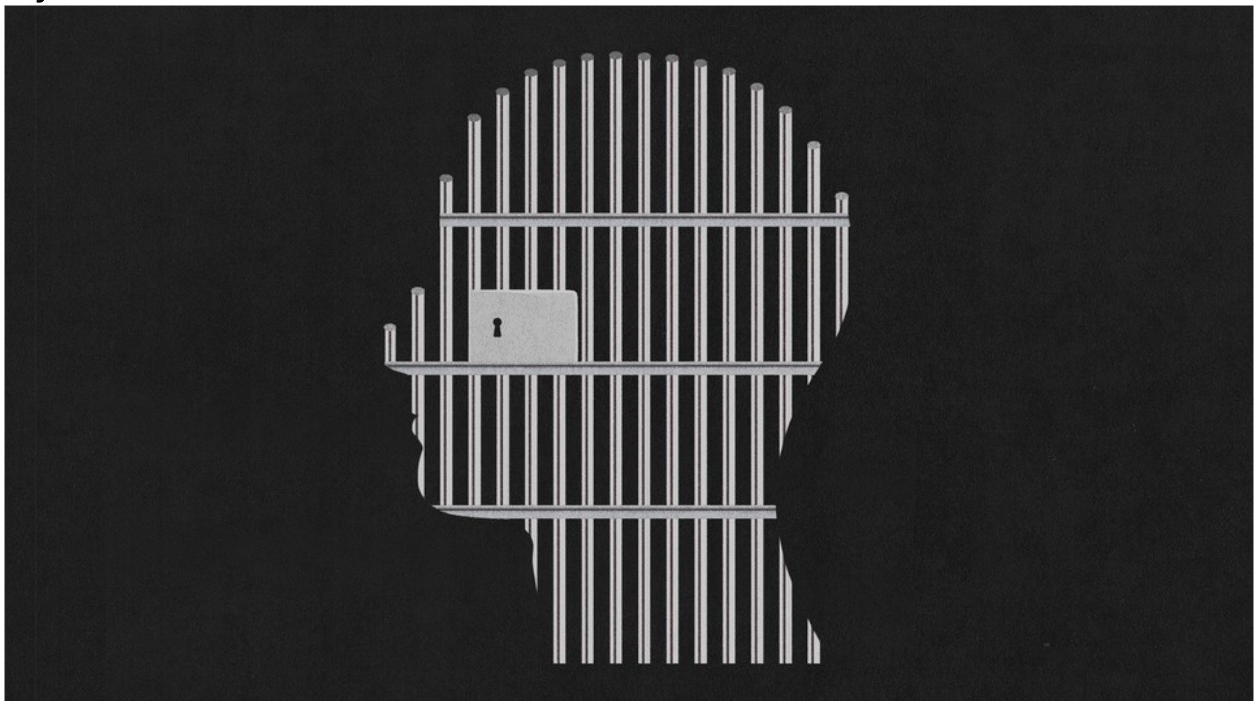
Locking People Up Is No Way to Treat Mental Illness

If we stopped using prisons to warehouse psychiatric patients, we could heal people and save tax dollars.

By Norm Ornstein and Steve Leifman



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Mental illness has touched nearly every family in America in one way or another. Recent reports suggest that the coronavirus pandemic has only exacerbated this situation, particularly for young people and children, as well as for health-care workers. Despite the ubiquity of mental illness, our ability to help those who have behavioral disorders recoup lives interrupted by them is deeply inadequate.

One of us has encountered the broken system firsthand, through the experience of following a son who had a psychotic episode at age 24 through a 10-year struggle with his brain disease, which was intensified by anosognosia, hampering his insight into his illness. The other, a Miami-Dade County judge, has worked for more than two decades to transform the criminal-justice system and how it deals with those with serious mental illnesses such as schizophrenia. Together, we documented this effort in the film The Definition of Insanity, which showcased reforms that have saved both lives and money. Our experience proved to us that even a broken system can be mended.

President Joe Biden's recent announcement of a new package of measures building on last year's American Rescue Plan and aimed at tackling the country's crises of mental health and substance use is extremely welcome, if overdue. The provision of services and treatments for and care of these conditions is antiquated, dysfunctional, and, in places, nonexistent. But throwing money at the situation won't alone solve it. Without a comprehensive overhaul of the system, we run the risk of wasting not only valuable tax dollars but a once-in-a-generation opportunity to fix it.

The failures in services for people with mental illness and behavioral disorders associated with substance use have resulted in mass incarceration becoming the country's de facto mental-health-care system. People with mental illnesses in the United States are 10 times more likely to be incarcerated than they are to be hospitalized. Those who don't end up in prison are likely to cycle repeatedly through patchy psychiatric care, spells of homelessness, and emergency rooms. And every year, about 2 million arrests are made of people with serious mental illnesses.

As a result, the makeup of our prison population tells its own tale: More than 70 percent of people in American jails and prisons have at least one diagnosed mental illness or substance-use disorder, or both. Up to a third of those incarcerated have serious mental illnesses, a much higher rate than is found at large. On any given day, approximately 380,000 people with mental illnesses are in jail or prison across the United States, and another 574,000 are under some form of correctional supervision.

Aside from the human cost,_the fiscal impact is astronomical. For example, Miami-Dade County currently spends $636,000 a day—or $232 million a year—to warehouse approximately 2,400 people with mental illnesses in its jail. In shocking contrast, the entire state of Florida spends only $47.3 million annually to provide mental-health services to about 34,000 people in Miami-Dade and Monroe Counties. And this expenditure leaves almost 70,000 people in those counties with no access whatsoever to mental-health services.

That disjunction is typical: Most states spend far more tax dollars incarcerating people with mental illnesses than treating them. And this spending doesn't even reflect the exorbitant costs of treating comorbidities—people with serious mental illnesses have higher rates of heart disease and cancer than people without psychiatric issues. They are more likely to be admitted to hospitals and stay longer, and are less likely to have insurance.

This situation is particularly shameful because proper treatment can work. Reform should begin by tackling mental and substance-use disorders not as criminal behavior but as illnesses. Arrest and incarceration should be the very last resort for people with serious behavioral-health issues. We need to apply a public-health model to the criminal-justice system, rather than a criminal-justice model to the behavioral-health system.

A good start would be to develop and fund a model crisis-response system for people with mental illnesses and substance-use disorders, just as we do for emergency-room medicine. The National Council for Mental Wellbeing recently published the "Roadmap to the Ideal Crisis System," the result of a five-year project by the Group for the Advancement of Psychiatry, which lays out the main elements and best practices for such a crisis-response apparatus. This ought to receive priority funding, as should the recommendations of the task force created by the Conference of Chief Justices and the Conference of State Court Administrators to examine the state courts' response to people with mental illnesses. The federal government should work closely with that initiative. (One of us was a co-author of the NCMW report, as well as a member of the task force.)

Alongside that program, we should implement a series of other measures. Far too many people with mental illness are incarcerated because of encounters with police that escalated. This is particularly true for people of color with mental illnesses: Already overrepresented in the criminal-justice system, they are at a greater risk of dying during an encounter with law enforcement. We need to develop a coordinated approach with law enforcement and the courts that makes diversion to treatment programs possible, both before and after an arrest, through peer-support specialists and programs like the police Crisis Intervention Team. Some cases could be heard in the civil-court system, rather than in a criminal court.

To help fund these treatment programs, we should limit the use of what's known as competency restoration to only the most serious offenses. Treating a person with mental illness simply to make it possible for them to stand trial, and for no additional purpose, is a shocking misuse of desperately needed resources. The funds saved by minimizing the practice could go instead to front-end, community-based prevention and treatment services.

We should also develop mobile-health-care units for rural and underserved communities to provide an array of services, including primary-health, mental-health, and substance-use screenings. And we must provide more access to telehealth counselors for people in need of crisis care, as well as to promote service coordination and continuity of care across treatment systems.

Another priority for action, also targeted at underserved communities, is creating regional treatment facilities for individuals with serious mental illnesses and complex needs who are otherwise likely to encounter law-enforcement agencies and the courts. These facilities need to offer a comprehensive and coordinated system of care for individuals with serious mental illnesses, especially those who experience chronic homelessness or who may already be frequent and costly recidivists in the justice and health-care systems. Such centers will need to provide various levels of residential treatment, day treatment and day-activity programs, outpatient behavioral health, and primary care. The health-care end of this will need to cover things as diverse as trauma services and dental work. And follow-up social services should include vocational rehabilitation, employment services, adult-education opportunities, housing assistance, and free legal advice. Miami-Dade is planning to open the first facility of this type later this year.

Amid this new capacity for treating behavioral-health conditions, we should not forget that law-enforcement officers themselves are far from immune. Various studies have reported their rate of post-traumatic stress disorder to be from 15 to 35 percent, compared with 3.5 percent for the public generally. Last year, more law-enforcement officers died by suicide than in the line of duty. Law-enforcement officers also experience high rates of substance-use disorders. Mental-health treatment should be made available to every law-enforcement officer outside their department, to ensure confidentiality and encourage take-up.

Training in de-escalation, together with help for officers in managing their own trauma and stress, can reduce violent encounters with police, and not just those involving serious mental illness. Miami-Dade County now has more than 7,600 police officers at all of its 36 agencies who are trained in Crisis Intervention Team techniques. In the five years before CIT training, which began in 2000, the City of Miami police had a total of 90 police shootings, but only 30 in the first five years following the training. And from 2014 to 2019, as more police were trained and the culture of the department changed, the number dropped to 16. From 2010 through 2019, the City of Miami and Miami-Dade CIT officers handled more than 105,000 mental-health-related calls, yet these resulted in only 198 arrests—a laudably low total. Thanks to CIT training and other diversion programs in Miami-Dade, the county has avoided spending $39 million a year on 400 years' worth of jail-bed days, and by closing one of its three main jails has realized a saving of $12 million a year.

Changing the way we do policing and manage behavioral-health problems in our courts can also go a long way toward addressing the racial disparities that have for so long tarnished the criminal-justice system. The experience of Miami-Dade County shows that reform, followed by the right services, can break the cycle for many who have struggled with homelessness and behavioral disorders, and enable them to move toward productive lives. And all of this saves money.

The president's latest budget promises $225 million, starting this year, to train a new cohort of paraprofessionals, many of whom will go to work in the mental-health field. That is an encouraging start, but, again, to get the spending right, we need to accurately determine the number of behavioral-health professionals needed to break this cycle of carceral warehousing of people with mental illness and substance-use problems. That will need to involve creating incentives for clinicians to get advanced training and then adequate compensation for the work of treating those with chronic serious mental illnesses.

Finally, the states need to modernize their civil-commitment laws, which allow for the court-ordered involuntary confinement of people with serious mental illnesses and substance-use disorders. Many of these laws are 50 years old and do not reflect modern science and medicine.

Granted, even Miami-Dade is still spending too much money keeping people with serious mental illness in jail. No one, least of all us, underestimates the challenges involved. With the pandemic spotlighting the need for a more deliberate approach to the delivery of these services, we have an opportunity to create a new vision for mental-health and substance-use treatment. If we take these commonsense steps, we will improve our public health and safety, save valuable tax dollars, and return hope and dignity to people in crisis who do not belong in our jails and prisons.