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CARCERAL STRATEGIES IN MENTAL HEALTH

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Introduction

As mental health concerns and awareness around mental health challenges have increased, policymakers have prioritized mental health policy. Within these conversations, there is a broad recognition that far too often people experiencing mental health challenges encounter the criminal legal system rather than accessing mental health supports.ⁱ In response, many policymakers have championed policies that aim to divert people experiencing mental health challenges away from prisons and jails and into mental health treatment. However, some of these policies, particularly those involving forced treatment, rely on carceral tactics and replicate incarceration.

Carceral practices have no place in mental health care. If a person is handcuffed, restrained, secluded, or otherwise harmed while receiving “treatment,” they are not receiving mental health care. These tactics retraumatize people and can increase mental health challenges. Mental health advocates and providers should resist the co-opting of mental health services by the criminal legal system and ensure that receiving mental health care is never traumatizing and that all mental health services are rooted in choice.

Instead, many mental health advocates and professionals support forced treatment, giving authority to the idea that it is mental health care. This not only harms the mental health of those being institutionalized, but it also diverts attention away from treatment options that support healing and build trust. The carceral system is using the language of mental health, while mental health systems continue to rely on carceral practices, blurring the line between treatment and incarceration.

Forcing people into treatment facilities reaffirms the harms of the past, further entrenching distrust in mental health systems.

Those systems have historically harmed Black and brown people, LGBTQIA+ people, people with disabilities, and people living with low incomes, including through other forced treatment policies. The continuation of forced care ensures that this harm is ongoing, further breaking trust between public health and mental health systems, and the communities with the highest levels of unmet need.

This brief analyzes state and local policies that adopt carceral approaches to mental health treatment, showing:

- Forced treatment is **carceral**;
- Forced treatment is **subject to less oversight**;
- Forced treatment is **ineffective and traumatic**; and
- Forced treatment **most harms marginalized communities**.

The Historical Roots of Forced Treatment

The United States has a long history of institutionalizing people with mental health challenges.ⁱⁱ Historically, people with disabilities and people of color, particularly Black people, were more likely to experience forced treatment including forced sterilization and forced lobotomies, and were often involuntarily institutionalized in asylums.^{iii,iv} Criminalizing the mental health needs and healing practices of communities of color is not new and has resulted in discomfort and distrust for many communities of color to seek mental health services.^v

Decades of advocacy from disability justice and mental health advocates led to the de-institutionalization movement, exposing abuses in mental health hospitals. In response, many states opted to close inpatient psychiatric facilities through the 1970s and 80s. However, the goal was not just the closure of harmful inpatient facilities – it was also to re-invest those dollars into community-based mental health care. Those investments were never realized.^{vi}

Now, lawmakers claim that community-based care has failed, despite never fully investing in it. Congress is considering reversing a 60-year policy banning Medicaid from treating people in mental hospitals, citing the rise in mental health conditions and homelessness.^{vii} Lawmakers claim the inpatient facilities of today are a far cry from the institutions of the 1960s, where patients were, among other things, kept in solitary confinement and abused.^{viii}



An Overview of Forced Treatment Policies at the State and Local Level

Today, individuals can generally be forced into mental health treatment if they are determined to pose a threat to themselves or others. Usually, this determination is first made by a law enforcement officer who may have either no mental health training or limited training. Law enforcement will then transport a person to a mental health facility where they will be screened by a clinician. If the clinician determines they require treatment, they are usually admitted to a residential treatment facility. While in these facilities, many individuals are subjected to restraint, seclusion, and forced medication.^{ix,x}

Recent policies in California and New York force people experiencing homelessness who do not necessarily have a mental health diagnosis into inpatient mental health treatment. Policies in Maryland, New York, Florida, and Kentucky allow for children to be removed from schools and forced into treatment. These school-based policies are longstanding while the policies focused on housing are newer. Collectively, they offer insight into the carceral tactics used in implementation, why policymakers are advocating these policies, and the impacts of forced treatment on the people subjected to it.



California

Policy Mechanism for Forced Treatment

Under the state's conservatorship law, individuals with a Serious Mental Illness (SMI) who are deemed "gravely disabled" can be placed into a Lanterman-Petris-Short (LPS) conservatorship.^{xi} Individuals under LPS conservatorships can be involuntarily treated, under criteria established in a 1967 law.

Senate Bill 43 broadens the list of reasons why a person may be subject to involuntary treatment by updating the definition of "gravely disabled."^{xii}

In practice, this change allows local authorities to detain, evaluate, and place homeless people who experience crisis in public into residential treatment more easily.^{xiii}

Implementation Example

The law went into effect in January 2024. All but two counties are delaying implementation.^{xiv}



Florida

Policy Mechanism for Forced Treatment

The Baker Act

The Baker Act authorizes the involuntary arrest, transport, hold, and psychiatric evaluation of children. Children can be held for up to 72 business hours in a psychiatric hospital.^{xv}

Implementation Example

More than **37,000 children** are “Baker Acted” each year.^{xvi}

Kentucky

Policy Mechanism for Forced Treatment

Chapter 645 – Mental Health Act

645.120 Emergency Hospitalization^{xvii}

An emergency petition can be filed if “a child appears in need of immediate hospitalization for observation, diagnosis, or treatment.” They must be evaluated within 24 hours.

Kentucky permits the hospitalization of minors without their parent’s permission.^{xviii}

A young person can be committed to inpatient treatment without being evaluated in-person by a psychiatrist. The clinicians who evaluate young people often work for the same institution that the young person would be treated in and thus have a financial incentive to commit the young person.^{xix}

Implementation Example

A mobile assessment is the first step toward involuntary hospitalization.

Schools may seek a mobile assessment for a child who staff believe is a danger to himself or others. It is intended for children who are suicidal, homicidal, or experiencing psychosis.^{xx}

In Jefferson County Public Schools (JCPS), mobile assessments are used at least **ten times** a day, every day. In the 2018–2019 school year, JCPS used the process at least **1,500 times**.^{xxi}

Maryland

Policy Mechanism for Forced Treatment

Md. Code, Health-Gen § 10-622 – Petition for emergency evaluation.^{xxii}

The emergency petition process is the first step in being involuntarily committed. It is supposed to be used for people with a SMI or those who are endangering their own lives or safety or someone else’s.

Implementation Example

Between 2015–2023, the Wicomico County, Maryland school district used the process **more than 750 times**. In 2022, **40 percent** of school-based emergency petitions were on children **12 and under**.^{xxiii}



New York City

Policy Mechanism for Forced Treatment

Child-in-Crisis Interventions

In 1998, New York City transferred school safety operations to the police department, resulting in schools calling 911 to address school discipline issues.

A 2014 legal settlement directed schools to only call 911 when students pose an “imminent and substantial risk of serious injury” to themselves and others.^{xxiv}

Mental Hygiene Law

Mayor Eric Adams interpreted the state’s mental hygiene law to allow for involuntary hospitalization of people who are deemed unable to care for their own basic needs.^{xxv}

Implementation Example

Child in Crisis Interventions

From 2010–2012, city-run and charter schools saw an average of **3,300** child-in-crisis incidents per year.

In 2017, the first year NYPD reported complete data since the settlement, schools saw an average of **3,200** incidents per year.^{xxvi}

Mental Hygiene Law

Since May 2023, about **130** people experiencing homelessness per week have been sent involuntarily to hospitals for evaluation.^{xxvii}



National Example: 988 Implementation

In the first year of 988’s implementation, one estimate held that forced psychiatric detentions may have increased by as much as 120 percent.^{xxviii} Survey data demonstrates that 55 percent of people with mental health concerns are hesitant about using 988 due to fear of being forced to go to the hospital.^{xxix} The increase in forced detentions may be the result of existing 988 policies -- 988 crisis counselors must also dispatch emergency services to 988 contacts when there is “imminent risk” to someone’s life that cannot be de-escalated during the call, and share pertinent data, including names, contact information, and addresses, with law enforcement entities.^{xxx} In addition, several states have Duty to Warn policies that require mental health professionals, including crisis counselors, to alert law enforcement about people who may be a danger to others or themselves.

Forced Treatment is Carceral

Many proponents of forced treatment policies, including some mental health advocates, laud them as progressive policies aimed at ensuring people experiencing severe mental health crises receive the care they need. In California, proponents argued that making it easier to force people into treatment will protect them from incarceration or chronic homelessness.^{xxxii}

But forced treatment, including institutionalization, is a carceral approach. Carceral tactics show up at every stage of the process:



Law enforcement officers are often the initial point of entry. They determine who is referred for an evaluation.

Florida: Law enforcement officers initiate most Baker Act evaluations in schools. State guidance encourages them to initiate evaluations and allow mental health clinicians (at the point of evaluation) to determine if criteria for forced treatment is met.^{xi} Mental health professionals are not required to be involved in the initial referral and police consult with them less than half the time.^{xxxii}



Individuals are restrained when being transported to services and can be restrained while receiving services.

New York and Maryland: Since 2017, around **1,370 students** have been handcuffed while waiting for an ambulance in New York City schools.^{xxxiii} In Wicomico County, Maryland, there were at least **117 instances** involving handcuffs in 2022.^{xxxiv} Handcuffs have been used on children as young as **five years old**.



If admitted, individuals can be held involuntarily for months. In some cases, they have no say over how long they're held or their treatment plan.

Florida: Young people committed to inpatient facilities have been taken to facilities far away from their homes and families, forced to wait for over twelve hours to be evaluated, placed in adult facilities, sexually and physically assaulted in facilities, and kept in treatment for over **100 days**.^{xxxv}



Failing to comply with a forced treatment plan can lead to continued contact with the criminal legal system.

California: Being placed under a conservatorship involves ongoing interactions with conservatorship courts. LPS conservators are often public conservators, but a shortage of funding means that conservators are not able to regularly check in on their clients.^{xxxvi}

Kentucky and New York: Parents who refuse to allow their children to be involuntarily hospitalized have been reported for child neglect.^{xxxvii,xxxviii}



Forced hospitalizations often increase an individual's financial instability, as people are unable to earn money while institutionalized. Individuals may also be charged for the services they received after they are discharged -- services they often didn't consent to.

In Florida, families are often charged by mental health facilities for care, including evaluations, provided involuntarily to minors.^{xxxix}



Forced Treatment is Subject to Less Oversight

Because many forced treatment policies do not routinely collect data on their use, they are subject to less federal and state oversight and provide the illusion of fixing structural problems.

In Florida, school districts are not required to keep and report Baker Act data. Many districts do not record when a Baker Act is initiated or who is being Baker Acted.^{xi}

In California, many counties, including Los Angeles County, do not report conservatorship data.^{xii} And while schools in New York are required to file reports on child-in-crisis incidents, they are not required to show which steps they took to manage the crisis before calling law enforcement.^{xiii}

The lack of reporting requirements can lead to the misuse and overuse of mental health evaluations. For example, Wicomico County, Maryland needed to improve its school discipline metrics due to a Department of Justice (DOJ) investigation. Since 2017, school suspensions and expulsions in the district, tracked by the DOJ, have declined. However, mandated trips to the emergency room have increased.

Federally, schools are not required to report removals for psychiatric assessments, meaning there is little oversight or knowledge of the practice.^{xiii} While districts claim to only use emergency evaluations when a student poses an immediate risk to themselves or others, parents, students, and other advocates argue that schools use the process whenever they want to remove a child from campus.

Forced treatment policies allow schools to claim they're improving school discipline practices and increasing access to mental health services. In reality, handcuffing students in schools will not improve school climate, update outdated facilities, bolster teacher retention, increase funding for mental health services, or create culturally affirming classrooms.

In short, forced treatment policies let states, localities, and school districts improve data outcomes without changing their policies or behaviors. The act of handcuffing an individual and transporting them involuntarily is now coded as the first step in a mental health evaluation rather than an arrest. Policymakers continue to tout these approaches as diverting people away from the criminal legal system and toward needed services. In practice, however, these policies incorporate mental health facilities into the criminal legal system's infrastructure.

Schools, mental health facilities, and policymakers all face perverse incentives for continuing to champion forced treatment policies, allowing for mental health services to continue to be co-opted by the criminal legal system. Whether individuals are institutionalized in prisons and jails or in mental health facilities, they're experiencing the same carceral techniques. These institutions should not be considered health care facilities and instead understood as medicalized carceral spaces. Many young people who have experienced forced treatment describe the experience as akin to jail, while many adults who've experienced forced care describe themselves as psychiatric survivors.



Forced Treatment is Ineffective and Traumatic

Many forced treatment policies prioritize residential or in-patient treatment. For example, California's new law passed in concert with a bill updating the state's online database of available beds in residential facilities.^{xiv}

Residential services are expensive to run, do not provide a full continuum of care, and are sometimes not connected with secondary services in the communities of discharged patients.^{xv}

A recent study found higher suicide attempts a year following discharge among individuals who experienced forced hospitalizations.^{xvi} Another study found that "patients who received coerced treatment for mental illness were less likely to view the help as beneficial compared to those who sought treatment on their own," particularly among people with a Serious Mental Illness (SMI).^{xvii} In-patient residential treatment is especially ineffective for young people. Youth in residential treatment tend to see higher rates of irregular discharge, including self-discharge and discharge against medical advice, which often has adverse outcomes.^{xviii} Substance Use Disorder (SUD) patients see an irregular discharge rate of 10%, compared to the physical health condition rate of 1.2%. Youth who are irregularly discharged face the risk of adverse effects, including suicide, due to incomplete treatment. Finally, many residential facilities routinely use physical restraints and seclusion.^{xix}

Rather than forcing people into institutionalized treatment, states and localities must invest in the mental health services people want and need. California's analysis of involuntary treatment determined that the state does not have enough mental health services to meet the need.

The report found that "a significant percentage of people with mental illness who need services aren't getting them, and those that do get very few," and "services offered in... communities are inadequate for making involuntary outpatient treatment work."ⁱ County leaders have echoed this concern since Senate Bill 43 passed, claiming they need more resources.

In short, the problem is not that people are refusing treatment – it's that treatment isn't available. Individuals forced into in-patient treatment may be unable to access ongoing community-based treatment when they are discharged. Individuals mandated to attend outpatient treatment may be unable to find care, which could result in noncompliance and further contact with the criminal legal system.

Rather than investing more funding into in-patient treatment, states and localities must finally make good on the promise of the de-institutionalization movement and fully invest in community-based mental health care that is culturally responsive, healing-centered, trauma-informed, and youth-friendly. Rather than forcing people into care, states and localities must ensure that everybody has access to affordable mental health care in the community they live in, recognizing that mental health care looks different for different people. Rather than pathologizing the adverse mental health outcomes people experience, the mental health system must work to address the root causes of mental health concerns including poverty, racism, and community violence.



Forced Treatment Most Harms Marginalized Communities

Generally, an individual can be forced into treatment if they pose a risk to themselves or others. However, the determination of who is "dangerous" often follows a racist and ableist logic. One study found that patients of color were more likely than white patients to be involuntarily admitted to a psychiatric unit, with Black patients and multiracial patients being the most likely to be involuntarily committed. Once inside a facility, Black patients are also more likely to experience coercive treatments, including the use of restraint and seclusion.ⁱⁱ

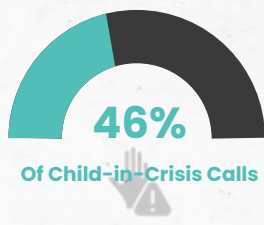
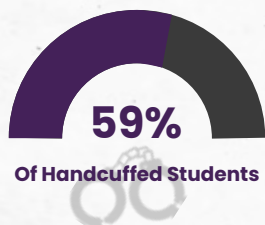
In school-based removals, Black students and students with disabilities are disproportionately impacted. In **Wicomico County, Maryland** more than half of the students subjected to Emergency Petitions were Black students,^{lii} although approximately 37 percent of the student body is Black.^{liii}

IN WICOMICO COUNTY, MARYLAND: BLACK STUDENTS MAKE UP



In **New York City**, 59 percent of all handcuffed students were Black, and 46 percent of all child-in-crisis calls involved a Black student, despite Black students making up only 25 percent of the student body.^{liv}

IN NEW YORK CITY, BLACK STUDENTS MAKE UP 25% OF THE STUDENT BODY BUT ACCOUNT FOR



In **Palm Beach County, Florida**, 40 percent of students Baker Acted were Black, despite making up 28 percent of the student population.^{lv}

IN PALM BEACH COUNTY, BLACK STUDENTS MAKE UP



Law enforcement is often called when a student is not abiding by ableist norms, with schools describing behaviors that are developmentally appropriate and/or manifestations of a disability as dangerous, violent, or aggressive. In response to these behaviors, young people with disabilities have been surrounded, chased, and physically attacked by law enforcement officers in the process of involuntarily committing them.

Often, law enforcement will escalate a situation by preventing a student from engaging in behaviors that support their mental health, such as by leaving the classroom to take a walk if they feel overwhelmed.^{lvi}

For example, a child with autism experiencing sensory overload was Baker Acted four times between third and fifth grade. Each time, the mental health clinician determined he did not meet the criteria for an involuntary examination.^{lvii} In Kentucky, a 7-year-old child with autism was surrounded by orderlies in an attempt to hospitalize her. When her parents intervened and refused hospitalization, they were reported for neglect to Kentucky's Child Protection Branch.^{lviii} In New York City, special education schools call the police for child-in-crisis interventions at four times the per-student rate of general education schools.^{lix}

Young people who are frustrated or overwhelmed do not generally pose a risk to themselves or others. Rather than criminalizing young people for expressing their emotions, forcing them to "manage" or "control" their emotions, or pathologizing an emotional response, schools should help students recognize and process their emotions in culturally affirming and non-punitive ways.

Forcing people with disabilities into treatment follows a harmful, ableist, and false argument that people with disabilities are unable to make decisions about their own lives. In the case of mental health specifically, studies routinely show that people with mental illness have decision-making capacity.^{lx}

The Right to Liberty and Security of Person enshrined in The Convention on the Rights of Persons with Disabilities (CRPD) prohibits the deprivation of liberty based on a person's disability. This right significantly challenges services, policies, and laws in countries that allow involuntary admission based on a diagnosed or perceived condition or disability, even when additional reasons or criteria are given for the detention, such as "a need for treatment," "dangerousness," or "lack of insight."^{lxi}

The over-incidence of Black students and students with disabilities being referred to involuntary evaluations underscores that law enforcement officers are more likely to view these communities as dangerous. Involuntary evaluations speak more to the racist and ableist logic of law enforcement officers than to the mental health of the person being evaluated.

Policy Solutions: Alternatives to Forced Treatment

Far too many people only have access to mental health resources in carceral spaces, underscoring how this country continues to only invest in carceral systems.

However, forced treatment is not the only option. States should adopt policies that prevent forced treatment and carceral approaches to care, address the social determinants of health, and invest in healing-centered care.

Policies to Prevent Forced Treatment and Carceral Approaches to Care

- Ban the use of restraints, seclusion, and other carceral techniques in mental health facilities.
- Incentivize school districts to remove police from schools through legislation like The Counseling not Criminalization Act.
- Issue guidance around removing law enforcement from mobile response teams and ensuring mobile response teams don't force treatment or hospitalization.
- Improve oversight and reporting on forced treatment:
 - *Require in-patient facilities to report how many individuals are being treated involuntarily and how long each involuntary stay lasts.*
 - *Require clinicians performing involuntary evaluations to report each evaluation, including if the criteria for an involuntary evaluation was met, what care was recommended, if the criteria for forced treatment was met, the time between entering the facility and when the evaluation occurred, if law enforcement initiated the evaluation, and if the individual was handcuffed while en route to the evaluation.*
 - *Require schools to report all forced mental health evaluations initiated in schools, including if law enforcement responded, if the child was removed from campus, if handcuffs or restraints were used, if the child has a disability, what steps were taken to deescalate the situation, and if the child was forced into treatment.*
 - *Require localities to improve oversight of their conservatorship systems, tracking how many people with disabilities are under a public conservatorship and what medical care they're receiving involuntarily.*
- Pass legislation to ensure that the clinician performing a mental health evaluation cannot work for the facility an individual is committed in or otherwise financially benefit from the individual being committed.
- Pass minor consent legislation that states that minors cannot receive in-patient mental health treatment unless both the minor and their parents consent to it and that either party can withdraw their consent at any time.
- End all systems of substituted decision-making, so that people can make their own formal and informal day-to-day decisions on an equal basis with others; set goals and propose steps to eliminate practices that restrict the right to legal capacity, such as involuntary admission and treatment; and replace these with practices that align with people's will and preferences, ensuring that their informed consent to mental health care is always sought and that the right to refuse admission and treatment is also respected.
- Change standards of care for SMIs and training/in-service requirements, including but not limited to training in coercive vs. non-coercive practices and power dynamics/hierarchies.
- Outline health data privacy protections that protect health data from law enforcement access, which is often the entry point for involuntary hospitalizations.
- Widen funding streams that allow access to counsel and medical legal partnerships.

Policies to Invest in Community-Based Care

- Create/expand career pathways for mental health workforce focused on building a workforce that has diverse identity and credentials.
- Actively involve people with disabilities in decision-making processes about policies and programs, especially those directly impacting them, which includes effective and full participation in public affairs.
- Develop community-based services and supports for people with mental and behavioral health conditions or disabilities.
- Provide permanent supportive housing with a housing-first approach. This strategy to end homelessness emerged as an alternative to withholding housing assistance until people first participate in or graduate from a treatment program. Housing First acknowledges that untreated mental health conditions or substance use challenges do not cause homelessness but that these issues are connected. A person's access to affordable and quality housing impacts their mental health, and vice versa. Permanent supportive housing that uses a Housing First approach has been proven to be beneficial, especially for people experiencing chronic homelessness who may need more supportive services.¹
- Invest in healing modalities outside of Western medicine and clinical practices, including peer support, art, music, access to green spaces, and culturally derived and Indigenous healing practices.
- Embed mental health supports into communities to ensure that people can access mental health supports where they live.
- If a mental health facility evaluates an individual who has been handcuffed or restrained, they should refer that individual to community-based services, including peer support services, that could support them in healing from the evaluation.

Conclusion: Healing from Forced Treatment

People experiencing mental health crises do not need to be “fixed,” “corrected,” or “reformed.” The U.S. economy and health care system do. The root causes of untreated mental health conditions, including homelessness and poor school climate, are not caused by an individual's choices.

Forced treatment will do nothing to end homelessness or improve school climate, but it will exacerbate the mental health crisis and increase stigma.

Policies that allow for forced treatment of people experiencing homelessness allow policymakers to claim they're addressing the issue without criminalizing homelessness. But these policies will not end homelessness. Instead, they will institutionalize people experiencing homelessness through carceral tactics, so they don't shelter in public spaces. Forcing people into residential facilities serves the same goal as criminalization: to make unsheltered homelessness less visible, rather than to end it.

Similarly, forced evaluations in schools allow policymakers to claim they're addressing the school-to-prison pipeline and prioritizing students' mental health. However, most young people still attend schools where the student-to-counselor ratio is far below what's recommended^{lxviii} and where culturally responsive, healing-centered mental health services are not available on campus. Forced evaluations will not address these structural barriers.

Forced treatment actively worsens the mental health of the people who experience it. Even if the mental health professional performing an involuntary evaluation recognizes that someone should not be committed to an in-patient facility, the person often arrives at the evaluation traumatized and distrustful of the mental health system.

Attempts to medicalize the school-to-prison and homelessness-to-prison pipeline should be called out. Mental health professionals should intervene when they see mental health being co-opted, and community-based providers should not participate in carceral approaches to care.

When people are abused and traumatized by mental health professionals and the mental health system, they will distrust the system and those in it who claim to be “helping them” or “providing treatment.” This can result in people being unwilling to seek any kind of formal mental health treatment, including help with the trauma they've experienced in the system itself.

Conversely, engaging people in their own health care has significant benefits. Shared decision-making between providers and patients can improve health outcomes, increasing care satisfaction, knowledge about treatment, and adherence to a treatment plan and reducing anxiety and unnecessary care.^{lxiv} Forced treatment removes freedom of choice and creates an environment in which patients are unlikely to feel safe, especially if they are restrained when being transported to and entering the facility.

People who have been traumatized, abused, and otherwise harmed by the mental health system deserve to define healing in their own terms and be supported when seeking out that healing. The goal of healing is not to conform to white, heteronormative, ableist, and patriarchal norms.

We must build a mental health system that not only rejects all carceral approaches to care, but also invests in the healing of those who have been harmed by these approaches. Many effective and nonclinical forms of mental health care, such as peer support, were in response to the harmful practices of the mental health system. People who had experienced institutionalized forced treatment created peer support networks to speak openly about their experiences and work towards collective healing.^{li} Forced institutionalization has never been part of the healing process – rather it compounds trauma and further fractures trust.^{lii} We need to build a mental health system where everyone has access to culturally responsive, trauma-informed, healing-centered, and community-based mental health supports.



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