Out of Sight, Out of Mind: Mental Illness Behind Bars

In the 1840s, Dorothea Dix traveled the country confronting state legislatures about the unconscionable treatment of prisoners and urging, in particular, the building of hospitals for those with psychiatric illness. By the 1880s, there were 75 psychiatric hospitals in the United States, and a survey estimated that less than 1% of prisoners had mental illness (1). For the next 90 years, it was widely accepted in the United States that people with mental illness belonged in hospitals rather than prisons.

Then it all came undone. In 1955, approximately 560,000 patients occupied state hospital beds; today the number is approximately 35,000 (1). It is no mystery where the patients went: In 1880, 0.7% of U.S. prisoners had serious mental illness; in the 1970s, the rate was approximately 5%, and today it is likely more than 20% (an estimated total of almost 360,000 inmates) (1). In a rather astonishing yet woefully unsurprising statistic, Torrey et al. (1) estimate that there are 10 times as many mentally ill persons in prisons than in state hospital beds. Furthermore, in their state-by-state survey of the "treatment of mentally ill persons in prisons and jails," as the article is ironically titled, the authors conclude that the resources and policies required for "treatment" of incarcerated patients are virtually absent (1). It would appear, then, that we somehow have achieved the complete reversal of policies initiated over 170 years ago to ensure the humane treatment of those with mental illness. How did we get here?

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The directionality of history would predict the continued progression of humankind toward a morally evolved state (2). Consistent with this concept is the revolution in natural law that occurred in the 17th century and that gave birth to the belief in the rights of the individual. Moral obligation was redefined as entailing respect for the life, integrity, and well-being of others rather than exclusively focusing on the role of man in divine history. Individuals were entitled to autonomy and freedom from suffering—critical underpinnings of the Enlightenment that left an indelible mark on our country and Western civilization (3). But maybe not so indelible. Mark Lilla has argued (4) that the advances of the Enlightenment are far from permanent gifts, but rather are part of a temporary stage in history before the pendulum swings back to the nonhumanistic political theology that ruled before the development of Enlightenment-inspired political philosophy. The abandonment and burgeoning incarceration of people with mental illness since the 1970s would, sadly, support the latter argument. And nowhere is the relentless and precipitous devolution in the care of those with mental illness

better demonstrated than in North Carolina, which in 2010 closed the doors of the hospital named in honor of Dorothea Dix.

The closing of state hospital beds in the United States is a grim reminder of the unintended consequences of good intentions—a not uncommon feature of American politics. Just as the profiteering that created the subprime mortgage crisis and ensuing economic collapse was propelled by the noble drive to create affordable housing in the 1990s (5), respect for individual autonomy—another noble instinct—inspired the deinstitutionalization movement (as well as the marked restriction of the use of forced administration of medication) in the 1960s. The idea was that with the creation of adequate clinical capacity, persons with mental illness could be returned to the community, where their opportunity for freedom would be maximized. This was exactly the road map followed in North Carolina. An outside consultant opined that the state spent far too much per capita on state hospital beds and far too little on community treatment (in which the state ranked 11th and 49th, respectively) (6, 7). Therefore, the beds should and could be reduced if the dollars were more appropriately directed toward local community mental health services. Great idea, except that in practice the beds were closed (the count was reduced from 2,870 beds in 1992 to 1,250 beds in 2010) and the money for community mental health was diverted to other priorities. Furthermore, recognition that mental health care for the indigent was (in a short-sighted view) a money loser led to the privatization of health care services. This solution was predictably followed by the cherry-picking by private mental health concerns of those patients who were able to pay for their mental health care. The indigent, then, were left not only without access to health care but additionally without the financial support that previously could have been derived from the more profitable sector of mental health care delivery that was exported to the private companies (who literally took the money and ran). The net result is that the emergency department has become the default locus of care.

That, however, is far from the end of the ongoing devolving process. With the dramatic decrease in the number of state hospital beds, patients back up in the emergency department for days at a time. The poor reimbursement for psychiatric beds relative to other (particularly procedural) medical beds leads to the further decommissioning of community psychiatric inpatient beds, thus exacerbating the problem. The closing of forensic beds at the Dorothea Dix Hospital results in the disproportionately high occupation of the reduced number of state hospital beds by persons from the criminal justice system awaiting evaluation. County regulations prohibit the return of patients until several weeks after completion of the evaluations, thus tying up beds, increasing average length of stay, decreasing throughput, and further reducing the number of available beds. The increased acuity of patients and the inadequate financial support for hospital staff result in an increased incidence of violence and injury (further depleting staff) and a reluctance to admit new patients (as the care of difficult patients, admissions, and discharges are among the most time-consuming staff activities). After discharge, mentally ill patients without follow-up treatment deteriorate and wind up exhibiting behavior that routes them through the revolving door of the emergency department or to jail. And once in jail or prison, those with mental illness often do not receive adequate treatment (again, because of insufficient resources) and may be exposed to the type of deplorable conditions that Dorothea Dix worked so hard to remediate. Furthermore, as Torrey et al. lament (1), the constraints surrounding the use of forced—and necessary—medication ensures that people with mental illness in

prison will remain ill and both vulnerable to and propagators of violence. Such is another unintended consequence of the well-intentioned defense of autonomy.

It is worth noting that with the exception of the clogged emergency departments (and the increasing numbers of homeless people), the events and conditions described above appear largely out of the view and consciousness of the public. Consequently, protests like that of Torrey et al. that our policies are disenfranchising people with mental illness and contributing to rather than remediating the burden to society of their disabilities fall on deaf ears. Once again, North Carolina is the negative exemplar. In 2011, there were 14 weekdays on which the University of North Carolina Hospital emergency department started the day with 10 or more patients, 19 in 2012, 90 in 2013, and 52 in the first 4-1/2 months of 2013. The response of the state government is to provide tax breaks on yachts and airplanes and for all who make more than $150,000 a year, increase regressive taxes, and simultaneously cut the division of Health and Human Services budget by hundreds of millions of dollars and require preauthorization for psychiatric medications (as the governor recently proposed). The moral therapy of the 19th century has been replaced by the immoral lack of therapy in the 21st. Out of sight, out of mind.

Torrey et al. provide sensible recommendations for the improvement of conditions and the implementation of more humane treatment of those with mental illness in prisons: 1) create the conditions that will permit the appropriate treatment of prisoners with mental illness; 2) implement jail diversion programs; 3) promote the use of assisted outpatient treatment for at-risk individuals; 4) get the data—determine the real cost of incarcerating those with mental illness (1). It is nonetheless hard for me to imagine that the logic and moral force of these arguments will prove persuasive in the face of two current social factors: the increasing centrality of bottom-line financial success in health care, which is an erroneous justification for denying care to the indigent; and a Calvinistic context that would have us believe that those who are not successful, those who are impoverished or mentally ill, are deserving of their fates. Can we really expect the data that Torrey et al. present to precipitate much-needed change in social policy when the tragedy of the killings at Sandy Springs Elementary School failed to mobilize measures to control access to firearms but instead led to demands to further restrict the rights of people with mental illness? If logic would motivate reform, would we continue to spend money on the most high cost, inefficient means of delivering care—emergency departments, inpatient hospitalizations, and incarceration—rather than investing in prevention in lower-cost, higher-efficacy health care delivery in the community? If morality would motivate reform, would we continue to lock up people with mental illness in prison and deny them access to treatment? The irony is that were Dorothea Dix alive today, she would not be advocating for more state hospital beds. Rather, she would insist that both our humanity and financial advantage would be served by administering the treatments that we have today, not in hospitals and certainly not in prisons, but in a community demonstrating respect for the basic human rights of its citizens.

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