

# The question of sanity restoration in jail

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**Abstract**

Severe mental illness, especially psychotic disorders that are worsening, acute or complicated, normally require intensive psychiatric care and treatment that is most appropriately provided in a mental hospital. For criminal defendants, transfer to a forensic security hospital has traditionally been the means of achieving hospital care for mentally disordered defendants who have been found incompetent to stand trial or not guilty by reason of insanity. In recent years, with the shortage of intermediate and long-term hospital beds in the United States, including forensic security hospital beds, jail-based competency restoration programs are being established, seemingly obviating hospital transfer. Potential advantages of and concerns about jail-based, as opposed to hospital-based, competency restoration programs are discussed in the literature. If defendants with severe mental illness traditionally treated in a forensic security hospital for competency restoration are now treated for competency restoration in jail, it is not inconceivable that insanity acquittees could one day be treated in jail for sanity restoration. With the premise that it is better to consider the potential consequences before this becomes a serious proposal and is implemented, this analysis examines the advantages and concerns that have been put forth for jail-based competence restoration programs as they may or may not apply to jail-based sanity restoration programs. Substantial commonality is recognized, but also some differences, as well as reason for skepticism of the purported virtues of either alternative to care and treatment in forensic security hospitals.

## 1 | INTRODUCTION

The possibility of jail-based treatment and restoration to sanity (RTS) of mentally ill offenders who are adjudicated not guilty by reason of insanity (NGRI) seems unthinkable. Yet not long ago jail treatment for restoration of competence to stand trial was not seriously contemplated and today jail-based competence restoration programs are a reality. Jail-based programs can and do restore defendants to trial competence. For example, from 2010 to 2016, the jail-based restoration to competence (RTC) program in the Yavapai County Jail in Arizona restored 226 (79%) of 306 defendants to trial competence (Bloom & Kirkorsky, 2019).

Unlike many countries, the United States has two types of correctional facilities. Administered locally by cities and counties, jails house pretrial detainees and inmates sentenced to less than 2 years for minor crimes (misdemeanors). State or federal facilities, typically remotely located, house offenders for 2 years or more having been convicted of a serious offense (felony).

In the mid-1970s, Stone (1976) argued that hospitals were overused for criminal defendants, as many transferred to the hospital were found to be competent to stand trial. Since then evaluations and determinations of incompetency have been accomplished without transfer and transfer has since occurred only after a court finding of incompetence and order for hospital treatment. In the latter part of the 20th century, the number of mentally ill persons in jails and prisons surged to unacceptable levels. As security hospitals have been substantially reduced even with the increasing demand for their services in jails and prisons (National Association of State Mental Health Program Directors, 2017), jail-based RTC programs were established as a potential, if partial, "solution".

In the United States five purposes are served by the forensic security hospital (FSH): (1) to restore an incompetent defendant to competence to stand trial; (2) to restore mentally ill offenders incompetent to sanity; (3) to treat convicted offenders who at the end of their sentence require hospital-level mental health services; (4) to treat and safely manage civilly committed patients whose potential for inpatient violence cannot be safely managed in a less restrictive hospital setting (Norko & Dike, 2009); and (5) to treat and safely manage jail detainees whose serious mental disorder is in need of hospital level and quality of services (Felthous, 2017). The first two purposes are the most traditional and customary uses of the FSH, typically justified by the need for hospital treatment as well as security provisions to reduce the risks of violence and escape. An adversarial hearing or a court order is uniformly required for admission for any reason.

Security hospital treatment has in recent decades become increasingly difficult to impossible to obtain for jail inmates who have not been found incompetent to stand trial (IST) or NGRI (Torrey, Zdanowicz, & Jennard, 2014). Even for those adjudicated as IST or NGRI, an unconscionably lengthy waiting time can ensue before a scarce hospital bed opens in the appropriate hospital, resulting in delayed treatment and the possibility of further deterioration in the individual's mental condition as well as a denial of constitutional rights.

Favorable reports of jail-based competency restoration programs as well as reviews analyzing the advantages and disadvantages of such programs have appeared in the forensic literature. The involuntary administration of antipsychotic medication to mentally ill offenders in jail and outside of a hospital has been gaining acceptance and, in some cases, is applied to defendants in jail-based competence restoration programs, although this practice is also not without controversy.

Those found NGRI or the jurisdictional equivalent in Argentina, Australia, Austria (Stompe, Frottier, & Schanda, 2007), Brazil, Bulgaria, Canada, German, Great Britain, Japan, the Netherlands, Nigeria, Switzerland (Graf & Dittmann, 2007), Turkey and the United States are typically sent to a mental hospital for treatment (Simon & Ahn-Redding, 2006), especially if they are dangerous and would not be safe risks as outpatients. In a few countries, the described law uses terms that are not explicit as to whether intramural psychiatric treatment occurs within a mental hospital or a mental unit within prison that may or may not approximate a mental hospital unit (e.g., "specialized psychiatric ward", "closed institution", "secure facility"). In general, however, countries with a developed criminal justice system and an insanity defense provide mental hospital treatment for those in need of this level and quality of care.

Although the legal objective of competence restoration (RTC) and sanity restoration (RTS) programs are different, treatment and improvement in the offender's mental disorder are common, core, essential clinical objectives of both. Only with improvement in the offender's incapacity-causing mental disorder can the legal objectives be realized. Traditionally this has meant hospitalization, where hospitalization was indicated for any severe mental disorder, for both competence and sanity restoration. Where the person's mental disorder rendered the offender incompetent or not mentally responsible at the time of the offense, yet he or she was deemed to be cooperative, treatment-compliant and at little risk for violence or escape, competency or insanity restoration could, if such a program were available, be treated in a less secure setting, perhaps a civil hospital or even in an outpatient program. Important was matching appropriate treatment and security measures to correspond to the needs of mentally disordered offenders. Both RTC and RTS programs were to be free of punitive elements and optimally therapeutic, and hence hospitals, not jails or prisons, were the designated treatment facilities. These general principles of treatment and management were equally regarded for both RTC and RTS programs.

So it may not be unreasonable to ask whether the justifications for jail-based treatment RTC programs, now increasing in number in the United States, would be just as valid for RTS programs, in particular for the treatment of psychotic conditions, which continue to be treated primarily, at least initially, in hospital settings. It seems prudent to address this possibility before it is considered by policymakers, based primarily on budgeting priorities, as has been the case for jail-based RTC programs (not enough hospital beds), and put into practice without further analysis.

The purpose of this present analysis then is to examine the purported advantages and disadvantages of jail-based RTC programs and consider whether and to what extent such considerations could apply to RTS programs, which up to now have been beyond the pale of serious discussion. We begin with a brief description of RTS programs in the United States. Next we review the principal advantages and disadvantages of jail-based RTC programs, including the possibility of jail-based involuntary medication. After addressing whether and to what extent these same advantages and disadvantages could apply to RTS programs, we suggest some treatment and policy implications that pertain as much to RTC as to RTS programs.

## 2 | TREATMENT TO RESTORE SANITY

Today hospital referral for treatment is the common disposition when a defendant is acquitted based on insanity, even as the insanity defense itself is heterogeneous throughout the states (*Kahler v. Kansas*, 2020). Throughout the many articles and book chapters written on correctional psychiatry and the insanity defense in recent decades, precious little has been written on the purpose of hospital treatment for mentally disordered insanity acquittees. Perhaps the purpose seems so self-evident, such as hospitalizing a patient for major surgery, that no expressed justification is needed. In contrast to hospitalization for major surgery, hospitalization of an insanity acquittee serves to protect the public from future violent acts, but this could be accomplished as well, if unfairly given the acquittal status, in a jail or prison.

With the improved effectiveness of newly discovered antipsychotic agents, increased concern about oppressed minorities and the chronic institutional confinement of mentally ill patients, the dehospitalization and community mental health movements gained traction in the 1960s and 1970s and progressed over the ensuing decades. Principles of least restrictive treatment and early hospital discharge also applied to insanity acquittees. With exaggerated public concerns that the insanity defense was overused (Lee, 2017) and that insanity acquittees posed an unacceptable risk of violence to the public, some states narrowed their insanity standard or eliminated it altogether. Many states tightened laws regulating the management of insanity acquittees to ensure greater public safety. For example, states enacted procedures for the original trial court to retain jurisdiction post-adjudication, as the offender progresses in graduated step-down placements through community release. Prosecutors were allowed to participate in furlough and release court hearings (Lee, 2017), and ongoing safe management was ensured by step-down community-release programs (Borum & Fulero, 1999; Lee, 2017). These procedures were primarily intended to

protect the public from the violent acts of NGRI acquittees. Case law and professional literature focused on striking the right balance between protecting the public and protecting the acquittee's due process rights, especially liberty interests. Insanity restoration programs, with ample periods of hospital treatment, followed by "step down" procedures with measured reduction in security levels, followed by conditional release, have been shown to be successful in reducing rates of criminal recidivism and relapse requiring rehospitalization in comparison with the treatment and release of individuals with serious mental illness from community hospitals or prisons (Norko et al., 2016; Reynolds, 2016).

If time-limited security were the only interest, jail or prison treatment and management might have sufficed. Not to be overlooked, however, was the need for appropriate treatment, that is humanitarian, effective and fair treatment (i.e., not at all like punishment). Hence, treatment was to take place in a hospital, appropriately staffed and programmed to address these aspects of mental healthcare. Better yet, FSHs, unlike jails and prisons, could be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), to further ensure quality hospital treatment, corresponding to that provided to nonoffending individuals with serious mental disorders in the community.

### **3 | COULD PURPORTED ADVANTAGES OF JAIL-BASED RTC PROGRAMS PERTAIN TO JAIL-BASED RTS PROGRAMS?**

To the author's knowledge jail-based sanity restoration programs do not exist, so anticipating advantages and disadvantages of such programs is hypothetical. Nonetheless, given that a core objective of both competence and sanity restoration programs is the effective and humane treatment of serious mental illness in a safe and secure setting, if this can be accomplished for competence restoration in a jail, a questionable proposition as already suggested, could not sanity restoration take place in jail (or a comparable prison facility) rather than in a FSH? Would not the same advantages and disadvantages pertain? Would such an analysis favor or disfavor jail-based sanity restoration? For this comparison, then, we return to the very same proposed advantages and concerns expressed for jail-based competence restoration. We begin with the six reasons to establish jail-based RTC programs identified by Danzer, Wheeler, Alexander, and Wasser (2019).

#### **3.1 | Hospital-based RTC hospital programs are no longer available**

The lack of available hospital beds is said to be the "root" of the problem (Torrey et al., 2014). One often hears that there are insufficient hospital beds and insufficient state revenue to support the creation of more beds, that this is reason to move RTC programs into jails (e.g., Ash et al., 2020). On the contrary, the lack of available hospital beds is the problem; its "root" would be found in the reasons for this dearth in the spectrum of mental health services. As formulated, this factor does not pertain to hospital-based RTC programs which continue to exist and fulfill their purpose. As a generalization, this statement is an exaggeration because in most jurisdictions in the United States the most common RTC programs are hospital-based. Increasingly common in recent decades however, the hospital-based RTC programs are fully occupied and a substantial portion of FSH beds are occupied by insanity acquittees, resulting in unconscionably long waiting times for defendants found IST to be transferred so that hospital treatment can commence. If FSH beds are in census fully or overoccupied, this could delay hospital transfer of insanity acquittees as well, although this has not received the attention that has been aimed at delay in hospital transfer of incompetent defendants. Much more useful than the observation that RTC beds, if not forensic security beds in general, have become so extremely unavailable, is to ask why this deficiency exists, and how it can be corrected.

Explanations for the dramatic reduction in RTC beds are to be found in the reasons that state hospital beds in general have been reduced, the increased mental health services now available in jails, and the unrelenting search by policy makers and administrators for ways of reducing the state's financial burden posed by individuals with serious mental illness.

Contrary to conventional assumption, the insufficient number of beds is not a matter of limited resources; it is a matter of political will and priorities. Even in today's climate of indifference to the most pressing needs of the most seriously mentally ill inmates, there are exceptional jurisdictions that have responded to this need (Finkle, Kurth, Cadle, & Mullan, 2009; Olley, Nicholls, & Brink, 2009). In Oregon and Washington federal courts found that prolonged delays in hospital transfer of inmates found to be incompetent violated their constitutional rights (*Oregon Advocacy Ctr v. Mink*, 2003; *Trueblood v. Washington State Department of Social and Health Services*, 2015). In both states the creation of more beds in the hospital-based RTC program was required (Felthous & Bloom, 2018). The state of Hawaii recently constructed a 144 forensic patient facility at the Hawaii State Hospital in Kaneohe, Hawaii (Office of the Governor-News release, 2018).

The argument of insufficient mental health resources for security hospital treatments is as untrue and misleading for RTC programs as it would be if applied to RTS programs. As already observed, FSH RTS programs today are amply funded, supporting, among other measures, extended hospital treatment that contribute to bed occupancy. The financial support of these programs is rarely questioned. Moreover, as hospital treatment for severely mentally ill inmates, even acutely psychotic inmates in urgent need of hospital transfer, has become increasingly unavailable in recent decades, intramural long-term treatment programs for sexual offenders have been developed in several states (Felthous & Ko, 2018), and the resources for such programs are not so threatened by policy-makers with fiscal concerns. Not only is "unavailability" of hospital-based RTS programs not a reason to move such programs into jails, but it is also a dubious justification for transferring RTC programs to jails.

### 3.2 | More economical

If jail-based RTC programs are more economical than hospital based programs, this should also be true for RTS programs. Indeed, analysis of some jail-based RTC programs showed that they substantially reduced the cost of competency restoration in comparison with hospital treatment (e.g., Ash et al., 2020; Rice & Jennings, 2013). In comparing competency and sanity restoration, any economic saving from the former would be based on the much larger number of individuals in need of restoration, whereas the savings from the latter will come from the lengthy treatment period for sanity restoration. This consideration alone, i.e., the per-capita cost of treatment, could also be a justification for jail-based RTS programs.

For both jail-based RTC and RTS programs, however, other economic aspects need to be considered. As noted below, many jails, even well programmed and resourced jails, fall short of fulfilling their obligation to provide those mental health resources that fall within their well-recognized responsibilities. Even before some jails today began to release inmates due to the Covid-19 pandemic (Aaro, 2020; Neidig, 2020; Tully, 2020), jails were releasing inmates because of overcrowding and inability to care for them properly (e.g., Bradbury, 2020). The release of more than 30,000 state prisoners as required by the U.S. Supreme Court placed additional strain on California's already overcrowded jails (Sacramento Bee and Publication Staff, 2019). If either RTC or RTS programs are developed in jails, will this drain already deficient resources? Or will other, outside creative funding be secured for such programs? Such economic concerns pertain equally to RTC and RTS programs.

At least initially, a stand-alone jail-based RTS program could be more expensive per capita, because it is more costly per capita to support an entire program for just a few individuals than a larger group. This depends on how "hospital-like" and specialized the respective programs will actually be. It may be that any substantial reduction in program costs is a result of reducing the full panoply of services provided in security hospitals and required to achieve and maintain JCAHO accreditation.

### 3.3 | No need for procedures and transfers that delay treatment

This is an issue that would involve hospital treatment regardless of whether the offender with mental illness had been adjudicated as incompetent or NGRI. If this is a justification for jail-based RTC programs, it is also a justification for would-be RTS programs.

In either case, however, one should ask why the procedures and why the delays. Once the individual is adjudicated IST or NGRI, if the court orders hospital transfer, there should not be further delay, unless the programmatic beds are full, a condition with a remedy given the political will. Unless the individual refuses the needed antipsychotic medication, there should be no delay in initiating pharmacotherapy regardless of whether treatment occurs in a jail or in a hospital, and regardless of whether the individual is adjudicated IST or NGRI.

Perhaps the most significant cause of delay in initiating pharmacotherapy is where the individual refuses needed antipsychotic medication. Medication refusers are either not accepted into the jail-based RTC program or are transferred to a state hospital if this refusal occurs while in the programs at San Bernadino, California (Rice & Jennings, 2014), and Atlanta, Georgia (Ash et al., 2020; Tatugade, Coffman, Roberts, & Brown, 2016), measures deemed prudent by Bloom and Kirkorsky (2014). Unknown from the scant literature on jail-based RTC programs is the extent to which such programs in general have and avail themselves of the options of hospital transfer for those defendants whose mental condition is not improving or is worsening regardless of whether they are medication-compliant. In such cases treatment may have been more efficient if the individual had been transferred to the FSH initially. Another consideration is whether a defendant's competency should be found to be unrestorable without first having transferred him or her for hospital treatment. In some jail-based RTC programs, if the patient's condition is deteriorating despite treatment efforts or if he refuses medication, he can, with appropriate procedure, be transferred to the FSH, where with further procedure (e.g., Ash et al., 2020) involuntary medication can be initiated.

Alternatively, the jail-based RTC may already have a *Harper* procedure (*Washington v. Harper*, 1990) in place for involuntary administration of medication. This is a controversial policy as it involves a misinterpretation and misapplication of *Harper* (see later), but it could, though without guarantee, appear to obviate hospital transfer. Although still questionable (Felthous, 2015), a *Harper* procedure would not raise the *Sell* pretrial concerns for insanity acquittees (*Sell v. U.S.*, 2003), where the offender has already been adjudicated. In either case the likelihood of delays should be affected primarily by whether the involuntary medication procedure follows a treatment-driven or rights-driven model (Pinals, Nesbit, & Hoge, 2017).

The procedural issues, greater pretrial, and potential delays in treatment pertain to both IST and NGRI defendants. If anything, the potential for delays should be less for insanity acquittees. So, this should be a less compelling reason for moving RTS programs into jails. Delays in initiating treatment for incompetent defendants are human-made delays that could and should be corrected with policy changes, such as by opening hospital beds for those in need of hospital care.

### 3.4 | Training opportunities close by

Jail-based RTC programs are typically established in large jails in metropolitan areas with medical and other professional schools and other large medical centers in the vicinity. This is clearly an advantage of jail-based RTC programs, although educational programs and jails do not always avail themselves of the opportunity for win-win collaboration and do not always maintain successful collaboration already in progress. Although a clear advantage, the difference need not be as extreme as first appears. For example, Chester Mental Health Center, the very remotely located maximum security hospital for the state of Illinois, was the primary site for the forensic psychiatry fellowship of Southern Illinois University (SIU). This FSH also supported inpatient experiences for medical students and those in the SIU combined medical-legal program for students earning both medical (MD) and law (JD) degrees at the same time. FSH faculty and trainees, participated via telemedicine in grand rounds in Springfield, Illinois, received lectures via

telemedicine from the law school in Carbondale and held seminars on landmark cases and in forensic psychiatry transmitted by telemedicine from the FSH to the medical school in Springfield. The potential advantage of jail-based RTC programs for nearby teaching institutions would be equally valid, with these same caveats and qualifiers, for jail-based RTS programs.

### 3.5 | Reduced incentive to malingering

There may be less incentive to malingering if one faces a jail-based program rather than a hospital-based program. Nonetheless, this may be more of a hypothetical than an empirically quantified advantage, as defendants in jail-based RTC programs have been known to malingering (e.g., in the jail-based RTC program of the Yavapai County Jail, AZ (Bloom & Kirkorsky, 2019)). If this were to become an established advantage of jail-based RTC programs, it could be an equally valid advantage regardless whether the program is a RTC or a RTS program. This possibility should elicit two other considerations: The forensic psychiatric or psychological evaluations should have addressed and screened out malingering regardless of whether the legal issue was competency or insanity, and regardless of whether or not incompetency or NGRI determinations would result in hospital-based transfer. The second consideration is whether a correctional setting is considered more punitive than therapeutic and whether it is actually less therapeutic and/or humanitarian than an actual hospital program, even if the desired outcome of competency restoration occurs in the majority of cases. If a jail setting disincentivizes malingering because it is more punitive and restrictive and less humanitarian than a hospital setting, this may be a less ethical setting for treatment of seriously mentally ill defendants and insanity acquittees.

The potential to disincentivize malingering for IST should be just as valid for NGRI as should be the potential concerns raised here. Also to be considered for both is whether the reasons that jail-based treatment may disincentivize malingering are acceptable conditions.

### 3.6 | Treatment can begin immediately

The treatment of jail inmates with mental illness should begin immediately regardless of whether they will eventually be found IST or NGRI. If hospitalization is needed and emergency legal criteria are satisfied, the inmate should be transferred within 24 to 48 hours. If found IST or NGRI, treatment should be initiated promptly regardless of whether the inmate is in jail or in a hospital. Again, the potential delay is in initiating involuntary medication when needed, which may require some judicial review. In its *Psychiatric Services in Jails and Prisons*, the American Psychiatric Association recommend the equivalency principle, viz., "The fundamental policy goal for correctional mental healthcare is to provide the same level of mental health services to each patient in the criminal justice process that should be available in the community" (American Psychiatric Association, 2000). This should mean that a psychotic patient who refuses indicated medication will be admitted to a hospital as is the practice in the community (Felthous, 2015). The equivalency principle is not mentioned, however, in the current edition and involuntary administration of psychotropic medication is now included among the essential mental health services to be provided in jail, state law permitting (American Psychiatric Association, 2016).

More than ordinary U.S. citizens, jail detainees have a right to treatment which is protected by the Due Process Clause of the Fourteenth Amendment to the United States Constitution (*Bell v. Wolfish*, 1979; *City of Revere v. Mass Gen Hosp*, 1983). Convicted prisoners also have a right to treatment based upon the prohibition of unusual punishment furnished by the Eighth Amendment (*Estelle v. Gamble*, 1976). The right to treatment includes psychiatric treatment and also applies to offenders adjudicated NGRI and determined to be in need of psychiatric treatment and whose condition requires the nature and level of mental hospital care. If treatment delayed is treatment denied with potentially adverse health risks as a result (e.g., see Section XII, Felthous, 2015) or violation of constitutional rights,

timely initiation of appropriate treatment of serious mental illness is imperative regardless of the legal status of the defendant or NGRI acquittee.

If treatment is delayed because either transfer or involuntary medication is delayed, and providing treatment in the jail reduces or eliminates the delay, this benefit of jail-based treatment would be equally valid for both competence and sanity restoration. However, the premise that such delays for either purpose must be accepted and left unchallenged and uncorrected is questionable.

## 4 | CONCERNS ABOUT JAIL-BASED RTC PROGRAMS

Kapoor (2011) was the first to express concerns about proposed and emerging jail-based RTC programs. She maintained that RTC programs may compromise the defendants' rights as patients and that treatment of individuals with serious mental illness who would normally be treated in a hospital further criminalizes those with mental illness. Today Kapoor argues by Connecticut's example that a state can enjoy a continuum of services including outpatient RTC programs without incurring long waits for IST defendants to enter a RTC program and without adding to the jails' legitimate mental health service burdens (Kapoor, 2020).

These concerns would generally also pertain to insanity acquittees, although some significant differences between the two statuses must be recognized. The main difference is that the incompetency status occurs pretrial whereas the insanity acquittee has already been adjudicated and found to be innocent of the charge based upon the insanity verdict. The insanity acquittee has a right not to be punished because of his insanity acquittal. Therefore, hospital treatment of his mental illness is appropriate; prison, purposed for criminal punishment, would not be appropriate. Jails, in contrast to prisons, serve a dual purpose: detainment of defendants awaiting trial and punishment for misdemeanors. Unless returned to jail for a post-sentencing hearing, insanity acquittees would normally not have a reason to be in jail. And certainly insanity acquittees should not be punished by placement in jail. Jail treatment for insanity acquittees who require hospital level of treatment would not amount to the least restrictive and most appropriate approach to mentally disturbed offenders who have been acquitted based upon insanity. Jail placement of insanity acquittees could be considered as cruel and unusual punishment and therefore as unconstitutional.

In their recent critical analysis of the newly developed jail-based RTC programs, Felthous and Bloom (2018) raised specific concerns. We now consider whether and how each of these concerns could be applied to jail-based sanity restoration programs.

### 4.1 | Insufficient suspension of criminal proceedings

The first of these is presented as a question of whether a defendant found by the court to be IST should, with this finding, remain in jail at all (Felthous & Bloom, 2018). If continued jailing of an inmate who is mentally ill and incompetent is improper, would it not be equally improper to maintain an inmate who is mentally ill and insane? The legal rights of these two conditions are somewhat different; the former not having been found guilty of a crime; the latter having been acquitted. In either case, any disposition with coloration of criminal punishment ought to be unacceptable where the appropriate treatment setting for the mental disorder would have been in a hospital.

The specific concern raised by Felthous and Bloom (2018) was whether continued detention of an incompetent person in a jail with a predominantly correctional environment fulfills the definition of suspending criminal proceedings. Once the person is found incompetent, his or her prosecution is not to resume until the person is no longer incompetent. Obviously prosecutorial hearings are to be suspended, but should the person also be treated, in terms of placement, more as someone with a serious illness than as someone awaiting trial when both define the person's condition?

This concern as formulated does not exactly pertain to the insanity acquittee who should face no further prosecutorial hearings. There should, however, be a very comparable and closely related concern: would continued detention of an insanity acquittee in a jail with a predominantly correctional environment be at all appropriate for a mentally ill offender who is innocent of the criminal charge(s) because of mental illness?

## 4.2 | Insufficient jail resources

The second concern is whether a jail has the resources to develop and staff a RTC program while first ensuring that it is addressing an inmate's mental health needs that are traditionally the responsibility of jails.

The nation's jails continue to struggle collectively to reduce the unacceptably high rate of jail suicides. Hayes and Kajdan (1981) identified 419 jail suicides in his first nationwide National Center on Institutions and Alternatives jail suicide study. Seven years later he registered 401 U.S. jail suicides (Hayes, 1989). Over the same period the rates of suicides in U.S. prisons dropped from 34 per 100,000 inmates in 1980 to 16 per 100,000 inmates in 1990 and then seemed to have stabilized. In U.S. jails, the rates of suicide, still unacceptably high, fell from 129 per 100,000 in 1983 to 47 per 100,000 in 2002 (U.S. Department of Justice, 2005). Earlier this century, Hayes (2010) found 366 suicides in U.S. jails in 2005 and 330 in 2006 for a total of 696 over the 2 years, about evenly split between holding and detention facilities. By 2014 however, the rate of jail inmates' suicides was 50 per 100,000 jail inmates, the highest rate in local jails since 2000. The fact that nearly half (47%) of all jail suicides between 2000 and 2014 occurred in general housing (Noonan, 2016) suggests that the potential for suicide among many jail inmates had gone undetected.

We do not have comparable statistics for state mental hospitals or FSHs, but Williams, Schmaltz, Castro, and Baker (2018) estimated that between 31.0 and 51.7 suicides occur per year during psychiatric hospitalization, based upon extrapolation of data from their study of suicides in U.S. hospitals.

After half a century, the rates and numbers of U.S. suicides in U.S. jails continues to be a major mental health problem of the government's making. Suicides are but one example of where jails need to improve the safety and mental health services for individuals entrusted to their care before taking on the state hospitals' responsibility of providing intensive psychiatric services for individuals with serious mental illness, whether they have been found to be IST or NGRI.

One recommended measure is constant observation of the acutely suicidal inmate (American Psychiatric Association, 2016; Hayes, 1995). Even this is often resisted by jail administration because, it is argued, that taking staff from another part of the jail creates safety risks where the jail is already understaffed. Jails are expected to provide those medical and mental health services that are available to individuals with serious mental illness in the community.

An increasingly recognized mental health responsibility of jails today is the task of supporting and planning the aftercare follow-up of inmates who need continuing mental healthcare (American Psychiatric Association, 2016). In their study of conditional release in Louisiana, Manguno-Mire, Coffman, DeLand, Thompson, and Myers (2014) found that those conditionally released from jail had far fewer days to their first incident (relapse, violation of rules of the conditional release or arrest) than those discharged from a security hospital (67 vs 575 days). The reasons for this discrepancy were not explained, but one must ask if treatment, preparation for discharge and aftercare planning in jails are as complete as in FSHs. Because the time of the inmate's release is unpredictable, this task can be more challenging than the planning of hospital discharge and aftercare. The American Psychiatric Association's work group has specified which services this mental health responsibility entails (American Psychiatric Association, 2016). Arguably, re-entry planning includes addressing the rehabilitation and treatment needs of inmates with substance use disorders (Meyer & Altrice, 2015).

There has been woefully insufficient research into the fate of mentally ill and substance use-disordered persons released into the community, but the few available follow-up studies indicate that post-discharge planning is

generally inadequate and in need of greater attention. European studies of released prisoners indicate a substantial elevation of suicide soon after release (Haglund et al., 2014; Pratt, Piper, Appleby, Webb, & Shaw, 2006). U.S. studies demonstrated elevated death rates from various causes, especially drug overdose, following release from correctional facilities (Joudrey et al., 2019). Investigators have recommended that increased resources be allocated to serve inmates who are at risk of suicide or have a substance use disorder and to facilitate this safe transition into the community (Haglund et al., 2015). Although resource-strapped jails must prioritize and first meet the immediate mental health needs of persons in their custody, ensuring continuity of needed care also seems a more proper function of jails than taking on responsibility of hospital care for the most seriously mentally ill inmates. Even if the funding for staff and programs of an RTC program were to be provided by an outside source such as the state, jail administration and healthcare providers must carefully examine how the introduction of such a new program would impact the rest of the jail and the jail's other established mental service obligations.

Jails have far less control over their admissions than hospitals and often are over-census. Even with risky overcrowding, they may be unable to exercise a "drive by" policy. With today's Covid 19 pandemic and civil unrest, some jails are experiencing extraordinary census fluctuations. Current proposals to reduce funding for law enforcement raise even more uncertainty about how police and sheriff departments will fund basic health services in their detention facilities, let alone new programs normally located in FSHs.

### 4.3 | Inappropriate setting for forced medication

The third concern is the questionable use of forced medication in jails using a *Harper* process for competence restoration (Felthous & Bloom, 2018). Still uncommon, involuntary administration of antipsychotic medication in jail offers the possibility of providing needed pharmacotherapy where timely hospital transfer has become unavailable. Felthous has argued against this practice (see Felthous, 2015 for a thorough analysis of this issue), but space does not permit the reiteration of these objections here. To be added, however, is the "slippery slope" concern that, to the extent that a jail treatment program is regarded as equal to a hospital treatment program, other consequences can follow. The Joint Report touted South Dakota as the only state with a statute for a *Harper* procedure for involuntary medication in jails (Torrey et al., 2014). Subsequently, in South Dakota mentally ill persons in need of hospital treatment and with no criminal charges were sent from the hospital emergency room to the county jail where they were admitted and could be administered antipsychotic medication involuntarily (Miller, 2017). This practice may have resulted in prompt treatment at reduced cost, but with departure from standard of care and still further criminalization of the mentally ill. Today five states allow jailing of mentally ill persons: New Mexico, North Dakota, South Dakota, Texas and Wyoming (Anderson & Kaczke, 2019).

Clinically and ethically the potential benefits and liabilities of involuntary medication in jail are essentially the same regardless of whether the inmate is in an RTC program or an RTS program, or neither. Involuntary medication of mentally ill defendants for restoration of competence additionally raises legal concerns involving autonomy and due process rights with which the U.S. Supreme Court was concerned in *Sell v. U.S.* (2003), when the consequence of involuntary restoration is resumption of prosecution. Rights may at least be tainted the coercive and criminal coloring of jail in comparison with hospital treatment. To the extent that jail housing emits hues of criminal punishment, involuntary medication in jail for sanity restoration may seem inappropriate, if not unconstitutional.

### 4.4 | Circumvents the problem itself

The fourth concern is that jail-based RTC programs, especially if they include involuntary medication, do not extricate the root cause of the problem: insufficient hospital beds. Jail-based RTC programs may appear to render hospital-based RTC programs obsolete and unnecessary, thereby undermining any remaining political will to correct

this deficiency. If RTS programs were to be placed in jail settings, hospital-based RTS programs may appear to be financially wasteful anachronisms. As hospital-level treatment for those with the most severe mentally disorders falls increasingly into disuse, FSHs will predictably become progressively defunded and “debedded” or closed, becoming even more, or perhaps absolutely, unavailable for jail inmates in need of hospitalization, a fate that has already befallen many such inmates who have not been found to be IST or NGRI (Torrey et al., 2014).

## 5 | DISCUSSION

As inconceivable as jail-based RTS programs seem to be today, thoughtful consideration of the potential advantages and risks of moving sanity restoration into jails ought to be addressed before this can become a reality. Before they existed, before they were conceived, RTC in jails was not given thoughtful consideration in the literature. As is the case today with jail-based sanity restoration, there was no prior experience upon which to base such a discussion. Today we have some experience and a little more thoughtful discussion on jail-based RTC programs. In this present analysis, the potential advantages and risks of jail-based RTC programs were reviewed for their applicability and comparability to jail-based RTS programs.

While addressing specific potential advantages and risks of jail-based RTC programs as they could pertain to jail-based RTS programs, one fundamental commonality ought not be overlooked: in both cases a basic purpose ought to be the treatment and improvement of the person's mental disorder. Consistent with this are two principles within the ethics code of the American Medical Association and the American Psychiatric Association – the principles of patient primacy and of supporting access to treatment (American Medical Association, 2003) – which should include transfer of mentally disordered inmates who need hospital-level psychiatric care (Felthous, 2013).

In Sweden, there is no IST or insanity defense; however, mentally ill defendants can be evaluated and, if they were/are mentally ill, sent to a FSH for treatment (Belfrage & Fransson, 2000). Once the mental illness is sufficiently improved with treatment, offenders can be transferred to an ordinary prison to complete their sentence (Belfrage & Fransson, 2000). In the United States, the state of Arizona has a defense and verdict termed “guilty except insane” (GEI), its legislators having changed the State's NGRI verdict in 1993 to the now GEI verdict, an abbreviated M'Naghten test. In 2007 Arizona changed its GEI law requiring the judge to “sentence” a GEI offender to a specific term in the state Department of Corrections (Kirkorsky, Shao, & Bloom, 2019). Additionally, the law now allows its Psychiatric Security Review Board (Az PSRB) to order the offender determined to be “dangerous or (having) a propensity to reoffend” to be “transferred to the state Department of Corrections for the remainder of the sentence to be served in a correctional facility [Ariz. Rev. Stat. Ann. 13-3994F4 (2016); Kirkorsky et al., 2019].

Even with the Swedish and Arizona models, the mentally ill offender is first treated in a FSH for appropriate treatment. However, the possibility in both systems of a defendant, who might in another system have been adjudicated as NGRI, being adjudicated as “guilty” instead is another step towards criminalizing this mentally ill population. Further criminalizing the mentally ill is the transfer of such an individual to an ordinary prison unit designed for punishment for crimes committed, not treatment. These changes in the insanity jurisprudence of advanced Western democracies suggest that the “treatment” of insanity acquittees in correctional facilities rather than hospitals, as is now done for incompetent defendants, is not so far-fetched.

One difference between the Swedish and Arizona models, and jail-based RTS programs, is that the former places this category of mentally ill offenders in prisons, not jails. Any possible difference, however, is not great. In many countries, there is no difference because prisons for sentenced offenders also house remand defendants. As in some jails, in some U.S. prisons psychotic prisoners can be involuntarily medicated in order to avoid appropriate hospital transfer. Because the disposition of NGRI acquittees occurs after adjudication of the criminal charge, prison-based RTS programs may be more conceivable than jail-based RTS programs. This would essentially be a difference without a difference, as most of the purported advantages of, as well as concerns about, jail-based RTS programs would apply equally to prisons.

Not unlike jails, prisons too have been subjected to massive overcrowding with resultant inadequate mental health services. In the states of Texas and California, this had led to federal class action lawsuits. The *Ruiz* decision in Texas (*Ruiz v. Estelle*, 1980) made both outpatient mental health services in prison units and hospital care more available to mentally ill prisoners in need of these services (National Association of State Mental Health Program Directors, 2017). The solution included building a new prison psychiatric hospital. In California, the U.S. Supreme Court's *Brown* decision (*Brown v. Plata*, 2011) resulted in the release of many prisoners, including many with serious mental disorders, in effect transferring the mental health responsibilities to the community (Sacramento Bee and Publication Staff, 2019). Without substantial costly improvements, prisons may be no more capable of providing actual hospital-level services than are large jails in the United States.

A potential advantage of jail-based RTS programs that would not be shared with prison-based RTS programs is their proximity to educational centers, including medical schools with their psychiatry departments. Like traditional state hospitals, prisons in the United States tend to be remotely located.

A significant difference between RTS and RTC programs is that the former have the added responsibility of preparing the offender for functioning adaptively and safely in the community. This includes risk assessments for suicide and violent criminal recidivism, as well as teaching the patients skills needed for independent living. Perhaps these services could be incorporated into jail- or prison-based RTS programs, but like other traditional hospital services at considerable expense for the requisite personnel and programmatic needs.

These services are not essential for RTC programs, as defendants will eventually await trial in jail after their competence is restored. However, jails should be providing aftercare planning for inmates in advance of their release, another function typically requiring more resources than are currently uniformly available to jails.

Treatment of the person's mental illness, especially when severe and normally requiring hospital-level services, is as appropriate and necessary regardless of one's legal status, and regardless of whether the person with mental illness has been adjudicated IST or NGRI, is charged but not yet so adjudicated, or is a civilian without any legal encumbrances. This is analogous to serious medical conditions.

Although space does not allow it here, a fully balanced analysis would include a discussion of potential advantages of hospital-based RTC and RTS programs. Not to be overlooked, however, are the advantages of hospitalized RTC programs proposed by Danzer et al. (2019) in their literature review: Hospitals can best provide humane care for individuals with serious mental illness, they provide multiple services in addition to the core services for RTC, have specialized and diversified provider experience and resources, and often provide the best hope for optimal administration of involuntary medication. With a little reflection, one can recognize that these advantages for RTC programs should apply equally to RTS programs.

## 6 | CONCLUSIONS

Without prior discussion in the literature, jail-based RTC programs are now operating in at least eight states (Kapoor, 2020). Most of the same advantages of RTC programs moving from FSHs to jails could apply to RTS programs. From the present analysis, most of the same potential risks would also apply to RTS programs. Careful analysis suggests that purported advantages in either case may be specious, exaggerated or offset by overlooked disadvantages. In both cases, attempting to treat persons with severe mental illness in jail who in the community would be afforded hospital quality and level of services is still another step in the direction of criminalizing those with serious mental illness in the United States.

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