Hurricane Katrina or the Zika epidemic. To exclude people from coverage outside fixed periods would be to so radically transform Medicaid as to render it simply an appendage of the commercial insurance market, costing the country Medicaid's vital first-responder capabilities.

How far Medicaid will move in the future remains to be seen. But expansion demonstrations, both proposed and under way, offer food for thought. Over its lifetime, Medicaid has evolved from a small companion to cash welfare and a means for funding nursing home care into a basic component of the U.S. health insurance system. Even as it changes, Medicaid must retain its ability to effectively cover the poor and respond flexibly to emerging population health needs. The nation needs nothing less.

Disclosure forms provided by the author are available at NEJM.org.

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Hard Time or Hospital Treatment? Mental Illness and the Criminal Justice System

Christine Montross, M.D.

In my work on the intensive treatment unit of a psychiatric hospital, I see many patients whose lives collide with the criminal justice system. Some are admitted to my care because they're seeking respite. Others are admitted — often brought in by police — because the community seeks respite from them.

I also see mentally ill people in correctional facilities, where I perform court-ordered psychiatric examinations to determine whether detainees are competent to stand trial. In this work, I have a glimpse into another kind of facility that houses people with psychiatric disease, and I can see the contrasting outcomes of the people in these two environments.

When law enforcement is involved, the trajectory of my patients' lives veers sharply. The consequences are unpredictable and range from stability and safety to unmitigated disaster. When patients are ill or afraid enough to be potentially assaultive, the earliest decision as to whether they belong in jail or in the hospital may shape the course of the next many years of their lives.

It's now well understood that the closing of state hospitals in the 1970s and 1980s led to the containment of mentally ill people in correctional facilities. Today our jails and state prisons contain an estimated 356,000 inmates with serious mental illness, while only about 35,000 people with serious mental illness are being treated in state hospitals[1] — stark evidence of the decimation of the public mental health system.

When a mentally ill person comes into contact with the criminal justice system, the decision about whether that person belongs in jail or in the hospital is rarely a clinical one. Instead, it's made by the gatekeepers of the legal system: police officers, prosecutors, and judges. The poor, members of minority groups, and people with a history of law-enforcement involvement are shuttled into the correctional system in disproportionate numbers; they are more likely to be arrested and less likely than their more privileged counterparts to be adequately treated for their psychiatric illnesses.[2]

The dearth of psychiatric beds also contributes to this trajec-

tory: mentally ill patients who spend days in emergency departments (EDs) awaiting therapeutic placement may become too agitated and aggressive to remain there. If no psychiatric beds are available, ED staff may see jail as the only secure option.

Dr. Reena Kapoor, a forensic psychiatrist at Yale University who ran an outpatient psychiatric program for people involved with the criminal justice system, describes another all-too-common dynamic: with psychiatric beds unavailable, patients who are brought to EDs by police undergo a cursory evaluation and are discharged without medications and without a viable follow-up plan. They "just end up back on the street, often in a matter of hours," says Kapoor. Unsurprisingly, without treatment, the behaviors that led to police involvement recur. Over time, police see this cycle of law-enforcement response, ED evaluation, and poor follow-up care as ineffectual, and they begin to consider jail — which at least offers a safe environment for longer-term assessment — a better alternative. Unfortunately, even when patients are arrested with quasi-therapeutic intentions, the consequences of ending up in jail can be dramatic and enduring.

A hospital's primary goal is therapeutic. On my unit, patients are seen and understood within a framework of their symptoms, diagnoses, and treatment plans. Even with a severely mentally ill population, the focus is on fostering health.

As clinicians, we're trained to intervene when we see signs of agitation and fear brewing. We don't always succeed in averting episodes of aggression, but frequently we do. Staff are trained in de-escalation. In addition to scheduled therapeutic groups and activities, we have a sensory room in which a patient can lie under a weighted blanket or listen to calming music. A psychiatrist is in house at all times, and a full range of medications to target psychotic symptoms can be adjusted within minutes if necessary.

Conversely, a jail's primary goal is security. And many aspects of correctional environments can exacerbate fear, aggravate psychosis, and spark aggression. Incarcerated people are viewed within a framework of their past criminal behavior and their potential future threat to safety and security. They may spend up to 23 hours a day in their cells and are monitored by correctional officers with little, if any, mental health training. Detainees who become agitated may wait days or weeks before seeing a psychiatrist, and the measures to keep them safe during psychiatric observation often involve seclusion in a bare cell designed to prevent self-harm, without sheets, blankets, possessions, or even clothes. Mentally ill detainees who remain in the general population of jails are particularly vulnerable to other inmates' brutality, and sometimes to correctional officers' abuse.

Whereas psychiatric hospitals and jails differ radically, the people I see in these two environments are remarkably similar. Indeed, the psychiatric case histories of patients and inmates are often indistinguishable.

Consider two psychotic men confronted by police for minor disturbances.

Mr. B. is a man I saw in jail who was paranoid when he was arrested. He did not leave a convenience store when the manager instructed him to, and then he hid behind a dumpster, refusing to come out when approached by police. When he finally emerged, he was taken to jail. His charges — criminal trespass and resisting arrest — carried a maximum combined sentence of 2 years in prison. But Mr. B.'s situation, like that of many psychotic detainees, became far more dire.

He was prescribed an antipsychotic medication in jail but refused to take it. He may have been paranoid about the pills' safety or may not have had insight into the fact that he needed treatment. At some point shortly after his arrest, he would not come out of his cell when asked to do so. So he was forced out — a procedure called a "cell extraction." Still paranoid, but with nowhere to hide, Mr. B. resisted this time by fighting back.

Assaultive detainees are typically sent to administrative segregation, a punitive form of isolation known to exacerbate symptoms of severe mental illness.[3] In addition, assaulting a correctional officer is a felony charge, which, in Mr. B.'s state, carries a maximum sentence of 15 years in prison and a $15,000 fine. If convicted, Mr. B. will spend years in prison, where he has a disproportionate risk of being victimized. He'll eventually leave prison on probation, whose legal requirements will be difficult for him to manage if his symptoms recur — setting him up to incur additional time behind bars.

Mr. T., for his part, caused a similar disturbance in the community, but was admitted to my unit after police decided to bring him to the hospital rather than to jail. Mr. T. was plagued by

paranoid delusions and believed the hospital was a facility where he was awaiting execution. Like Mr. B., he refused to take prescribed antipsychotic medication.

One night, Mr. T. became convinced that the hospital staff were preparing to execute the patients on the unit. "Tonight's the night they're going to kill us all!" he suddenly screamed. In what he believed was self-defense in a moment of mortal peril, Mr. T. severely assaulted several staff members. Two suffered concussions; Mr. T. hit one of them so hard that her supervisor said "she flew off her feet like a rag doll." When another staff member tried to subdue Mr. T., the patient brought him to the ground, kicked him in the head, and injured the staff member's knee to such an extent that it required surgery.

Despite the attack's severity, none of the injured workers thought it appropriate to press charges. They explained that Mr. T. had been acting out of his illness, and though he inflicted an enormous amount of damage, he didn't do so with malicious intent. "He was in pure terror," the nursing supervisor told me. "He thought he was fighting for his life."

An audio interview with Dr. Montross is available at NEJM.org

Mr. T. eventually began taking appropriate medications, and his symptoms responded. After 15 days he was discharged home with outpatient treatment arranged by the hospital team.

Mr. B., in contrast, remains incarcerated and faces the prospect of spending the next decade and a half of his life in prison. His story is not an aberration. Countless detainees have similar stories. A man who was tearing up toilet paper in a shopping mall and shouting profanities at passersby and who had been arrested 20 times this year for similar offenses has spent 6 months in jail as a result. A woman spent 38 days in jail after being arrested for sleeping on the floor of a city hospital that, when she was booked, she listed as her home address. If such detainees become assaultive, as some of my patients do, the manifestations of their symptoms lead to punishment, incarceration, and lost years of their lives.

As physicians, we are uniquely positioned to call attention to the circumstances that result in our patients being housed in places of punishment rather than places of healing. We can also push for the expansion and funding of programs that seek to rectify these injustices. Given the vast scope of the problem, a combination of solutions — including the foundation of insurance parity for mental health care — is necessary. "If you dramatically increase the number of crisis options," points out Joel Dvoskin, chair of the Nevada Behavioral Health and Wellness Council, "police will be less likely to arrest."

Proven options exist — from crisis intervention teams in Connecticut trained to respond to mental health crises in the community[4] to crisis stabilization and health care diversion programs in Miami-Dade County, Florida, and elsewhere that have dramatically reduced arrests.[5] But such interventions are too few and far between. Chicago's mental health specialty courts, for example, process approximately 300 people every year, according to Cook County Sheriff Tom Dart, who notes that the Cook County Jail "houses 3000 people with mental illness every day."

When psychiatrically ill people exhibit symptoms out of keeping with society's norms, should they be taken to a place whose primary obligation is therapeutic or one whose primary obligation is security? I believe that as our patients' advocates, we must speak out about the significant consequences of such decisions, which may condemn sick people to a tragic and unjust fate.

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