, or they are consigned to solitary confinement, which exacerbates their mental disorder and worsens their prognosis. In the asylum the inappropriate behaviors were not tolerated and the patient was subjected to increasingly intense control mechanisms including restraint, strong psychotropic medications, ECT and lobotomy. The same staff that administered the involuntary medications and ECT worried that the patients were becoming passive, lacked initiative and looked like zombies. In prison, where a culture of punishment makes mental health treatment very problematic, treatment for prisoners who act inappropriately is usually limited to isolation in a cell (a segregation cell, or briefly when there is a suicidal crisis, an Observation cell which is similarly isolative) along with medications, or medications-over-objection if the prisoner is uncooperative. Then, in both the asylum and the prison, the bizarreness and aggression of the symptoms mount as the staff become more convinced the patient or prisoner is in dire need of more controls, and then the use of force and control mechanisms such as forced medications and solitary confinement escalate.

Prisoners with serious mental illness, especially if they are not provided a relatively safe and therapeutic treatment program, are prone to victimization by other prisoners and staff (Human Rights Watch, 2001). In men’s prisons, the slang term for prison rapist is “Booty Bandit.” Consider the Booty Bandit’s options in selecting potential victims. He wants to choose his victim well, the wrong choice might lead to lethal retaliation. If he rapes or robs a gang member, or even a prisoner with friends, he would be forever vulnerable to deadly
retaliation. But if he selects a prisoner with significant mental illness, a loner who would not likely have friends who would retaliate, he is more likely to get away with the rape and avoid retaliation. In women’s prisons, rape and sexual assaults are more often perpetrated by male staff, but women who have experienced earlier traumas and those suffering from mental illness are likewise singled out for victimization (Human Rights Watch 1996). And of course the repeated traumas they are forced to endure in prison make prisoners’ mental disorders and their prognoses far more dire.

There is a frequent occurrence in prison solitary confinement cells that eerily recalls Goffman’s analysis of asylums. When a prisoner with mental illness is deprived of his clothes as well as other amenities that we typically think of as providing means for self-expression, he is very likely to resort to increasingly extreme forms of resistance to what he perceives as an unfair and oppressive situation. Perhaps he “floods the range” (stops up the toilet and flushes it repeatedly so that water overflows and floods the entire pod), perhaps he smears or throws excrement, or perhaps he cuts himself or practices other forms of non-suicidal self-harm (we rarely see non-suicidal self-harm or “cutting” in adult males, except in prison isolation units where the prevalence is quite high, see Kaba, 2014). The staff become increasingly frustrated and angry and resort to progressively more severe forms of force. Perhaps they perform a cell extraction, or they place the prisoner in four- or five-point restraint, or they use a “restraint chair” with straps that tighten more as the prisoner struggles to get free. The scene is all too reminiscent of the asylum, with the same self-fulfilling prophecies and the same kind of accelerating madness. And the ultimate effect is the same, the individual with serious mental illness is eventually subdued and quieted, but the mental illness is exacerbated and made more difficult to treat in the process. Then, fearing that this kind of treatment might be applied to them if they misbehave, other prisoners with serious mental illness who are not in the solitary confinement unit comply with the overutilization of psychotropic medications and, like patients in the asylums, become more and more like zombies.

Individuals suffering from mental illness who receive adequate treatment and spend their time in peaceful and encouraging circumstances (for example, a loving home or a halfway house where they are encouraged to study, form healthy relationships, and accomplish the steps they need to traverse if they are ever to enjoy meaningful employment) have a fighting chance of being able to keep their
illness under control and do relatively well (Mendel, 1989). On the other hand, the equivalent individual (i.e., someone who suffers from the same mental illness) who is repeatedly traumatized, maybe raped, has neither stable residence nor gainful pursuits, and is shuffled from one relatively uncaring service provider to another will suffer a worsening mental disability and will have a much bleaker future (likely including incarceration). The take-away message is that prisoners with mental illness must be provided a safe place to serve their sentences (they need to be safe from victimization, from the unrestrained expression of their own most troubling proclivities, and from damaging conditions such as crowding and solitary confinement) and need to be provided an adequate level of mental health treatment and rehabilitation so that they are prepared to succeed in the community after they are released.

De-institutionalization (asylum) and Re-Institutionalization (prison)

Deinstitutionalization was the brainchild of pioneers in community mental health (Caplan, 1970; Breakey, 1996). President Kennedy signed the Community Mental Health Act in 1963, and community mental health centers were erected to serve catchment areas around the country with substantial federal subsidies. Ronald Reagan, as Governor of California in the 1970s, liked the concept of deinstitutionalization. He proceeded to downsize the state mental hospitals. The idea of the community mental health pioneers was that patients from the hospitals would be released to receive better quality care in the community, where clinicians in adequately funded community mental health centers would utilize resources in the community to house them and provide treatment and rehabilitative services. But the funds for community programs did not materialize. Disappointed community mental health clinicians appealed to Governor Reagan to designate state funds for their programs and Reagan responded that the state did not have the funds. The federal grants to community mental health centers were allocated for five years with the possibility of a three year extension. Then, state and local governments were expected to take over the funding. But California’s experience became typical for the entire country, and public mental health programs in the community were subjected to repeated budget cuts over the decades that followed. Other social service safety net services such as
affordable housing were cut as well. As a result, the population of community residents with serious mental illness received fewer wrap-around services. Many were unemployable, resorted to illicit substances and alcohol, and eventually found their way into the jails and prisons. New laws were created that facilitated the mass incarceration of individuals with serious mental illness. For example, long sentences for crimes related to substance abuse, and laws against panhandling or sleeping in the park disproportionately affected individuals with serious mental illness (Torrey, 1997).

By the 1980s, while the prison population was growing geometrically, the proportion of prisoners suffering from serious mental illness was also expanding. This was largely due to the incremental underfunding of public mental health treatment, including clinics that were born of the community mental health model. With a growing proportion of prisoners suffering from serious mental illness, and correctional mental health services being quite inadequate, the plight of prisoners suffering from serious mental illness is worse than it would have been in the asylums. Crowding in prisons, victimization, a lack of meaningful rehabilitation programs and long stints in solitary confinement all exacerbate whatever mental illness is already apparent, and in very many cases these harsh conditions actually cause psychiatric breakdowns and disability in prisoners who had no previous history of mental illness (Human Rights Watch, 2003).

There is serious mental illness, individuals afflicted with psychiatric disorders. And then, as in the asylums, there is general madness in our prisons, including the sometimes bizarre acts of prisoners suffering from serious mental illness, but also including actions on the part of staff and individuals who do not suffer from a mental illness that exacerbate the chaos and bizarreness of the prison situation. Thus, officers’ abusive behavior – pepper spraying prisoners, beating them up, locking them in solitary, or in cages while they undergo therapy – adds to the general madness and meanwhile causes more than a few mental breakdowns (Fellner, 2015). Certainly living under harsh conditions worsens mental illness. But “cell extractions” are part of the general madness as well, and they also exacerbate mental illness. And then the prisoners protest with progressively more bizarre acts of resistance against officers they perceive as abusive. They throw excrement or scream in violation of orders, custody officers respond with increasingly harsh “use of force,” and the general madness grows out of control.

Policy Issues and Considerations
There is a worthy debate in progress today about re-creating the asylums, the idea being, instead of consigning so many individuals with serious mental illness to jail and prison, they can be sent to asylums (Sisti, Segal, & Emanuel, 2015; Sisti & Emanuel, 2016; Neier & Rothman, 2015). It is a proposition that comes of desperation, given the horrible plight of prisoners with serious mental illness and the inadequacies of mental health care in corrections following deinstitutionalization (Kupers, 1999 & 2013). I believe Sisti and Emmanuel have in mind setting up quality mental health services within refurbished state mental hospitals and setting up quality controls that would prevent the re-enactment of the kind of bizarre acting out and over-pacifying of patients that was typical in the asylums. But that is not the topic I want to address here. Rather, I think it is critical that we first determine, consensually, what a quality mental health treatment program should look like, and then the question whether that program should be instituted in a new generation of asylums, in the community, or in jails and prisons becomes easier to address.

On one level, it does not matter whether the treatment is offered in asylums, in the community or behind bars. If the treatment is under-budgeted and inadequate, it will fail and prognoses will be dire. There were very effective treatment regimens in the asylums of old, for example at Chestnut Lodge and Austin Riggs. There are very effective community mental health interventions in the community. And there are some model prison mental health programs, for example I have visited Residential Treatment Facilities in several states where prisoners with serious mental illness are housed in a special cell block and have mental health professional available to help them adjust to their life in prison, encourage them to adhere to their treatment plan and prepare them to succeed when they are released from prison (Lovell, 2001). But programs in all three sites suffer terribly when they are underfunded.

Correctional mental health programs are relatively under-funded. The prison population has multiplied geometrically in recent decades and the proportion of prisoners with serious mental illness has actually grown. Yet the mental health resources have not grown apace. This means that each clinician’s caseload has grown tremendously and most clinicians report they do not have time to spend talking to their prisoner/patients very much. I believe that clinicians tend to more often identify malingering or “no Axis I diagnosis” in prisoners they examine if their caseload is too large and they lack sufficient time to effectively treat the patients they diagnose with mental disorders. Many assessments in solitary confinement units occur at cell-front,
usually the prisoner and clinician stooping down to talk through the food port of the cell door. There is no confidentiality in such an arrangement, and the prisoner is not likely to be forthcoming about emotional problems or suicide inclinations within earshot of prisoners in neighboring cells and staff passing by.

There is no way for currently inadequate public mental health services - in hospitals, in the community and in correctional facilities – to become more effective and humane unless funding is increased. I wish I could offer a plan that does not require greater funding up front. But I think the up-front expenses are more than compensated for by savings in future trouble. When an inadequately treated prisoner suffering from schizophrenia is victimized on the prison yard and sent to solitary confinement for fighting or disobeying orders, and his psychotic condition is exacerbated and made more resistant to treatment because of the damaging effects of isolation, then the costs of managing that prisoner in years to come multiply rapidly. Keeping him in solitary confinement is very expensive, much more expensive than would be the hiring of additional correctional mental health staff who would then have time to talk to him and others like him in depth and figure out, in collaboration with custody staff, a management and treatment plan that would be more effective and make it unnecessary to use so much isolation and force.

As long as I am on the subject of finances, I should emphasize the need for a long-range perspective in funding. In community mental health, I advocate for halfway houses where chronically disturbed individuals can reside with a modicum of clinical supervision and avoid hospitalization and incarceration. When city and county governments look for opportunities to cut their budgets they often decide to defund the halfway houses. This is fiscally foolhardy. They are simply looking at the immediate cost of the program and deciding that cutting that item in the budget will save them money for the next quarter, but they are ignoring the fact that some of the current residents of the halfway houses will be homeless, many will show up at the hospital emergency room in crisis, and many will find their way into jail. Instead of simply looking at the dollar amount of the halfway house budget for the quarter, they should be looking at the total cost of homelessness, hospital emergency room visits and jail services, and if they do so, I argue, they will see that spending the relatively modest amount the halfway houses cost will save them a much greater sum over the years in other services (Rosenheck, 2016). They also need to consider a longer time period than the current quarter’s budget, they need to look at
overall costs for a year or several years to see the savings that will accrue from adequately funding the halfway houses. Similarly, it is short-sighted to cut the budget for mental health services within the prisons when the result will be prisoners with serious mental illness spending more time in solitary confinement. The long-range costs of the isolation will be much greater than the costs this quarter of adequately supervising prisoners in rehabilitation services and mental health treatment.

It is not easy to compare costs of asylum care, community mental health and incarceration. In each setting, there are different levels of services and costs. Thus, in asylums, there is the question of providing intensive talking therapy, which is expensive. In the community, is housing covered? Is early intervention with psychosis? (Rosenheck et al., 2016) Is psychotherapy? How often does the consumer see the psychiatrist? In prison, is the individual with mental illness in minimum security, maximum or supermax? And are mental health services provided? In Florida, the estimated cost per state hospital patient per year is $76,750.¹ The Federal Bureau of Prisons reports corrections costs between $20,000 and $40,000 per year per prisoner, more if receiving mental health care and even more in supermax.² And Soucheray (2013) compared a population of individuals with serious mental illness treated in the community, including emergency room and hospital expenses, with a matched population who spent time behind bars. Treatment in the community averaged $68,000 per year compared to $95,00 for those who spent time behind bars. We need more research about funding, but a consensus is emerging that quality mental health care on the front end saves a lot of money on the back end when the prisoner ends up warehoused in solitary confinement.

I do not favor a return to the asylums. The institutional dynamics and the isolation from society are too damaging. I am a community psychiatrist, and firmly believe that we must try very hard to return individuals with serious mental illness to the community where they would likely live the best quality life their condition permits. But there we must provide them quality wrap-around services so they can adjust and live the best quality lives they can, given their emotional problems and disabilities. We can see by looking closely at state psychiatric hospitals today, more of their beds than ever are being filled with forensic patients, including defendants found not-guilty-by-reason-

² https://www.bop.gov/foia/fy12_per_capita_costs.pdf
of insanity and ex-prisoners on post-release civil commitment. Security has to be beefed up. High security state hospitals start to look and sound like prisons.

Prison is not a viable alternative. The high rate of suicide in prison is only one of many indicators that prison mental health services are far from adequate (Patterson & Hughes, 2008). There is a widely held but erroneous assumption that correctional mental health care is relatively adequate, and that the best place for the indigent individual with serious mental illness to receive treatment is behind bars. This false assumption actually serves to rationalize the consignment of even more individuals with serious mental illness to prison. Thus, in many states the law provides for a finding in criminal trials that the defendant is “guilty but insane.” The jury can find the defendant guilty, not guilty, not guilty by reason of insanity (NGRI), or “guilty but insane” (Grisso et al., 2003). Because many jurors believe that prison is the best place for a severely disturbed individual to receive needed mental health treatment, when given the choice, they opt for “guilty and insane” (La Fond, 1990). Perhaps they also fear that a “NGRI” finding would result in the defendant eventually being released when the defendant seems too dangerous for that. But in the several states where I have investigated correctional mental health care and where “guilty but insane” is an option in jury instructions at trial, prisoners who have been found “guilty but insane” do not receive any different mental health care than do other prisoners, and for the most part that care is quite substandard (ACLU of Colorado, 2013; Cohen, 2014).

There are a very large number of prisoners suffering from serious mental illness today. They will not be released tomorrow. So while I recommend against consigning people with serious mental illness to correctional facilities, I also believe mental health services in jails and prisons must be upgraded for those already condemned to reside therein, and I believe a community mental health model can work in correctional facilities.

As in the community, a community mental health model in corrections requires a spectrum of treatment modalities at different levels of intensity. There needs to be sufficient screening, assessment, outpatient, inpatient, crisis intervention, intermediate care, and case management for the population being served. Clinicians need to form trusting therapeutic relationships with prisoners suffering from mental illness. This is not so easy to accomplish in corrections. Research shows that the more trusting and caring the therapeutic relationship, and
the more continuous it is over time, the more likely the patient is to comply fully with treatment and function the best he or she can, given the level of psychiatric disorder (McCabe et al., 2013). This is the rationale for the continuous treatment team and the assertive community treatment model in CMH, where a subpopulation of the mental health caseload in the community is assigned to a team of clinicians who have continuing responsibility for them (e.g., the clinicians will visit patients at home if they fail appointments, see Teague et al., 1995).

While believing mental health services behind bars need to be brought up to the standard of care in the community, I do not believe adequate mental health treatment can be accomplished in correctional facilities. The culture of punishment is too entrenched, and as every psychologist knows it is much more effective to offer positive rewards than mete negative punishments when the aim is to improve the behavior and condition of individuals with serious mental illness. If community mental health practitioners were given adequate funding for their programs, public mental health would become far more effective than it is now.

Having averred my preference in the current debate about re-establishing asylums and ending the failed project of deinstitutionalization, I should mention some other measures that I consider crucial if there is to be effective community mental health. We need to end solitary confinement in the jails and prisons. The damage caused by the enforced isolation and idleness is too great and often too irreparable (Scharff-Smith, 2011). If jail and prison staff were prohibited from placing prisoners in isolation, then they would collaboratively invent management and treatment plans in the institutions that would greatly reduce the madness, both extreme and irrational behaviors on the part of disturbed prisoners and the excessive use of force on the part of staff. In order for this general plan to be realized, there needs to be a drastic downsizing of jails and prisons. This means there need to be significant changes in sentencing laws. The war on drugs has sent millions of people to prison who do not need to be there. Their lives are harmed by the prison experience, their substance abuse is not effectively deterred, and the result of incarcerating so many people with substance abuse is that the prisons experience an
unprecedented wave of overcrowding and become filled with prisoners suffering from serious mental illness. There have been exciting developments in behavioral health courts, substance abuse courts and diversion from jail to community resources (Stettin et al, 2013). These very successful ventures must be expanded and improved upon. There also needs to be a revitalization of wrap-around safety net services in the community. The people who find their way into jails and prisons have typically been failed by our public schools, dropped out of school, have turned to illicit substances to mitigate the pain of traumas in their lives, had no luck finding meaningful work, have become homeless and then have run afoul of the law. We need to upgrade public education so that well-trained teachers with smaller classrooms can figure out a way to prevent troubled students from dropping out. We need to provide job training and we need to generate jobs and full employment. We need to better fund public mental health services in the community so that consumers will more readily adhere to treatment plans and improve their emotional health. We need to provide everyone with housing, and I have only begun the list here of components in an effective social welfare safety net and public mental health program.

Summary

The plight of patients in the asylum in the 1940s and 50s is contrasted with the plight of prisoners with serious mental illness today. The institutional dynamics are explored as well as the reasons why adequate mental health treatment is quite problematic in the prisons. Community mental health emerges as the preferable model and bolstering the social safety net is proposed as a prerequisite for effective community mental health services.

References


Patterson, R.F. & K. Hughes. (2008) Review of completed suicides in the


<http://www.northcarolinahealthnews.org/2013/07/01/nc-state-study-shows-why-it-costs-less-to-treat-mentally-ill-than-incarcerate-them/>


mental illness in prisons and jails: a state survey. A Joint report of the Treatment Advocacy Center and the National Sheriffs’ Association, April 8. 


Glossary

Asylum. A public mental hospital, usually referring to state hospitals of the 1940s and 1950s.

Deinstitutionalization. The downsizing and closure of state mental hospitals.

Prisonization. The process whereby prisoners give up their identity in the free world and join prison culture.

Supermax. A prison unit dedicated to solitary confinement.

Malingering. Feigning or exaggerating symptoms for secondary gain.

Cell extraction. A forceful take down in a segregation cell.

Disturbed/disruptive. A prisoner who is both suffering from mental illness and acting out behaviorally.

Culture of hostility. A cyclic process where more harsh punishments are meted for increasingly unacceptable prisoner behaviors.

Residential treatment facility. Intermediate mental health care program in prison.

Guilty but insane. A jury instruction distinct from not guilty by reason of insanity.

Discussion Questions

1. Does the consignment of many prisoners to solitary confinement reduce violence or gang activity in the prisons?, or does it simply cause damage to those who are isolated?

2. Are the prisoners in isolation really “the worst of the worst”?
3. Do you believe that a prisoner should have constitutional rights, for example the right to defend him or herself at a disciplinary hearing and the right to be free of cruel and inhuman treatment?

4. In what ways is the situation of the prisoner with serous mental illness in solitary confinement like or unlike the situation of inmates in 1940s and 1950s asylums?

**Learning Assignment**

Go to the Solitary Watch website, select one story about the experience of a prisoner in solitary confinement, copy and paste that story onto your file, and then discuss the case including the social context of the prisoner’s isolation, the details of life in isolation, the ill effects on the prisoner, and the recourse the prisoner has if he or she feels the segregation is unwarranted or unfair.

**Internet Resources**

ACLU National Prison Project:  
<https://www.aclu.org/aclu-national-prison-project>

Solitary Watch:  <http://solitarywatch.com>

NAMI:  <http://www.nami.org>

Human Rights Watch:  <https://www.hrw.org>