
“The Incarceration Revolution”¹: The Abandonment of the Seriously Mentally Ill to Our Jails and Prisons

Joseph D. Bloom

In 1848 Dorothea Dix, the famous 19th century advocate for the indigent mentally ill, appealed to the United States Congress to support the set-aside of a very large tract of land that was to be used for the “Relief and Support of the Indigent Curable and Incurable Insane.” She stated:

It will be said by a few, perhaps that each State should establish and sustain its own institutions; that it is not obligatory upon the general government to legislate for maintenance of State charities.... But may it not be demonstrated as the soundest policy of the federal government to assist in the accomplishment of great moral obligations, by diminishing and arresting wide-spread miseries which mar the face of society; and weaken the strength of communities?

The proposed legislation, the “12,225,000 Acre Act,” did pass the Congress, but was vetoed by President Franklin Pierce, who stated in his 1854 veto statement:

I have been compelled...to overcome the reluctance with which I dissent from the conclusions of the two Houses of Congress.... If Congress has power to make provision for the indigent insane...the whole field of public beneficence is thrown open to the care and culture of the Federal Government.

I readily...acknowledge the duty incumbent on us all...to provide for those who, in the mysterious order of Providence, are subject to want and to disease of body or mind but I cannot find any authority in the Constitution that makes the Federal Government the great almoner of public charity throughout the United States. To do so would, in my judgment, be contrary to the letter and spirit of the Constitution...and be prejudicial rather than beneficial to the noble office of charity.²

For most of our country’s history, the federal government followed the position taken by President Pierce and avoided major responsibility for the public mental health system or for that matter, now, for a national health system. In fact, the only time the federal government assumed a significant role in the care of the mentally ill was between the end of World War II and the election of Ronald Reagan in 1980. This era began with great optimism and ended with all the seeds of

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the current crisis in mental health care clearly apparent as the forces that were unleashed began to unfold.

Prior to and after the election of President Reagan, the states had the major responsibility for the care of the seriously and chronically mentally ill. The earlier

President Kennedy's concern was translated into a bill that was introduced into Congress one month before his death,⁴ enacted soon after, and signed by President Johnson. The passage of this legislation created the community mental health center movement.

I began my psychiatric residency in that same year, 1963, and experienced the community mental health center movement on a personal level. The movement was conceptually elegant. Each state was governed by a mandatory state mental health plan that divided the state into des-

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state era was characterized by the large state mental hospital, while the current state era is characterized by the criminalization of the mentally ill. In order to describe the current condition, I will use the public mental health system in the State of Oregon as a case study. Oregon is chosen because of my 30-year experience with the public mental health system in this particular state. I believe and hope to illustrate that Oregon's problems in the delivery of public mental health services are very similar to those that exist in most states.

The Federal Era in Mental Health Services

The linchpin of the federal era was John F. Kennedy's 1963 Presidential Message on Mental Illness and Mental Retardation. President Kennedy described the failures of the past and looked forward to a new direction for the country. He stated:

There are now about 800,000 (such) patients in this Nation's institutions — 600,000 for mental illness and over 200,000 for mental retardation. Every year nearly 1,500,000 people receive treatment in institutions for the mentally ill and mentally retarded. Most of them are confined and compressed within an antiquated, vastly overcrowded, chain of custodial State institutions.... This situation has been tolerated far too long. It has troubled our national conscience — but only as a problem unpleasant to mention, easy to postpone, and despairing of solution. The Federal Government, despite the nationwide impact of the problem, has largely left the solutions up to the States. The States have depended on custodial hospitals and homes. Many such hospitals and homes have been shamefully understaffed, overcrowded, unpleasant institutions for which death too often provided the only firm hope of release.... The time has come for a bold new approach.³

ignated catchment areas. Each area was assigned a priority score for the development of a community mental health center responsible for the mental health care for the catchment area population. It was anticipated that catchment areas might differ as to the characteristics of their distinct populations. Using the developing methods of psychiatric epidemiology, the goal was to measure the amount and types of mental illness in the particular population and then tailor services to the particular needs of that population. Each mental health center was to have inpatient, outpatient and partial hospitalization services, a 24-hour walk-in service for immediate care, along with a branch of consultation and education designed to strengthen the mental health fabric of the community. Local administrative control and accountability were part of the CMHC governance and, of course, there was the promise of adequate funding.

Most importantly the institutions that housed such large numbers of mentally ill individuals were slated to be closed. Hospitalization, if needed, was to take place either in the community mental health center's inpatient service or in the developing psychiatric inpatient services in local community general hospitals.

Unfortunately, in retrospect, and for a variety of reasons, the community mental health center movement was a conceptual success, but an actual failure. Not enough centers were funded. For those that were, the funding formula in the federal legislation was based on a decreasing federal match with state funds, and many states did not pick up the costs. In addition, the centers themselves were accused of not focusing sufficient resources toward the problems of the chronically mentally ill.

President Jimmy Carter attempted to refocus the federal program on the problems of the chronically mentally ill. He came to the presidency with a strong commitment to mental health services which he and

his wife helped to strengthen in the State of Georgia. As president, in 1979, he delivered a message on mental health which:

...establishes a new partnership between the federal government and the states in the planning and provision of mental health services. It seeks to assure that the chronically mentally ill no longer face the cruel alternative of unnecessary institutionalization or inadequate care in the community.⁵

In his message President Carter noted that although 700 community mental health centers had been built, serving some 3 million patients annually, the majority of the country's population were not served by federally funded community mental health centers. During the same time period what actually did occur was the accelerated discharge of the state hospital patients into local communities. This came about for many reasons including the advances made in psychiatric drug treatment, and the great pressure coming from the legal and patient rights community driven in part by reforms in civil commitment laws.⁶ The results, as is evident, from President Carter's words, were large numbers of chronically mentally ill individuals in the community, many who were faced with inadequate community level care.

To put President Carter's words in perspective, in 1955 there were 558,239 state and county psychiatric beds in the United States.⁷ When he took office in 1976 there were 222,202 beds in the country, and when he left office in 1980 there were 156,713 beds.⁸ (For reference later in this paper, in 2005 there were 52,539 beds in what was left of state and county hospitals for the mentally ill.⁹) This was the time that the terms "deinstitutionalization,"¹⁰ "the homeless mentally ill,"¹¹ and "the chronic mental patient in the community" first appeared in the mental health literature,¹² and we first began to be concerned with the mentally ill as they became a significant population within the nation's jails and prisons.¹³

The federal era ended with the election of President Reagan. He ended support for federally funded community mental health centers and instead funded block grants to the states to be used within general guidelines to support state services. However, it is important to note that since that time federal support of mental health programs has remained in the form of financial support to individuals and states through the Medicare and Medicaid programs. In essence federal leadership and national policy were replaced by financial support for individuals.

The New State Era in Mental Health Services: Oregon — A Case Example

Is the public mental health system in Oregon representative of the services provided in other states? There are several studies that compare states on various indices related to mental health care. In 2006 the National Alliance for the Mentally Ill (NAMI) compared state mental health systems using a detailed quality index that rated programs along ten defined criteria¹⁴ ranging from comprehensive services and support, to access to acute and long-term care treatment, to adequate funding. These criteria were adopted to support recovery oriented treatment models which most public mental health programs support today.¹⁵ Five states received a grade of B with the highest scoring states being Connecticut and Ohio. Seventeen states received a C, 19 a D, and 8 were awarded an F. Oregon received a C+, while South Carolina received a B-. NAMI identified that the most urgent need in both of these states was "funding." South Carolina was ranked 32nd in per capita funding for mental health while Oregon ranked 40th. NAMI gave the country as a whole a national grade of D.

In 2008, the Treatment Advocacy Center issued an online report that evaluated the adequacy of the number of state and county hospital beds in each state using a scale developed by an expert panel organized by the survey's authors.¹⁶ In 2005, there were 17 public hospital beds per 100,000 in the U.S. population. The expert panel determined that 50 beds per 100,000 was the minimum number needed to provide adequate service. Eleven states, including South Carolina (10.6 beds per 100,000) were determined to have a "critical bed shortage" in public beds, while Oregon was listed with 20 other states as one category better in the "severe bed shortage" range, with 19.2 beds per 100,000. Only one state, Mississippi, at 49.7 beds per 100,000 was at the minimum number determined by the expert panel. From these two surveys at least, Oregon does not appear to be an outlier.

Oregon's Programs

As in most states Oregon traditionally funded its state hospitals with general fund dollars while community funding is based on a "state-county partnership" written into law in 1973. Community programs are administered at the local level by county health and/or mental health departments. This partnership was altered in the decade between 1993-2003 when the Oregon Health Plan was most prominent. Since 2003 the Oregon Health Plan (OHP) has been in decline,¹⁷ but some of the mechanisms that were set in place for the OHP, which included the establishment of specific

insurance products and some mental health carve outs, remain in place.

Oregon's State Hospitals

My colleagues and I recently examined the inpatient bed situation in Oregon in both state and private hospitals¹⁸ and found that for the most part Oregon's psychiatric hospitals are full to capacity. In addition, the state is, in essence, running a forensic inpatient system for those who enter the hospital under the state's civil commitment or criminal justice standards, those who are incompetent to stand trial, and those who enter under the jurisdiction of the Psychiatric Security Review Board.¹⁹ We found in another study²⁰ that over the past 20 years civil emergency holds have increased as the population of the state has increased, while actual civil commitments have diminished by 50 percent. The state hospitals now predominantly serve the civil commitment court (24% of the state hospital population) and the criminal courts (63% of the state hospital population). The state hospitals contribute minimally to the general welfare of the non-court adjudicated Oregonian. In the same study (cited above) we found that over the last decade the number of general hospital psychiatric beds had significantly decreased in Oregon, and this decrease mirrors the national situation. It is extremely important to note that there is, in essence, no room for the voluntary patient in either state or the community hospital beds.

In addition to the issues related to those who are served at the state hospitals, Oregon's major state hospital, the Oregon State Hospital (OSH), is operating under very heavy strain. Oregon is one of the oldest western states and OSH is one of the oldest state hospitals in the west. It was originally built in 1883 and most of its "newer" buildings are close to 50 years old. To understand the current pressures affecting OSH, it is helpful to understand three recent lawsuits and one threatened lawsuit.

The first suit,²¹ heard in the Federal District Court for the District of Oregon²² and decided in favor of the plaintiffs in 2002, sought to compel the State of Oregon to provide more expeditious treatment for criminal defendants who had been found incompetent to stand trial and who were languishing in Oregon jails waiting for beds at the Oregon State Hospital. The plaintiffs, presented data that showed that seriously mentally ill individuals were held in jails under very poor circumstances, for abnormally long periods of time, awaiting evaluation or treatment beds at the state hospital. Data was presented on 105 individuals who had been found incompetent to stand trial of criminal charges. These individuals spent an average of 32 days in jail waiting for a bed. Forty-eight were held for more than

30 days and nine were held for more than 60 days. Only 19 were transported to the hospital in fewer than seven days. The judge's final order stated that admissions to the state hospital "must be done in a timely manner, and completed not later than seven days after the issuance of an order determining a criminal defendant to be unfit to proceed to trial because of mental incapacities."

The second law suit, settled in 2003, was a class action suit²³ brought against Oregon's two state hospitals, contending that the defendants failed "to develop the array of community-based mental health services needed to meet the special needs of a group of patients, causing them to remain unnecessarily institutionalized in Oregon state hospitals." This case was Oregon's response to the 1999 United States Supreme Court decision in *Olmstead v. L.C.*²⁴ in which the Court held that states were required to provide community based treatment when treatment professionals had determined that these placements were justified. The Oregon case was concluded with a settlement agreement which applied to "civilly committed adults in Oregon state hospitals" and "who had not been discharged within 90 days of the ready-to-place determination of their Treatment Team." The state agreed to develop additional community based facilities and resources to accommodate members of the class.

The third law suit, *Harmon v. Fickle*,²⁵ finalized in 2006, alleged that the State failed to provide adequate numbers of professional and direct care staff at the state hospital; failed to provide adequate and "meaningful" treatment; had violated multiple plaintiffs' rights to privacy; and failed to protect patients from harm. The settlement agreement stated that the state would take "all necessary steps within their control" to increase the staff patient ratio by both hiring more staff and by reducing the state hospital population by developing secure residential treatment options in the community. The state legislature made funds available to achieve these goals, but to date neither goal has been reached. The hospital has been unable to hire sufficient staff, mainly nursing and psychiatric staff, and attempts to contract for more community secure residential placements especially for those hospitalized from the criminal courts have met severe resistance in several of Oregon's communities.

These problems at the Oregon State Hospital led to a 2006 Department of Justice investigation under the authority of the Civil Rights of Institutionalized Persons Act (CRIPA).²⁶ In January of 2008 the Justice Department issued its findings, a stinging critique of the hospital.²⁷ The CRIPA investigators found that the hospital failed to protect patients from patient to patient assault, and from the physical dangers inher-

ent in the aged facilities themselves. There was a heavy emphasis in the report on the problem of inadequate nursing care. In addition the report faulted aspects of psychiatric and psychological practices including lack of adequate assessments, medication management, and overuse of seclusion and restraint, with additional weakness found in discharge planning.

The 2007 Oregon Legislature responded to the CRIPA investigation with a significant financial commitment to build two new state hospitals with a total of 1100 beds. The numbers of professional staff needed for these hospitals was not actively debated, and the need is only now beginning to become apparent to state leaders within the executive and legislative branches. The question of how to find the requisite numbers of nurses and physicians is yet to be addressed along with the sticker shock that will no doubt accompany this discussion.

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Oregon's Community Mental Health Programs

The situation is not much better with regard to Oregon's community mental health programs. These programs serve predominantly three categories of clients: those who remain as OHP beneficiaries, those who receive traditional Medicare and Medicaid benefits, and those with no coverage of any sort (the medically indigent). There is limited funding with limited treatment options available for the medically indigent.

Cascadia Behavioral Health, a not-for-profit private agency, operated on contracts with state and local governments and on fee-for-service revenue. The program provided mental health services to 20,000 clients in five of Oregon's largest counties, particularly in Portland, the state's largest city, and at its height had a budget of some \$60 million per year.

The Cascadia story provides an instructive lesson in regard to the problems inherent in community mental health programs in this state. What it says is that these programs operate very close to the margin. In essence, they are grossly under-funded by both state and county

governments. If they are not extremely well managed, they will run into trouble, as was the case with Cascadia Behavioral Health. State and county officials responsible for oversight were not sufficiently aware of the problems because too little attention was paid to program evaluation and oversight.

Consequences

President Carter stated in 1979 that "unnecessary institutionalization" has given way to "inadequate community care." He was correct, and in retrospect the dynamics were clear, resulting from the rapid reduction in the number of inpatients; closure of beds; increased vigilance, legal and otherwise, at the front door blocking easy access to the remaining beds; decreasing federal responsibility for the community mental health center movement; and the inability or unwillingness of states to assume the necessary financial burden to adequately fund hospital and community programs. All of these factors have produced the current situation with the most negative result being the large-scale criminalization of the mentally ill.

"Unnecessary institutionalization" has been replaced in many places by unavailable institutionalization. This situation is highlighted by the Oregon data, and nationally by the Treatment Advocacy Center,²⁸ the National Association of State Mental Health Program Directors,²⁹ the American Medical Association and the American College of Emergency Physicians,³⁰ President George W. Bush's New Freedom Commission,³¹ and a recent commentary in the *American Journal of Psychiatry*.³²

This situation in Oregon and across the U.S. leads to an inevitable pathway to the nation's jails and the prisons.³³ In a recent commentary in the *Journal of the American Medical Association*, H. Richard Lamb and Linda Weinberger,³⁴ citing evidence from the National Commission on Correctional Health Care, reported that in 2006 there were "at least" 341,000 incarcerated persons with severe mental illness in the United States, representing approximately 15% of incarcerated individuals in that year.

Bernard Harcourt contributed an added dimension to the discussion of mental hospital institutionalization in the United States by analyzing aggregate data from mental hospitals and jails and prisons in the years 1928-2000.³⁵ He noted that hospitalization rates peaked in 1955 and declined rapidly after that date reaching the low levels cited in this paper (deinstitutionalization) and also noted that since the

early 1980s the country is in an expanding period of criminal incarceration (the “incarceration revolution”). By combining data from both mental hospitals and the jails and prisons, Harcourt found that the current combined level of institutionalization had not yet reached the aggregate levels that existed in 1955. He also noted an inverse relationship between decreasing total institutionalization and the national homicide rate. Harcourt argues for further investigation to look for precise explanation for this finding.³⁶

From the criminal justice system perspective, the current era is characterized as an “incarceration revolution,” while from the mental health perspective the era of deinstitutionalization has given way to the era of the criminalization of the mentally ill. The public mental hospitals now have the lowest number of beds in decades, and over the last decade we have been losing community hospitals beds, even as our population continues to increase.³⁷

Are There Any Solutions?

Here it is appropriate to briefly discuss the question of national policy and the political process. First and foremost, there needs to be a national mental health plan, a consensus plan that is actively supported by the federal government.

We haven’t had clear national mental health policy since the administrations of Presidents Kennedy, Johnson, and Carter. There was some hope of positive movement early in the presidency of George W. Bush when in 2002 he appointed the New Freedom Commission on Mental Health charged with studying the mental health service system and making recommendations for improvements in the system.³⁸ The president set out five Principles to guide the Commission, one of which, however, stated that:

The Commission shall follow the principles of Federalism, and ensure that its recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the States and Indian tribes.

Reminiscent of President Pierce, this statement meant that President Bush was not interested in the development of national policy that would govern approaches in each state. That said, the Commission did make a serious effort to comprehensively describe the state of the country’s mental health service system, including its current deficits, and developed six goals for improving the system. The Commission also recognized the work of promising programs from various parts of the country. But, in keeping with the spirit of the new federalism, little comprehensive federal policy changes

were recommended and little attempt was made that would bind the country to another major and unified approach that would address the current problems and look to a better future.

In addition, at the political level, recent decades of American politics have fueled the incarceration revolution. In many areas of political life, politicians have used fear and sensationalism as pathways to election. Data is certainly not king in the public arenas. Incarceration is far cheaper when compared to mental hospitalization, and in every political race in this country the pledge of “no new taxes” has become an effective route to electoral success. And further, the police, courts, and jails and prisons remain the last resort, governed by laws which make it very difficult to pass the buck, as states have done in mental health care. The buck stops inside the doors of the jails and prisons. A rational conclusion would be that we probably do not have the political will to move into a new era of revitalization of the public mental health programs.

If, however, there was a chance to move away from the “incarceration revolution” and attempt to rebuild the public mental health programs, we would be wise to look to the past for some guidance as there were many excellent program models that were developed that might serve as guides to future systems.

We have already noted the innovative program models embodied in the federally funded Community Mental Health Center (CMHC) of the 1960s and 1970s, which were based on the principles of public health psychiatry.³⁹

In addition, there certainly is a need for a concerted effort to rebuild and expand psychiatric inpatient capacity. This is not a call for the reconstruction of the total institutions of the past, but for an adequate number of psychiatric beds in our communities to provide the necessary inpatient evaluation, treatment, and stabilization services that form the backbone of modern acute psychiatric services. Additionally, communities need an adequate number of public sector beds in acute care facilities to provide the necessary backup to criminal justice system detainees with severe mental illnesses. In 1960, Portia Bell Hume and Edward Rudin⁴⁰ described the funding received by the state of California’s mental health program from the federal government via the Hill Burton Act and from the state’s Short Doyle Act. Both of these well-known laws were designed to encourage the development of general hospital psychiatric units. We are greatly in need of similar commitments now at both the state and federal levels.⁴¹

Included with the need for a revitalization of inpatient mental health services is the re-development of functional civil commitment laws. In years past civil

commitment was the diversion method of choice for removing individuals from the criminal justice system and transferring them to the mental health system. Civil commitment provided hospitalization for individuals suffering severe psychiatric decompensation, before their behaviors brought them into contact with the criminal justice system. For those already in the criminal justice system and charged with minor crimes, civil commitment provided the major route for diversion into the mental health system. A constructive alternative to current civil commitment laws was developed by the American Psychiatric Association in the early 1980s. This model statute was never implemented among the states,⁴² but it is time to review it again as it contained many forward-thinking approaches to civil commitment.

It is important to note that currently, and only in a few communities, mentally ill individuals charged with crimes may be diverted from jail by the developing system of mental health courts.⁴³ These methods, although promising and somewhat effective, do not take mentally ill persons out of the criminal justice system, thus leaving them vulnerable to the heightened stigma associated with such involvement.

In closing, although this article has focused a great deal of attention on inpatient care, it is important to conclude by acknowledging that it is the outpatient, residential, and occupational components of a mental health program that really comprise the core of the services. All inpatient treatment are only in the service of a rapid reintegration of individuals into their communities, and into as productive situations as they are capable of achieving. Great strides have been made in these areas, but these advances cannot be realized without adequate support. Perhaps this will ultimately come from national mental health parity legislation. Perhaps adequate or even excellent outpatient care will come ultimately from a functional national health insurance program, or perhaps from a separate national mental health policy, but it must come as the central focus of a comprehensive mental health program if the national mental health plan is to be successful.

Note

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