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From Prisons to Asylums, and Back: Mental Health Policy in the Age of Neoliberalism

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Honors Thesis

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Abstract

This thesis seeks to explain why rates of severe mental illness in the criminal justice system have risen steadily throughout the past three decades, despite an increasing acknowledgement of the importance of mental health to overall health. Legislative, scientific, and societal advances have aimed at increasing access to and bolstering the quality of mental health care. Yet, the large numbers of severely mentally ill persons residing in the criminal justice system imply care in the community is not adequately serving their needs, or that, for whatever reason, they are not seeking care. I begin my analysis by considering mental health care through a justice lens, laying out three conditions that must be met if justice is to be served for persons with severe mental illness. The first is material-based and is that persons with severe mental illness should have access to the material resources necessary for them to thrive on par with the rest of society. The second two are value-based and have more to do with the recognition this group receives. First off, there should not exist institutionalized stigma attached to persons with severe forms of mental illness, and, second, policies should reflect the unique needs of this population. When all three of these conditions are met, parity of participation is achieved. This justice framework guides the rest of my paper, as I explore the current state of the United States mental health system, the consequences of its focus on mainstreaming, and the historical reasons why the system developed in the way it did. I end by looking forward to small-scale policy changes that move persons with severely mental illness closer to participatory parity. I ultimately conclude that, although these policies likely will aid in achieving some degree of participatory parity for this highly marginalized population of individuals, we as a society have a long way to go before such an ideal can be reached.

Introduction

The primary research question this thesis seeks to answer is why, despite mental health parity legislation and an increasing awareness of the importance of mental health care in America, the rates of persons with mental illness in the criminal justice system continue to rise. According to a November 2014 report by the Treatment Advocacy Center, a non-profit organization advocating for the improvement of treatment laws for mental illness, approximately 20 percent of inmates in jails and 15 percent of inmates in state prisons have been diagnosed with a severe mental illness.¹ This statistic stands in stark contrast to the much lower 6.4 percent of inmates reportedly suffering from such illnesses in 1983. Although I recognize that mental illness is more frequently diagnosed today than it was 30 years ago, research unequivocally shows a definite switch from state mental hospitals to prisons and jails as the primary providers of inpatient mental health care for persons with severe mental illnesses.² This marked increase is surprising given the host of legislation passed during this same time period to increase access to mental health services. On April 8, 2008, the Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law. This piece of legislation, which requires that insurance companies treat mental health the same way they do physical health, was viewed as a major milestone by mental health advocates in Congress, as it would supposedly increase access to treatment for individuals with all forms of mental illness.³

Following the passage of the MHPAEA, Patrick Kennedy, a United States Senator with a history of mental illness is quoted as saying:

¹ Treatment Advocacy Center, "How Many Individuals with Serious Mental Illness are in Jails and Prisons?" *Treatment Advocacy Center*, November 2014, accessed February 2, 2015, <http://www.treatmentadvocacycenter.org/problem/consequences-of-non-treatment/2580>.

² Ibid

³ Colleen Barry L. Barry, Haiden A. Huskamp and Howard H. Goldman, "A Political History of Federal Mental Health and Addiction Insurance Parity," *The Milbank Quarterly*, 88 (2010): 406, accessed October, 2014, doi:10.1111/j.1468-0009.2010.00605.x.

This legislation is one more step in the long civil rights struggle to ensure that all Americans reach their potential. For far too long, health insurance companies have used the stigma of mental illness and substance abuse as an excuse to deny coverage for those biological disorders.⁴

Such quotes, uttered by fellow Congressional leaders, sufferers of mental illness and other mental health advocates in the days and weeks following the law's passage, imply victory for Americans diagnosed with mental illness. Given the significant strides our country has made in the way we view and treat mental illness, this is a believable assumption. Organizations like the National Alliance on Mental Illness (NAMI) and Mental Health America (MHA) have worked tirelessly to reduce the stigma traditionally attached to these illnesses. And, although there is still a long way to go, medical researchers have discovered much about the causes of mental illnesses and thus have developed new and better methods for treating them.⁵ Despite these legislative and scientific victories, prisons and the streets continue to serve as the dumping grounds for many people with these illnesses. This paradox forms the basis of my inquiry. Medical professionals and the general public have agreed that prisons and jails are not suitable environments for persons with mental illness. So why does the criminal justice system today house nearly as many persons with severe mental illnesses as it did over 150 years ago?⁶

This thesis seeks to unpack the historical and political forces that have created and sustained the above-explained paradox. I do so by identifying problems with the public mental health system and exploring its development. I then address the question of whether the achievement of federal mental health parity legislation is likely to improve the quality of life for those Americans suffering from severe mental illnesses. I argue that the concept of community

⁴ Fred Frommer, "After 12 Years, Wellstone Mental Health Parity Act is Law." *MPR News*, October 8, 2008. Retrieved from http://www.mprnews.org/story/2008/10/03/parity_finalpassage.

⁵ Richard G. Frank and Sherry A. Glied, *Better But Not Well: Mental Health Policy in the United States Since 1950* (Baltimore, Maryland: The Johns Hopkins University Press), 44.

⁶ E. Fuller Torrey, Aaron D. Kennard, Don Eslinger, Richard Lamb, and James Pavle, "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States," *Treatment Advocacy Center*, May 2010. Retrieved from http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

mental health care, although well founded, was not effectively implemented. A lack of organization and neoliberal policies of the 1980s impeded the realization of a community-based continuum of care for mental illness. Furthermore, policymakers did not account for the fact that releasing mentally ill persons into the community would not automatically lead to freedom in a substantive sense. Given these realities, I provide suggestions for policymakers moving forward. I begin my inquiry with a discussion of what justice looks like for persons with mental illness.

What does justice for people with mental illness require?

Capability is primarily a reflection of the freedom to achieve valuable functionings. It concentrates directly on freedom as such rather than on the means to achieve freedom...in this sense it can be read as a reflection of substantive freedom.
-Amartya Sen

Introduction

Justice for persons with mental illness requires a different kind of parity than that which has garnered so much attention in the policy realm over the course of the last two decades. Although parity under insurance is an important piece of mental health reform, it alone cannot achieve justice for the mentally ill. A set of normative requirements for the treatment of mentally ill individuals in a democratic society like the United States is needed to ensure that justice is served for this group of citizens. I have developed such a set, relying heavily on concepts put forth by two prominent scholars, Amartya Sen and Nancy Fraser. Through a discussion of freedom, political agency and participatory parity, I lay out the ideological foundation for my argument for greater continuity of care in mental health. This section will proceed in three parts. In the first part, I outline the history of civil rights for the mentally ill. This will be followed by a discussion of procedural versus substantive equality and the unfreedoms often associated with the former. The third section explains Nancy Fraser's concept of participatory parity and its potential application in mental health policy.

Amartya Sen's Capabilities Approach

Amartya Sen, a development economist who advocates for a comprehensive view of development, provides a good starting point for uncovering the type of public policy that would lead to justice for the mentally ill. Sen's capabilities approach to the evaluation of individual and social well-being is more inclusive than some of the more traditional approaches. While theorists like John Rawls and Ronald Dworkin tend only to focus on whether a person has the instrumental means to achieve well-being, the capabilities approach looks at whether that person is able to use those instruments.⁷ More broadly, Sen's approach differs from three oft-cited schools of thought in ethics and economics: classical economics, utilitarianism and libertarianism. Unlike classical economists, Sen conceptualizes development as more than an increase in income or economic standing. For instance, Sen would say that rich countries in which some citizens lack access to basic healthcare should not be labeled as fully developed.⁸ Utilitarianism, on the other hand, in prioritizing the importance of mental satisfaction, does not leave room for the kind of constructive dissatisfaction that Sen views as a necessary prerequisite for positive social change. I focus mainly on Sen's criticism of the libertarian approach; out of which I argue today's approach to mental health policy emerged.

The libertarian school of thought emphasizes procedures for liberty, while virtually ignoring the consequences of such procedures. This approach to social evaluation focuses on whether a person has the instruments needed to achieve well-being but pays scant attention to whether a person has the ability to use these instruments.⁹ Sen's capabilities approach goes a step further, taking into account substantive outcomes. He illustrates the idea in a book about freedom and

⁷ Amartya Sen, *Inequality Reexamined* (New York: Russell Sage Foundation, 1992): 42.

⁸ Amartya Sen, *Development as Freedom* (Knopf Doubleday Publishing Group, 2011): 16.

⁹ Sen, *Inequality Reexamined*, 42.

inequality, drawing a comparison between “well-being freedom” and “achieved well-being.”¹⁰ While the former is procedural in nature and focuses only on the “levers of control,” the latter is a product of effective freedom.¹¹ For those individuals who possess constraints that may interfere with their capacity to provide for their needs and pursue their ambitions, procedural freedom can be quite limiting.¹² In essence, Sen’s approach to social evaluation reminds us that procedural equality does not always lead to substantive equality. It is important to recognize that Sen’s vision of freedom, although it serves a primer for thinking about how justice for the mentally ill might be achieved, is still highly individualistic and does not provide a call for collective action. For this reason, I have chosen Nancy Fraser’s concept of participatory parity as the primary model to guide my discussion of justice. Fraser tries to provide a way of uniting procedure with substance in a manner that is appropriate for a democracy and thus gives the non-ill a reason to care about individuals with mental illness.

Participatory Parity and Severe Mental Illness

Nancy Fraser’s concept of participatory parity provides a framework for rethinking mental health policy and the rights of mentally ill individuals. Participatory parity constitutes the normative core of Fraser’s unique conception of justice. According to Fraser, the majority of oppressed groups in society suffer from both maldistribution and malrecognition. In order for the criteria of participatory parity to be met, both redistribution of resources to and recognition of oppressed groups must occur. When both of these preconditions are met, all individuals are

¹⁰ Ibid, 40

¹¹ Ibid, 65.

¹² Wendy Brown, “Neo-liberalism and the End of Liberal Democracy,” *Theory and Event* 7, no. 1 (2003): 7. Retrieved from <https://uranthplsc379.files.wordpress.com/2013/10/wendy-brown-neo-liberalism-and-the-end-of-liberal-democracy-theory-event-71.pdf>.

given the status of a full partner in social interaction, allowing the integration of recognition and redistribution under one core norm.¹³

Politics of redistribution generally focus on socioeconomic injustices that are rooted in economic institutions. When evaluating social justice through this lens, the victims of injustice are particular economic classes. To address maldistribution, material resources must be redistributed such that participants' in social life have independence and political "voice." Social arrangements that institutionalize deprivation, exploitation, and gross disparities in wealth, income and leisure are replaced with those that institutionalize equality of opportunity and outcome.¹⁴ While redistributive justice is fairly straightforward in terms of how it can be achieved, justice through recognition can be accomplished in a variety of ways.

In general, politics of recognition attempt to remedy cultural injustices that stem from social patterns of representation, interpretation, and communication by ensuring that institutionalized value representations do not unduly burden particular groups in society.¹⁵ Misrecognition can occur in more ways than some might automatically conceive. On one hand, a group can suffer misrecognition when they are labeled as different from the rest of society. This form of misrecognition certainly applies to persons with mental illness, as historically negative views of this group of individuals has led others in society to avoid living, socializing, or working with, renting to, or employing persons with such illnesses.¹⁶ Universalist claims for recognition seek to remedy this injustice by reaffirming the equality of all social groups and thus unburdening misrecognized ones. Misrecognition can also occur when a society fails to acknowledge a

¹³ Nancy Fraser, "Social Justice in the Age of Identity Politics: Redistribution, Recognition, and Participation," Lecture, Tanner Lecture on Human Values, Stanford University, May 2, 1994.

¹⁴ Fraser, "Social Justice in the Age of Identity Politics," 31.

¹⁵ *Ibid*, 6-7.

¹⁶ Frank and Glied, *Better But Not Well*, 133.

group's distinctiveness.¹⁷ As I will explain in detail later, mentally ill persons suffer misrecognition in this way when mental health services are not tailored to their distinct needs. Differentialist claims for recognition seek to enhance group differentiation so as to ensure that any unique characteristics are recognized or unique needs met. Mentally ill persons have experienced both kinds of misrecognition throughout American history, and although policies have attempted to remedy these injustices, none have succeeded in granting mentally ill persons parity of participation.

History of Civil Rights for the Mentally Ill

Mental health policy has, at several points throughout American history, considered the civil rights of the mentally ill as its core tenant. Many of the reforms enacted have been oriented towards social justice in one way or another. In the nineteenth century, inadequate and sometimes inhumane treatment of mentally ill persons in poorhouse and jails prompted the construction of state mental hospitals.¹⁸ At the time, very little was known about mental illness and the colonial practice of placing these “demented” individuals in poorhouses and jails still abounded. Hospitals tailored to this population seemed like a humanitarian alternative that would allow mentally ill persons to actually receive medical and custodial attention, as opposed to wasting away in jail cells. Dorothea Dix, a schoolteacher from Massachusetts, led the effort, ultimately establishing 32 hospitals in 18 states.¹⁹ Over the next 100 years, however, these hospitals deteriorated into something arguably worse than the poorhouses and jails they had been

¹⁷ Fraser, “Social Justice in the Age of Identity Politics,” 31.

¹⁸ David Rochefort, *From Poorhouses to Homelessness: Policy Analysis and Mental Health Care* (Westport, Connecticut: Auburn House, 1993), 36; Jennifer Erkulwater, *Disability Rights and the American Social Safety Net* (Ithaca, New York: Cornell University Press), 53.

¹⁹ Meighan B. Haupt. *The Vital Role of State Psychiatric Hospitals*. Technical Report. National Association of Mental Health Program Directors, July 2014. Retrieved from http://www.nasmhpd.org/Publications/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014.pdf.

created to replace.²⁰ It was an effort that began as a marriage of redistribution and recognition that deteriorated once the redistributive piece languished. Institutions that were founded on humane missions no longer had the resources to be humane. As a result ,an increasingly negative opinion of institutionalization began brewing during World War II. Referred to as the era of seeing patients “as people,” the decades leading up to the 1960s illuminated just how limited the rights of mentally ill persons had become, despite eighteenth century reformers’ efforts to enhance them. Popular newspapers and magazines decried the conditions of the state hospitals. Author Mary Jane Ward, for example, categorized mental hospitals as “snakepits” in her 1946 novel about a woman’s recovery from mental illness. Nearly 100 years after Dix’s crusade, civil rights concerns again ignited a major shift in mental health policy, away from the asylums created for this very reason decades earlier.²¹

Commonly termed deinstitutionalization, the years between 1965 and 1985 involved a straight and determined march from hospital-based care to community-based care, with little consideration of anything in between. A coalition of rights-based advocates, frustrated with the lack of agency mentally ill persons possessed to decide the course and location of their treatment, began this march.²² Their efforts rested on the Fourteenth Amendment guarantee of protection under the law. A 1976 speech at the Washington D.C. branch of the ARC, a national organization that promotes and protects the human rights of people with intellectual and developmental disabilities, called attention to the fact that this was not happening: mentally ill persons at the time lived “a dehumanizing life with none of the constitutional, civil and legal

²⁰ Erkulwater, *Disability Rights*, 53.

²¹ George W. Paulson, *Closing the Asylums: Causes and Consequences of the Deinstitutionalization Movement* (Jefferson, N.C.: McFarland & Co., 2012), 127.

²² Paulson, *Closing the Asylums*, 163.

rights and liberties which [others] take for granted.”²³ In addition to organizations and individuals who advocated on behalf of the mentally ill, the courts also played a key role in facilitating the movement away from state mental hospitals.

Early on, there was a distinct split between those who wanted to enhance the positive rights of the mentally ill and those who preferred to focus on negative rights. Dr. Morton Birnbaum, who is often called the “father of the civil rights movement for the mentally ill,”²⁴ “right to treatment” theory was cited in a variety of court cases in the 1960s and 1970s.²⁴ His theory states that patients have a legal right to treatment that gives him or her “a realistic opportunity to be cured or improve his mental condition.”²⁵ At the time Birnbaum authored his theory, patients could not be released from hospitals until they improved; however, in many cases, they were not receiving the caliber of treatment that would allow for such improvement. The Bazelon Center, then called the Mental Health Law Project, refused to help Birnbaum enhance funding for institutionalized care. This led to his theory being legally employed in a different way than he originally intended. In an interview with Pete Early, Birnbaum explained that his goal was never to give patients the right to refuse necessary treatment but rather to force states to start treating patients.²⁶ While Birnbaum wanted to ensure better care for the mentally ill, many advocates wanted to give this group the right *not* to be treated if that was what they preferred. *Lake v. Cameron* (1966) established that the mentally ill should be treated in the least restrictive setting. *Leonard v. Schmidt* (1972) established that an individual must be declared both mentally ill and dangerous before he or she could be committed. *Donaldson v. O’Connor* (1974) reaffirmed the

²³ Melvin D. Heckt, “The Mentally Retarded Citizen and the Law,” *The Arc of Washington*, Washington, D.C., August 21, 1976. <http://mn.gov/mnddc/past/pdf/70s/76/76-MRC-MDH.pdf>.

²⁴ Pete Early, *Crazy: A Father’s Search Through America’s Mental Health Madness* (New York, NY: Berkeley, 2007): 2538.

²⁵ Morton Birnbaum “The right to treatment” *American Bar Association Journal* 46 (1960): 499-504.

²⁶ Early, *Crazy*, 2564.

1972 case in its conclusion that a patient has a right to liberty unless he or she is dangerous. These court cases created the current divide between community-based care and institutionalized care by splitting positive from negative rights. Patients were not given an affirmative right to treatment but rather an affirmative right *not* to be treated.

A key thing to keep in mind about deinstitutionalization is that, despite its civil rights roots, it probably would not have happened had the only argument been a human one. Although some early legislation tried to shift care to the community, civil rights advocates were not able to make significant headway until federal programs provided some means of support in the community for people with mental illness. The introduction of Federal programs like Medicaid, Medicare, and Social Security Insurance (SSI) in the 1960s made the human argument for transferring the mentally ill from institutions to the community economically logical for states.²⁷ These programs were not created with the mentally ill in mind; however, they became the primary provider of resources to released mental patients. Between 1955 and 1965, during which the Community Mental Health Centers Act of 1963 was passed, the number of institutionalized patients dropped by just two percent per year. Conversely, between 1970 and 1975, during which the country experienced a large increase in federal social welfare spending, the number dropped by 11 percent annually.²⁸ SSI in particular created powerful incentives for releasing patients into the community, perhaps too quickly. First off, 1972 amendments to the legislation required Congress to “grandfather in” anyone enrolled in state assistance programs when the Social Security Administration assumed responsibility in 1974. Second, and perhaps more directly tied to the magnanimous increase in the pace of deinstitutionalization, SSI stipulated that, while disabled persons living in the community were eligible for benefits, patients residing

²⁷ David Mechanic, “More People Than Ever Before Are Receiving Behavioral Health Care in the United States, But Gaps and Challenges Remain,” *Health Affairs* 33, no. 8 (2014): 1417.

²⁸ Erkulwater, *Disability Rights*, 90.

in public hospitals and group homes were not. This created a fairly easy decision for states, which could either release the mentally ill into the community, knowing they would likely be picked up by SSI, or renovate state hospitals to conform to the regulations handed down by the Courts.

This timeline of the extended civil rights movement for the mentally ill reveals a desire on the part of a variety of actors to recognize persons with mental illness as equal citizens and to provide these individuals with the tools necessary achieve to well being. Reflecting on deinstitutionalization, however, many of the legislative and judicial advancements have been nothing more than symbols of what should be. Patients' rights advocates achieved some of their goals, and persons with mental illness are substantially better off today than they were 100 years ago.²⁹ Deinstitutionalization removed the physical walls that had literally and figuratively separated the mentally ill from the rest of society. In addition, the new model of treatment in community settings achieved greater agency for mentally ill persons. To reemphasize Sen's argument, though, procedural gains cannot be counted as successful without ensuing gains in substantive well being. One scholar writes:

The importance of symbolic recognition, especially for groups that have been stigmatized and discriminated against, can never be overestimated, but it could nevertheless be argued that this is inadequate until supplemented by material improvements in the quality of people's lives.³⁰

Community mental health certainly achieves symbolic recognition; however, it has developed into recognition without redistribution. Justice, however, requires more than just fair procedures, as fair procedures without any substantive backing do not always lead to equality of opportunity. Does the public mental health system today sufficiently satisfy the requirements of participatory

²⁹ Frank and Glied, *Better But Not Well*.

³⁰ Niraja Gopal Jayal, "The Challenge of Human Development," *Journal of Human Development and Capabilities: A Multi-Disciplinary Journal for People-Centered Development* 10, no. 3 (2009): 360, accessed March 2015, doi: 10.1080/19452820903041782.

parity and provide mentally ill persons with the capabilities to use these resources? This question frames the following analysis of the community-based and highly mainstreamed public mental health system, as it exists today.

The Current State of Mental Health Care

Mental health services – for those with severe or not so severe illnesses – are no longer as distinctive, with their own set of dedicated providers, institutions, and policy-making bodies. Today people with severe mental illness receive benefits largely from programs that also serve people with other disabling conditions. People with mental illnesses of all types have their medical care paid for by the same organizations that pay for physical health care. Mental health care has been mainstreamed.

-Richard G. Frank and Sherry A. Glied

Introduction

A general problem in the United States, which spills over into mental health policy, is that we do not provide universal positive rights to social aid. Instead, we have what is called a residual welfare state. We let the market distribute resources, leaving the state to come back in later to insufficiently correct glaring injustices. For example, the federal government provides a host of grants to poor mothers and their children, as well as checks to the unemployed. In the case of the sick and disabled, rather than providing universal access to care, we condition care on one's health status. Forms of assistance include Medicare, Medicaid, and income support for the disabled, who are permanently impaired; some community mental health services and other patchworks of care for the mentally ill, who are considered sporadically or temporarily impaired; and employer-sponsored health care or no care at all for the well. As a result, public aid is not available until an individual can demonstrate sickness. In this way, the welfare state crystalizes a distinction between wellness and illness in medicine. Since mental illness is best understood on a continuum, persons with such diseases would benefit from recognition of universal rights rather than conditional rights.

Bifurcation between Wellness and Illness

The conditioning of treatment on a person's ability to demonstrate sickness is a natural outgrowth of our country's tendency to draw a sharp distinction between wellness and illness. For more than a century, the biomedical model of disease has dominated American medicine. This model, which stems from Louis Pasteur's germ theory of disease, understands illness as a deviation from normal biological functioning due to known or unknown natural causes.³¹ In this model of disease, practitioners recast illness, which scholar Arthur Kleinman defines as a human being's experience of symptoms and suffering, in technical, medically understood terms.³² I am in no way challenging the claim that both physical and mental illnesses stem from biochemical defects. Rather, I am pointing out the potentially adverse effects of approaching treatment through this bifurcated lens.

Our central focus on the prevention, diagnosis and remedy of disease promulgates the idea that, by eliminating causes of an illness, practitioners eliminate the illness itself.³³ In the case of many mental illnesses, this is simply not the case, as the most severe mental illnesses often require constant care and management. In addition, research shows that serious mental illnesses can be better managed when identified and treated early on, prior to the onset of the severe symptoms that would land a person in an emergency room.³⁴ In the context of Western medicine, though, a person is either ill or well, and there is little in between. Under the current fee for service payment system (FFS), for example, insurance companies reimburse providers for specific services instead of basing payments off of expected costs associated with a "clinically

³¹ George Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196, no. 4286 (1977): 130. Retrieved from http://www.jstor.org/stable/1743658?seq=1#page_scan_tab_contents.

³² Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York, NY: Basic Books, 1989): 5.

³³ Engel, "The Need for a New Medical Model," 129.

³⁴ National Alliance on Mental Illness. *Mental Illness: What You Need to Know*. Brochure. 2013.

defined episode” of care.³⁵ This bifurcation between wellness and illness discourages the development of a continuum of care for the treatment of mental illness, particularly for those individuals diagnosed with a severe and persistent mental illness (SPMI). As I will explain below, many individuals with these kinds of diseases require continuous care over the course of their lifetimes. As such, this population of individuals is never truly “well.”

The Unique Nature of Severe and Persistent Mental Illness (SPMI)

The 1999 Surgeon General’s Report on Mental Health defined SPMI’s as including disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, and severe depression and bipolar disorder.³⁶ Although these diseases are relatively rare, affecting just .05 percent of the American population, they must be given in-depth attention in today’s increasingly mainstreamed mental health care system.³⁷ In the context of mental health, mainstreaming refers to the intertwining of the mental health care system with the general health care system, the latter of which oftentimes lacks appropriate knowledge and training regarding the unique needs of the severely mentally ill. Mainstreaming also encourages the over-diagnosis of less severe illnesses, such as ADHD. This over-diagnosis is likely a result of the need to wedge the condition into a medicalized category before accommodations and care are forthcoming.

Persons with SPMIs have the most need for comprehensive and continuous treatment and tend to suffer most when a continuum of care is lacking in mental health treatment. The consequences of not being able to access care are the most severe for these individuals, who

³⁵ Suzanne Delbanco, “The Payment Reform Landscape: Bundled Payment,” *Health Affairs Blog*, July 2, 2014, <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/>.

³⁶ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, *Mental Health: A Report of the Surgeon General* (Rockville, MD, 1999), 287. Retrieved from <http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf>.

³⁷ “Mental Health Conditions,” National Alliance on Mental Illness, accessed October 2014, <http://www.nami.org/Learn-More/Mental-Health-Conditions>.

often have difficulty navigating even the most basic daily tasks.³⁸ As I will explain in subsequent sections, the risk of drug abuse, homelessness and incarceration are particularly high for this group. SPMI tend to be chronic in nature and thus to oscillate between periods of exacerbation, when symptoms worsen, to periods of latency, when the illness is less disruptive.³⁹ Furthermore, research indicates that schizophrenia's course over time varies considerably from person to person.⁴⁰ The presence of a biochemical defect, then, is a necessary but not sufficient condition for disease. Instead, the onset and course of schizophrenia is the result of an interaction between biological and environmental factors. There are instances in which a patient possesses a biochemical defect but does not show signs of illness. According to the present conception of illness as a curable defect, such an individual is not ill. He or she is well. This is a dangerous categorization to make in the case of mental illness, given the variability in the clinical expression of SPMI's. This leads one to question the mainstreaming of mental health care that has occurred over the past several decades. Policies reflecting such a bifurcated understanding of illness leave many mentally ill individuals with limited options in terms of continued care over the course of their lifetimes.

Mental Health Exceptionalism vs. Mainstreaming

The tension between policies based on mental health exceptionalism and those based on the mainstreaming of mental health care is not new and, in fact, has been a topic of debate for the past several decades. There are two primary schools of thought surrounding this concept. Advocates of mental health exceptionalism believe that special rules should be created for mental illnesses compared to other classes of disease. They argue that, due to the unique dilemmas faced by mentally ill individuals, mainstream health programs cannot adequately

³⁸ *1999 Report of the Surgeon General*, 272.

³⁹ Kleinman, *The Illness Narratives*, 7.

⁴⁰ *1999 Report of the Surgeon General*, 226.

provide for this population of individuals. Kiesler (1995) neatly states that while general medicine is oriented to acute care and hospital-based services, mental health policy should be oriented to long-term support, outpatient treatment, and community integration. David Mechanic notes:

It is understandable that mental health advocates insist on parity, but they must do so with the realization that persons with chronic disabling mental illness, and even many of those with less severe illnesses, require a different mix of services than does the conventional medical patient.⁴¹

Going along with this, Frank and Glied (2006) point out that the general medical arena is not set up to provide the full range of psychosocial services necessary for comprehensive treatment, including but not limited to the provision of housing, job training, psychiatric care, and stable, long-term employment.⁴² This is where our institutions run afoul of science, which increasingly breaks down the mind-body distinction. Parity legislation, by defining parity as the same coverage for care of mental and other medical illnesses, explicitly overlooks these sets of services that are unique to the care of severe mental disorders. Furthermore, the overall system is already fragmented in nature, and thus the inclusion of mental health care into the general medical arena presents a host of administrative difficulties.⁴³ Given the distinctive nature of mental health care, this group of scholars finds it more harmful than helpful to disregard policies of exceptionalism in mental health.

Those scholars on the other side of the debate can be divided into two main camps. First, there are those who focus on the economic and pragmatic motivations for including mentally ill individuals within the general medical sector. Mainstream programs, such as Medicaid, Medicare, and SSDI, provide agencies serving the mentally ill with an unprecedented stream of

⁴¹ David Mechanic, "Integrating Mental Health into a General Health Care System," *Hospital and Community Psychiatry* 45, no. 9 (1994): 894, accessed February 2015, doi: 10.1176/ps.45.9.893.

⁴² Frank and Glied, *Better But Not Well*, 49-50.

⁴³ David A. Rochefort, "Mental Health Reform and Inclusion of the Mentally Ill," *International Journal of Law and Psychiatry* 19, no. 3/4 (1996): 234, accessed February 2015, doi: 10.1016/S0160-2527(96)80002-1.

funding that has greatly increased consumer choice and standards of care.⁴⁴ Thus, inclusiveness and mainstreaming of individuals with even the most serious mental disorders has resulted in tremendous gains in economic support for mental health services. Other scholars focus their argument in support of mainstreaming on social equity concerns. Mental health exceptionalism, by painting an entire group of people as “different,” inhibits the opportunities of mentally ill individuals and disadvantages them in society, according to this point of view.

Deinstitutionalization and reintegration into the community were necessary in transitioning away from paternalistic policies that ostracized and marginalized this group.⁴⁵ In the years since, several waves of reform have added layers of mainstreamed options

Each of these schools of thought hinges its argument on the same component of participatory parity: recognition. If the goal of mental health policy is participatory parity, we should redistribute resources and accord equal recognition to those diagnosed with a mental illness. Proponents of mainstreaming emphasize the importance of the latter; however, they assume equal recognition can only be achieved by treating everyone in society the same. The problem with this assumption is that, sometimes, equal recognition can only be achieved by treating certain groups differently. The important question, which neither group leaves room to ask and which is central to achieving justice for persons with mental illness, is, “Which approach allows a mentally ill individual the ability to participate in decisions that affect his or her life?” This requires looking at the process (does the process affirm the dignity and capacities of the mentally ill individual?), *as well as* the outcomes (are the capabilities of the mentally ill

⁴⁴ Frank and Glied, *Better But Not Well*, 49-50.

⁴⁵ Dan A. Lewis, William R. Shadish Jr., and Arthur J. Lurigio, “Policies of Inclusion and the Mentally Ill: Long-Term Care in a New Environment,” *Journal of Social Issues* 45, no. 3 (1989): 176, accessed February 2015, 10.1111/j.1540-4560.1989.tb01563.x.

enhanced?). The structure of the mental health system today is highly mainstreamed, meaning that, while the process is equal, the outcome is not always so.

Sen and Fraser prove useful in assessing the efficacy of a mainstreamed system in achieving justice for persons with mental illness. The question is whether the system today simultaneously bestows dignity upon the mentally ill and offers universal access to quality mental health care. Under the current system, care is provided in a variety of settings, both public and private, and by a range of medical professionals. The types of facilities that offer mental health services can be boiled down to three levels of care: 24-hour hospital inpatient, 24-hour hospital residential and less than 24-hour outpatient. Specific types of facilities include psychiatric hospitals, general hospitals with a separate psychiatric unit, VA medical centers, outpatient clinics, residential treatment centers (RTCs) and multi-setting (multi-service, non-hospital) mental health facilities.⁴⁶ The Substance Abuse and Mental Health Services Administration's (SAMHSA) released its third iteration of the National Mental Health Services Survey in 2010 (N-MHSS 2010). Data from 10,374 facilities was included in the report, 77 percent of which are privately operated. According to survey responses, the most commonly offered treatment approaches of these facilities include cognitive/behavioral therapy, individual psychotherapy, group therapy, and psychotropic medication therapy.⁴⁷

A major argument for such a mainstreamed system is that the provision of mental health care in the least restrictive setting avoids stigmatization. In treating a person with a mental illness in the same arena as we would someone with heart disease theoretically allows that individual to receive quality mental health care without the stigma historically connected with

⁴⁶ Substance Abuse and Mental Health Services Administration, *National Mental Health Services Survey (N-MHSS): 2010. Data on Mental Health Treatment Facilities*. BHSIS Series S-69, HHS Publication No. (SMA) 14-4837 (Rockville, MD), 9.

⁴⁷ *Ibid*, 10.

such. Frank and Glied point out that, for many individuals with less severe forms of mental illness, this has happened.⁴⁸ Mainstreaming has been moderately successful in improving access to and standards of care. The switch to this type of care has allowed more individuals to receive mental health services. In 1990, for example, inpatient hospital care accounted for 40 percent of mental health expenditures. By 2009, this number had dropped to 25 percent. To understand how prevalent outpatient care has become, one need not look past the following statistic. In 2010, nineteen times as many active clients were treated in specialty care outpatient settings than were in inpatient and residential settings *combined*.⁴⁹ In addition to specialty mental health care providers, the primary care sector has also assumed substantial responsibility for mental health treatment. In recent decades, an array of mainstream programs and providers have assumed a large share of the mental health services sector, many of whom do not have the specific knowledge and expertise to manage the most severe mental illnesses. Studies find that general medical practitioners administer 59 percent of all psychiatric drugs.⁵⁰ Although many mental illnesses can be successfully managed in the community, severe mental illnesses require careful evaluation and constant monitoring, both of which can be difficult in a mainstreamed setting. Thus, in the case of SPMI, less restrictive settings are sometimes not conducive to quality care for this population because the care is less specialized.

There exists a general assumption around mainstreaming that all mentally ill individuals can be treated, cured, released and left to live independently in the community. Sen uses the metaphor of an unemployed man who receives an unemployment check. He argues that the outcome is not the only standard of justice. In the process of losing his job and receiving a

⁴⁸ Frank and Glied, *Better But Not Well*, 138.

⁴⁹ *National Mental Health Services Survey*, 11.

⁵⁰ Tami L. Mark, Katharine R. Levit, and Jeffrey A. Buck, "Datapoints: Psychotropic Drug Prescriptions by Medical Specialty," *Psychiatric Services* 60, no. 9 (2009): 1167, accessed November 2014, doi: 10.1176/ps.2009.60.9.1167.

check, the man is demoralized and loses job skills. In the case of mental illness, proponents of mainstreaming assumed that reintegrating the mentally ill into the community was enough; however, this point of view is not attentive enough to figuring out what would happen once ill persons were in the community and what institutions would be needed to sustain them. Our society's romantic conception of "community" seems to have clouded the fact that creating and sustaining such requires a high level of intentionality. The community mental health system, however, was carried out more haphazardly than intentionally and, as a result, the system is anything but "community"-like. Compared to other quality assurance practices, mental health facilities are least likely to systematically follow up with patients after they have been discharged. Only half of the mental health facilities surveyed by SAMHSA in 2010 engaged in post-discharge client/patient outcome follow-up as part of their standard operating procedures.⁵¹ We can place people in the "community," but more is required if we want them to flourish and be accepted. The failure to think through these important issues about what it takes to create a supportive community for persons with SPMI leads to some major consequences for individuals diagnosed with this class of mental illness.

Criminalization of the Mentally Ill: A Consequence of the Current System

Psychiatric disorders are the only kind of sickness that we as a society regularly respond to not with sympathy but with handcuffs and incarceration. And as more humane and cost-effective ways of treating mental illness have been cut back, we increasingly resort to the law-enforcement toolbox: jails and prisons.

-Nicholas Kristof

⁵¹ *National Mental Health Services Survey*, 18.

Introduction

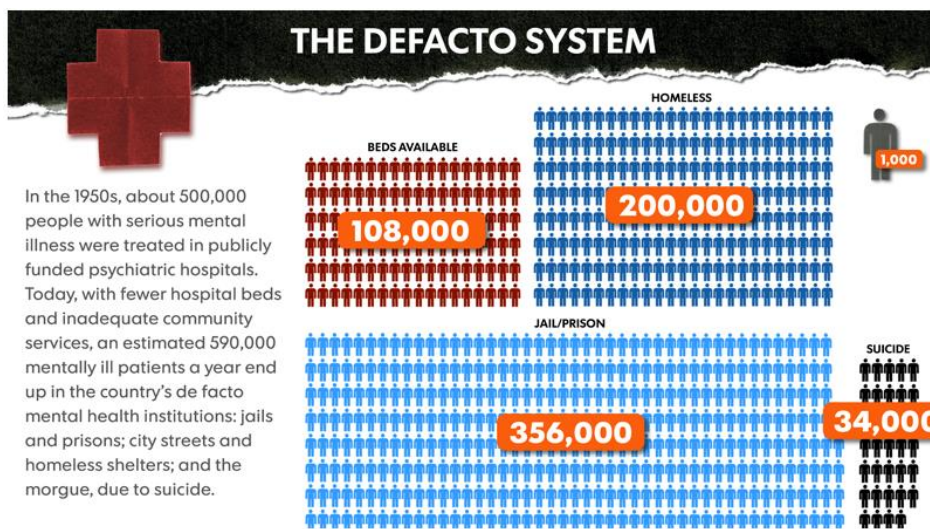
In addition to the public and private mental health systems that provide a hodgepodge of treatment services, a significant amount of “treatment” is also provided by a third entity: the United States Criminal Justice System. The criminalization of the mentally ill is the most jarring consequence of our incomplete mental health system, as well as my motivation for writing this thesis. National studies and individual state reports on mentally ill individuals in jails and prisons done since the late 1990s estimate that between 15 and 20 percent of jail and prison inmates have a serious mental illness.⁵² In 2011-2012, the National Inmate Survey (NIS), an annual research study performed by the Bureau of Justice Statistics (BJS) and RTI International, a not-for-profit research organization, included questions regarding the mental health of inmates for the first time in its three year stint. Inmates were asked, among other things, if they had ever been told they had manic depression, bipolar disorder, or other depressive disorders, schizophrenia or another psychotic disorder, post-traumatic stress disorder, or an anxiety or other personality disorder.⁵³ According to the survey results, an estimated 36.6 percent of prison inmates and 43.7 percent of jail inmates reported being told by a mental health professional that they had one of the aforementioned disorders.⁵⁴ Although I realize that a greater number of mental illnesses are diagnosed today than in 1983, the subset of the most severe mental illnesses have generally been recognized throughout this period of time. These statistics suggest that the current conception of mental illness as something that can be cured or eliminated with the correct combination of medications and minimal follow-up has had deleterious effects on society’s ability to care for those with the most severe illnesses.

⁵² Torrey et al., “More Mentally Ill Persons are in Jails and Prisons,” 4.

⁵³ Bureau of Justice Statistics, *National Inmate Survey: Year 3*, Survey, February 26, 2013.

⁵⁴ U.S. Department of Justice, Bureau of Justice Statistics, *Sexual Victimization in Prisons and Jails Reported by Inmates 2011-2012*, by Allen J. Beck, Marcus Berzofsky, Rachel Casper, and Christopher Krebs, NCJ 241399 (Washington, D.C., 2013), 24.

Today, a mentally ill person is more likely to be found in the criminal justice system than in inpatient psychiatric facilities. Both of these settings provide around the clock care financed by the United States government; however, only one is designed with the well-being of the mentally ill in mind. As of 2004-2005, there were more than three times as many mentally ill individuals residing in the criminal justice system as there were in psychiatric hospitals.⁵⁵ This study includes both public *and* private psychiatric hospitals, as well as psych units of general hospitals.⁵⁶ If we were to look only at the public mental health services system, thus limiting our analysis to the number of patients in public psychiatric hospitals, these numbers would be even more pronounced. For certain states, the likelihood of being in prison rather than inpatient treatment is even higher than the abovementioned average. In Nevada, for example the odds were 9.8 to 1 that an individual would be in a jail or prison compared to a hospital.⁵⁷ The only state in which the odds are 1 to 1 is North Dakota. In essence, jails and prisons have become the *de facto* mental hospitals.⁵⁸



Source: Szabo, "The Cost of Not Caring"

⁵⁵ Torrey et al., "More Mentally Ill Persons are in Jails and Prisons," 8.

⁵⁶ *Ibid*, 7.

⁵⁷ Torrey et al., "More Mentally Ill Persons are in Jails and Prisons," 8.

⁵⁸ *Ibid*, 9.

Prisons to Asylums

Over the course of the last two centuries, mental health policy has created a vicious cycle of events. The criminalization of the mentally ill is not a new practice but rather something that was the norm more than 200 years ago. In the early 1800s, policies had not yet developed for dealing with mentally ill persons in a humane way. At the time, very little knowledge existed about the origins of mental illness. On the whole, it was viewed not as an illness at all but rather as the result of reduced intellectual capacity and distractedness.⁵⁹ As I mentioned in the previous section, civil rights advocates worked tirelessly to change the inhumane practice of locking up mentally ill persons without adequate treatment and attention. Their differentialist claims for recognition of the mentally ill as possessing unique needs led there to exist one inpatient psychiatric bed for every 3000 individuals by the mid-1800s. This number was certainly not adequate, however, given that there is now recommended 15 beds for every 3000 individuals.⁶⁰ Dorothea Dix, arguably the most famous mental health reformer, finished Jones' work. By 1880, there were 75 public psychiatric hospitals for a U.S. population of 50 million, and the mentally ill constituted less than one percent of prison and jail populations.⁶¹

Asylums Back to Prisons

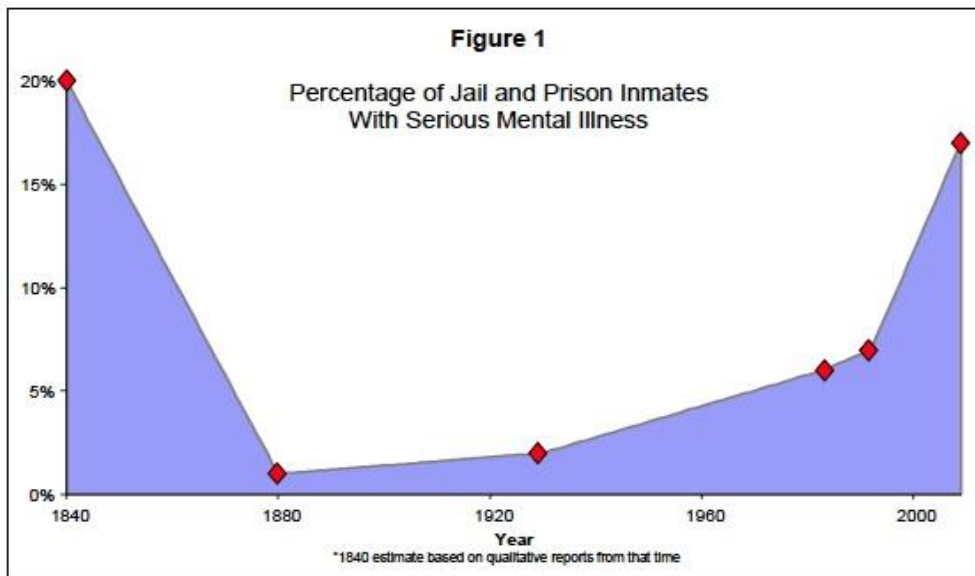
After adjusting for population growth, the number of mentally ill persons residing in the criminal justice system today is almost equivalent to the number in the mid-nineteenth century. An illogical reversal has occurred. As of 2004, one inpatient psychiatric bed existed for every 3000 people, meaning that an individual with a serious mental illness was 10 times more likely

⁵⁹ Rochefort, *From Poorhouses to Homelessness*, 19.

⁶⁰ Torrey et al., "More Mentally Ill Persons are in Jails and Prisons," 4.

⁶¹ E. Fuller Torrey, Mary T. Zdanowicz, Aaron D. Kennard, H. Richard Lamb, Donald F. Eslinger, Michael C. Biasotti, and Doris A. Fuller, "The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey," *Treatment Advocacy Center*, April 2014, 11.

to acquire a bed in 1955 than in 2004.⁶² In 44 of 50 states and the District of Columbia, a prison or jail in that state alone holds more individuals with serious mental illness than the largest remaining state hospital.⁶³ The below graphic illustrates the stark similarity between the situation in 1840 and that in 2010.



Source: Treatment Advocacy Center, 2010.

As Figure 1 shows, the 16 percent of jail and prison inmates assumed to suffer from a serious mental illness today mirrors the 20 percent shown in 1840. The “humane” alternative of turning severely mentally ill persons loose in the community without adequate treatment and attention was in reality a transinstitutionalization of these individuals.⁶⁴ The closure of state hospitals that was meant to improve the quality of care for patients instead led to their being arrested and locked up in a different type of facility. A 1981 New York Times editorial reads, “Deinstitutionalization has become a cruel embarrassment, a reform gone terribly wrong, threatening not only the former mental inmates but also the quality of life for all New Yorkers.”

⁶² Torrey et al., “More Mentally Ill Persons are in Jails and Prisons,” 8.

⁶³ Torrey et al., “The Treatment of Persons with Mental Illness in Prisons and Jails,” 5.

⁶⁴ Early, *Crazy*, 1283.

These institutions that currently house large amounts of the severely mentally ill are just as bad as were the deteriorating asylums in the mid-twentieth century. Designed to dehumanize and punish, these institutions provide just the opposite of what severely ill mentally individuals need, that being care and support.⁶⁵

“Command and Control” Culture

The term “corrections” is a euphemism. At their core, jails and prisons are punitive, not rehabilitative, in nature.⁶⁶ The “command and control” nature of prison culture is deleterious for individuals suffering from severe mental illnesses.⁶⁷ Prison management is wholly based on obedience to rules, and there is a general assumption that all misconduct is volitional. The term “corrections” has become a euphemism. At their core, jails are punitive, not rehabilitative, in nature.⁶⁸ As such, prisoners are held responsible for their actions, regardless of their individual circumstances.⁶⁹ Yet, prisoners diagnosed with a severe mental illness are more prone to misbehave due to factors related to their illnesses. According to the most recent statistics surrounding mental illness and prison behavior, disciplinary problems are disproportionately common among mentally ill inmates. In Federal prisons, 41.2 percent of mentally ill inmates were formally charged with breaking prisons rules, compared with 32.7 percent of other inmates. The situation was even worse in State prisons, where more than 6 in 10 mentally ill inmates had been formally charged. In addition, mentally ill inmates in Federal prison were more than twice as likely to have been in a fight since admission.⁷⁰ These statistics elucidate the difficulty

⁶⁵ Early, *Crazy*, 1064.

⁶⁶ Norbert Konrad, Vollm Birgit, and David N. Weisstub, *Ethical Issues in Prison Psychiatry* (New York: Springer, 2013), 61.

⁶⁷ Mechanic, “More People are Receiving Behavioral Health Care,” 1418.

⁶⁸ Konrad et al., *Ethical Issues*, 61.

⁶⁹ Sasha Abramsky and Jamie Fellner, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness* (New York: Human Rights Watch, 2003), 53.

⁷⁰ U.S. Department of Justice, Bureau of Justice Statistics, *Mental Health and Treatment of Inmates and Probationers*, by Paula M. Ditton, NCJ 174463 (Washington, D.C., 1999), 24.

inmates with mental illnesses have adhering to the strict guidelines of Federal and State prisons alike.

Given the high rates of misconduct among mentally ill inmates, correctional officers must balance recognition of the role mental illness can play and the need to establish authority and keep order. Since safety of the prisoners and security of the facilities are the main goals of correctional officers, order, obedience, and discipline are often prioritized.⁷¹ Correctional officers normally have little training in how to recognize and handle mental illness and are instructed to automatically refer any disobedient inmate to the disciplinary process.⁷² According to a 2001 survey by the National Institute of Corrections, 40 states provide some mental health training to correctional officers; however, such training is limited. In fact, only seven of the prison systems surveyed provided more than four hours of training. Correctional officers interviewed in a New York prison described the incarceration of mentally ill inmates as the facility's "biggest problem" given their lack of knowledge on how to handle them. This information suggests that, even if prison culture encouraged special exceptions for mentally ill inmates in the disciplinary process, correctional officers would likely be inadequately trained to recognize when such exceptions should be made.

Overreliance on Psychotropic Medications

Due largely to understaffing, prison psychiatrists sometimes have a difficult time providing compassionate, private, and patient centered-care.⁷³ Although both psychotherapeutic and psychopharmacological treatments exist in correctional facilities, prison psychiatrists

⁷¹ Abramsky and Fellner, *Ill-Equipped*, 75.

⁷² Abramsky and Fellner, *Ill-Equipped*, 68.

⁷³ Dominic A. Sisti, Andrea G. Segal, and Ezekiel J. Emanuel, "Improving Long-term Psychiatric Care: Bring Back the Asylum," *Journal of the American Medical Association* 313, no. 3 (2015): 244, accessed April 2015, doi: 10.1001/jama.2014.16088.

disproportionately rely on the latter.⁷⁴ According to a report by Human Rights Watch, therapies are often not multidisciplinary or individualized but limited to medication management.⁷⁵

Reliance on psychotropic medications as the primary method of treatment for treating SPMI's is neither scientifically nor ethically sound. When interviewed about the effectiveness of antipsychotics in disease management. Rachel Diaz, the Director of the Miami Chapter of the National Alliance on Mental Illness (NAMI), said:

Taking these drugs is not like swallowing an aspirin. Mental illness is not going to disappear because you take a pill. You do not become well. The sickness will always be there because the chemistry in your brain is not correctly balanced.⁷⁶

After reading this bold assertion regarding the dangers of relying too heavily on medication to manage mental illnesses, I was shocked by several statistics about correctional practices in Virginia. During a meeting of the Behavioral Health Care Subcommittee in downtown Richmond, Virginia, I learned that a total of 9,316 prescriptions for psychotropic medications were given to mentally ill inmates in Virginia in July 2013. Given the population of just over 6300 mentally ill inmates in the system, this meant that some patients were on 2 or 3 medications at a time. Yet, over the course of that same month, each mentally ill inmate received just 2.5 hours treatment hours each.⁷⁷ Ethical guidelines instruct prison psychiatrists to provide medically relevant care while an inmate is incarcerated. The practice of placing mentally ill inmates on one or multiple medications, and providing minimal psychotherapeutic treatment in conjunction with the medication, does not fall in line with these guidelines.

⁷⁴ Konrad et al., *Ethical Issues*, 16.

⁷⁵ Abramsky and Fellner, *Ill-Equipped*, 109.

⁷⁶ Early, *Crazy*, 1813.

⁷⁷ Joint Commission on Behavioral Health Care, Behavioral Health Subcommittee, Virginia State Capitol, Richmond, October 20, 2014.

Solitary Confinement

The combination of an intensely regimented routine, an inability on the part of mentally ill inmates to follow prison rules, and the tendency of prison staff to treat all inmates, regardless of their mental health status, alike in the disciplinary process leads to a disproportionately large amount of mentally ill inmates in solitary confinement. Each day, over 80,000 U.S. prisoners are in solitary confinement, 25,000 of whom are housed in supermax prisons, or facilities made up solely or mostly of solitary cells.⁷⁸ Prisoners who reported having been placed in solitary confinement were more likely to have an extensive history of previous psychiatric treatment.⁷⁹ Specifically, nearly a third of inmates placed in solitary confinement have at least one preexisting psychiatric condition.⁸⁰ In 2004, over 800 of the 4,400 inmates in disciplinary lockdown in penitentiaries across the state of New York were mentally ill, and 480 had been diagnosed with a SPMI.⁸¹ Isolation can be harmful for any prisoner, much less someone with a mental illness. The lack of social interaction and stress can exacerbate symptoms of mental illness.⁸² Individuals with previous mental problems often deteriorate in this environment and those who were healthy beforehand sometimes develop symptoms in isolation.⁸³

Sexual Victimization of Mentally Ill Inmates

Serious mental illness is a major risk factor for prison rape and sexual violence. This population of individuals is more vulnerable to sexual abuse for a variety of reasons, including medication side effects that lower their inhibitions and an inability to form the kind of support

⁷⁸ National Alliance on Mental Illness. *Solitary Confinement*. Fact Sheet. 2014.

⁷⁹ Luke Birmingham, "Mental Disorders and Prisons," *Psychiatric Bulletin* 28 (2004): 396, accessed January 2015, doi: 10.1192/pb.28.11.393.

⁸⁰ David H. Cloud, Ernest Drucker, Angela Brownee, and Jim Parsons, "Public Health and Solitary Confinement in the US," *American Journal of Public Health* 105, no. 1 (2015): 20, accessed January 2015, <http://search.proquest.com/docview/1644296751/fulltextPDF/767DB1F715C742A1PQ/1?accountid=14731>.

⁸¹ Correctional Association of New York, *Mental Health in the House of Corrections: A Study of Mental Health Care in New York State Prisons* (New York, NY, 2004), 6.

⁸² Abramsky and Fellner, *Ill-Equipped*, 209.

⁸³ Konrad et al., *Ethical Issues*, 14.

network necessary to deter abuse.⁸⁴ As a result, inmates diagnosed with serious mental illnesses are more likely to be victimized more than once, more likely to be threatened, and more likely to be injured during an attack.⁸⁵ In 2011-2012, 6.3 percent of state and federal prison inmates under serious psychological distress reported being sexually victimized by another inmates, while only 0.7 percent of those without any sign of mental illness reported such victimization. In jails, the statistics were 3.6 percent and 0.7 percent respectively. In this same year, 5.6 percent of inmates under serious psychological distress reported being victimized by staff, compared with 1.1 percent without mental illness.⁸⁶ A June 2004 study found that 57 percent of prisoners in New York's intermediate care units reported not feeling safe in the general population.

Revolving Door Phenomenon

Disproportionate rates of recidivism suggest incarceration is not benefitting mentally ill persons.⁸⁷ Two-thirds of inmates with serious mental illness are rearrested and half are hospitalized within the first 18 months of arrest.⁸⁸ A primary reason for these high rates of recidivism have to do with the lack of community mental health services, housing and jobs once mentally ill inmates are released.⁸⁹ Ex-convicts face incredible discrimination in the job market. This, combined with the atrophying of what family and social ties they had before incarceration, can contribute to a downward spiral. The correctional focus on punishment as opposed to rehabilitation creates a missed opportunity to provide mentally ill inmates with the life-skills necessary for them to thrive in the community following their release.⁹⁰

⁸⁴ National Prison Rape Elimination Commission Report, *National Prison Rape Elimination Report*, Report, 2009, 72-73.

⁸⁵ *Sexual Victimization in Prisons and Jails*, 23.

⁸⁶ *Sexual Victimization*, 26.

⁸⁷ Torrey et al., "The Treatment of Persons with Mental Illness in Prisons and Jails," 6

⁸⁸ Konrad et al., *Ethical Issues*, 52.

⁸⁹ Martha Rosenberg, "Is Slamming the Jail Door Shut Mental Health Treatment? No Says Rep. Patrick Kennedy," *Epoch Times*, November 22, 2014.

⁹⁰ Abramsky and Fellner, *Ill-Equipped*, 110.

Why is the system the way it is?

Neoliberalism normatively constructs and interpellates individuals as entrepreneurial actors in every sphere of life. It figures individuals as rational, calculating creatures whose moral autonomy is measured by their capacity for “self-care” – the ability to provide for their own needs and service their own ambitions.

-Wendy Brown

Introduction

Over the past 50 years, political and ideological forces coalesced to create and sustain the current system. It is a system that can be described as a drawbridge with missing links. The excessively rapid pace of deinstitutionalization, driven by a political desire to (a) save money and (b) respond to the exacerbated outcries of civil rights advocates, introduced fragmentation into the system.

With only half of the proposed community mental health centers (CMHCs) built and no government-facilitated programs to connect recently released patients with treatment in the community, the movement fell apart. Upon closure of the hospitals, many patients with chronic diseases became homeless, utilizing emergency room departments for episodic care and shelter.⁹¹ Neoliberal policies of the 1980s exacerbated the already problematic situation by substantially reducing funding for community mental health services, prioritizing freedom and individualism over meaningful equality and collective responsibility, and instituting a system of social control disguised as a war on drugs. It makes sense to go through these events chronologically, starting with deinstitutionalization and community mental health’s failure to create a continuum of care, and continuing with an overview of neoliberalism and the policies that stemmed from it. By the conclusion of this section, I hope to have successfully illustrated how poorly designed infrastructure and neoliberal policies coalesced to fashion a broken system.

⁹¹ Sisti et al., “Improving Long-term Psychiatric Care,” 243.

Community Mental Health and how it failed to establish a Continuum of Care

Deinstitutionalization did not unfold in a way that was advantageous for persons with SPMIs. Community mental health, as conceptualized by mid-century policymakers, was never fully realized. An analysis of several key speeches and reports prior to the passage of the Community Mental Health Centers Act of 1963 insinuates that lawmakers had the well-being of mentally ill persons in mind when the law was created. A network of CMHCs retained an exceptionalist attitude toward mental illness, providing all of the same services as mental hospitals. At the same time, providing these services in the community removed some of the stigma attached to institutionalized persons. This matched the vision of advocates, who also envisioned the CMHC program as a new kind of asylum that would integrate former mental patients into community life.⁹² In theory, the proposed movement satisfied both preconditions for parity of participation. It broke down the literal barriers between mentally ill persons and the rest of society, whilst still recognizing the unique needs of this population. Furthermore, it allocated public resources to a disadvantaged group.

The Joint Commission on Mental Illness and Mental Health was created by Congress in 1955 to survey the mental health system and provide recommendations for improving care for the mentally ill. The Commission was made up of individuals from 20 organizations, and included representatives from public health, hospital, physical therapy, educational, nursing, social work, rehabilitation, pediatric, and government agencies.⁹³ In being included in the Commission, each of these specialties was clearly viewed as a vital part of the development of a robust mental health treatment system. The fact that the Commission was composed of such a diverse group of constituents demonstrates a perception of mental illness as psychodynamic and

⁹² Erkulwater, *Disability Rights*, 59.

⁹³ Jack R. Ewalt, "Goals of the Joint Commission on Mental Illness and Health," *American Journal of Public Health* 47, no. 1 (1957): 19, accessed October 2014, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1551089/pdf/amjphnation01084-0023.pdf>.

encompassing a combination of biological, social and environmental factors. The Commission's final report, *Action for Mental Health*, included recommendations for improving multiple aspects of the system, involving the outpatient, inpatient, and ex-patient portions. Specifically, the report identified a need for broadening the role of the outpatient system, breaking down barriers between inpatient care and the community, and providing continuity of care once patients were released from outpatient or inpatient treatment facilities.⁹⁴ There was a clear goal of integration and continuity of services, as well as an understanding of the distinctive nature of this class of illnesses.

With the aforementioned goals in mind, Congress passed the Community Mental Health Centers Act in 1963. This piece of legislation relating to the construction of Community Mental Health Centers (CMHCs) was contained in the larger Public Law 88-164, which also addressed related topics like research for mental illness and the training of special education teachers. The Act authorized a total of \$150 million to be appropriated to states for the construction of public and other nonprofit CMHCs. These treatment facilities were alternative institutional arrangements to state mental hospitals and, as such, were established in direct competition to the latter.⁹⁵ Money was to be given to states based on population, the need for CMHCs, and the overall financial needs of the state. In order to receive federal funds, each State was to designate one state agency to oversee the construction of the centers within their jurisdiction. This agency would then administer federal funds to public and private service providers, as well as set minimum standards for their operation and maintenance. In order to become a licensed CMHC and receive funding, public or nonprofit agencies were required to submit an application through

⁹⁴ Joint Commission on Mental Illness and Health, *Action for Mental Health: Final Report, 1961*, (New York: Basic Books, 1961), 172.

⁹⁵ David L. Cutler, Joseph Bevilacqua, and Bentson H. McFarland, "Four Decades of Community Mental Health: A Symphony in Four Movements," *Community Mental Health Journal* 39, no. 5 (2003): 387, accessed September 2014, 10.1023/A:1025856718368.

their respective state agencies.⁹⁶ CMHCs were established under a catchment-area concept, with each CMHC responsible for providing services in a defined geographic area. There was to be one CMHC per catchment area, the population within each catchment area ranging from 75,000 to 200,000.⁹⁷

From the beginning, the country struggled to fulfill the goal of providing citizens' access to an interconnected network of services. For one, CMHCs developed separately from the public mental hospital system, making integration of the two difficult.⁹⁸ Although speeches and reports prior to the passage of the CMHC Act emphasized the importance of a combination of outpatient *and* inpatient care, this dual development presented challenges to achieving this. Once patients were released from institutional settings, it was not clear whose responsibility it was to care for them. When they were in mental hospitals, all of their needs – social services, education, income support, etc. – were met in one place. Upon release, it was suddenly up to these individuals to navigate a disconnected network of service providers.⁹⁹ In August 1974, the National Institute of Mental Health's (NIMH) "Need for More Effective Management of Community Mental Health Centers Program" highlighted several impediments to the coordination of service delivery, one being poor working relationships between the centers and State mental hospitals. Patients were being released into catchment areas without any notice to the centers.¹⁰⁰

Funding for community mental health did not grow in proportion to need during its first decade of existence.¹⁰¹ When the CMHC program was discontinued by the Reagan administration in 1981, just 754 of 1500 eligible catchment areas nationwide had applied for and

⁹⁶ *Community Mental Health Act*. Public Law 88-164, 291.

⁹⁷ Government Accountability Office, *Returning the Mentally Disabled to the Community: Government Needs to Do More* (Washington, D.C., 1977).

⁹⁸ *Ibid*, iii

⁹⁹ *Ibid* 23

¹⁰⁰ Government Accountability Office, *Need for More Effective Management of Community Mental Health Centers Program* (Washington, D.C., 1974), 44.

¹⁰¹ *Need for More Effective Management*, 64.

received funding.¹⁰² Half of all patients discharged from hospitals during the first wave of deinstitutionalization ended up homeless or imprisoned due to this lack of facilities and personnel. Furthermore, a formal connection between release from a mental hospital and placement in the CMHCs that had been constructed was almost non-existent. Community mental health, although a good idea, was poorly implemented. On February 5, 1963, President John F. Kennedy spoke to Congress about the importance of returning mental health care to the community in which individuals live. He claimed that this more natural setting would facilitate a better understanding of individuals' needs and "make it possible for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society."¹⁰³ His words paved the way for the passage of the critical pieces of mental health legislation that I outlined above. Had the system been fashioned in line with the text of this legislation, the situation today may very well have looked different, with severely mentally ill individuals possessing a broader range of freedoms.

The two requirements of participatory parity are (a) redistribution and (b) recognition. With regard to the first, redistribution, CMHCs were supposed to provide mentally ill individuals with a full range of necessary treatment options. The Community Mental Health Centers Act of 1963 instructed government officials to construct an integrated network of services that were accessible, affordable and effective in managing mental illness.¹⁰⁴ Had this network fully materialized, it would have given former patients the resources needed to exist as equal participants in social interaction. Community mental health also satisfied the second requirement, that being recognition. A discrete, community-based system for mental health

¹⁰² Cutler et al., "Four Decades of Community Mental Health," 387.

¹⁰³ Kennedy, John F. "Special Message to the Congress on Mental Illness and Mental Retardation." Speech, February 5, 1963. <http://www.presidency.ucsb.edu/ws/?pid=9546>.

¹⁰⁴ *Community Mental Health Act*. Public Law 88-164, 291.

services recognizes the distinctiveness of the group of people being served without stigmatizing them in the same way institutionalization had. The placement of the system apart from mainstream medicine ensures that the unique needs of the mentally ill are met. The placement of this system within the community discontinues the long-standing marginalization of this group. Thus, the *concept* of community mental health satisfies both of Fraser's preconditions for participatory parity and grants mentally ill individuals the status of full partners in social interaction. Yet, somewhere in the transition between hospital-based and community-based care, both of these things were lost. The centers themselves, as well as the distinctiveness of the movement, fell short of the redistributive goals articulated at the start of deinstitutionalization. Following, I review some of the initial attempts to bring community mental health in line with its stated goals.

Initial Attempts to Remedy the Disconnect Between Hospital and Community Care

Despite these initial struggles, continuity of care was almost immediately identified as an issue and related legislation was passed. Between 1975 and 1980, Congress passed three key pieces of legislation with provisions to remedy the disconnect between hospital and community-based care. The Special Health Revenue Sharing Act required states to establish and implement a plan to: (a) eliminate inappropriate placement of individuals in institutions, (b) ensure the availability of appropriate noninstitutional settings, (c) improve the quality of care within State mental hospitals, (d) screen individuals being considered for inpatient care in a mental health facility to determine if such care is necessary, and (e) ensure that follow-up care is provided for individuals discharged from mental health facilities.¹⁰⁵ All of these requirements share a common goal of improving and integrating institutional and non-institutional care to create a coordinated system of services fit to address the entire spectrum of mental illnesses. The last

¹⁰⁵ *Health Revenue Sharing and Health Services Act*, H.R. 2954.

requirement in particular directly acknowledges a divide between State mental hospitals and the new CMHCs. Shortly after the passage of the Special Health Revenue Sharing Act, Congress passed the Community Mental Health Centers Amendments of 1975. This piece of legislation also tried to close the gap between hospital and community-based care. Of the seven new services it required CMHCs to provide, follow-up care for residents of their catchment areas who have been discharged from a mental health facility was one of them. As part of this requirement, CMHCs were to coordinate services with those provided by other health and social services agencies.¹⁰⁶

The National Mental Health System Act of 1980 was the final serious attempt to bring community mental health in line with its original goals. The legislation explicitly acknowledged that the transition to community mental health failed to provide released patients with the support necessary to survive in the community and formulated a plan to address this problem. The beginning of the Act reads:

The process of transferring or diverting chronically mentally ill individuals from unwarranted or inappropriate institutionalized settings to their home communities has frequently not been accompanied by a process of providing those individuals with the mental health and support services they need in community-based settings.¹⁰⁷

The contents of the legislation reiterated the goals of the two aforementioned laws and incorporated many of the recommendations given by President Carter's Commission on Mental Health. In formulating these recommendations, the Commission heard testimony from over 400 individuals regarding their experiences in the community mental health system. Thus, the 1980 National Mental Health Systems Act was well founded, based upon what was actually occurring on the ground. Yet, the majority of the law, as well as the two laws described above, never fully

¹⁰⁶ *Community Mental Health Centers Amendments of 1975*, Public Law 94-63.

¹⁰⁷ *Mental Health Systems Act*, Public Law 96-398, §1177.

took effect due to shifting institutions in the 1980s. Despite serious attempts to fashion an integrated system of community mental health services in line with Fraser's conception of justice, events of the 1980s changed the course of community mental health and led us to where we are today.

The 1980s and the Rise of Neoliberalism

The 1980s characterized a large intellectual shift in how Americans viewed the relationship between economics and morality. Neoliberal policies halted and even reversed many social welfare gains of previous decades.¹⁰⁸ While liberal democracy, which, although still conforming to capitalist values, provides a kind of insulation between market values and moral and political principles, neoliberalism infuses market values into all aspects of social life. In a regime operating on the basis of such rationality, economic growth, not overall social welfare, forms the basis for state legitimacy. Brown writes:

In neoliberal terms, democracy does not signify a set of independent political institutions and civic practices comprising equality, freedom, autonomy, and the principle of popular sovereignty but rather, indicates only a state and subjects organized by market rationality.¹⁰⁹

Throughout the 1980s, this rationality was reflected in the policies enacted to promote individual responsibility. Specifically, the 1981 Omnibus Budget Reconciliation Act, which ended most federal funding to state mental health agencies (SMHAs), combined with the War on Drugs to further fragment the system of mental health care and funnel severely ill persons into the criminal justice system.

The neoliberal brand of thinking diverges significantly from the rhetoric of civic responsibility that abounded two decades earlier. In his 1964 State of the Union Address, Lyndon B. Johnson declared an “unconditional war on poverty,” laying out a comprehensive

¹⁰⁸ Rochefort, *From Poorhouses to Homelessness*, 65-66.

¹⁰⁹ Brown, “Neo-liberalism and the End of Liberal Democracy,” 12.

plan to address a variety of civil rights issues. He spoke at length about hope and opportunity for every American citizen, labeling poverty as a national problem that required a combined national, state and local effort to eradicate and prevent. “Very often a lack of jobs and money is not the cause of poverty, but the symptom,” Johnson said. “The cause may lie deeper – in our failure to give our fellow citizens a fair chance to develop their own capacities, in a lack of education and training, in a lack of medical care and housing, in a lack of decent communities in which to live and bring up their children.”¹¹⁰ Just two decades before the proliferation of a neoliberal ideology, Johnson identified lack of substantive equality as an issue deserving of national attention. Attention was certainly awarded, as a wealth of federal action was taken to address the issue of inequality of opportunity. Medicaid, the Department of Housing and Urban Development (HUD), and Head Start were just a few of the federal programs created in the 1960s to equalize opportunity.

Community mental health was among the many programs instituted during this era of social responsibility, during which it was politically important to ensure that every American citizen had the capabilities necessary to direct the course of his or her life. As I mentioned much earlier, advocates of deinstitutionalization viewed mental institutions as oppressive and recognized a need for systematic reform. The practice of locking up individuals simply for being “disadvantaged” or “different,” was increasingly criticized as legal discrimination.¹¹¹ The idea behind deinstitutionalization, however, was not to release severely mentally ill into the community without assistance. Instead, policymakers envisioned the CMHC network as “the asylum of the community,” the purpose of this new kind of asylum being to equip mentally ill

¹¹⁰ Lyndon B. Johnson, "State of the Union Address," Speech, January 8, 1964. <http://www.americanrhetoric.com/speeches/lbj1964stateoftheunion.htm>.

¹¹¹ Erkulwater, *Disability Rights*, 51-53.

individuals with the resources necessary to be self-sufficient.¹¹² The previous analysis of community mental health legislation revealed this intent. The understanding of what it means to give individuals “a fair chance to develop their own capacities,” however, changed dramatically between Johnson’s presidential tenure and that of Ronald Reagan in the 1980s.

By the late 1960s and early 1970s, a view was emerging that disadvantaged groups had themselves, and not larger society, to blame for their condition.¹¹³ While personal and individual freedoms in the marketplace were guaranteed, the social safety net was disappearing. Each individual was to be held responsible and accountable for his or her own actions, regardless of any constraints that may interfere with that person’s capacity to provide for their needs or pursue their ambitions. Thus, the concept of citizenship was shifting from something collective in nature to something excessively individualistic. If an individual, for whatever reason, was not able to successfully navigate the neoliberal playing field, he or she was assumed to have some kind of character weakness. In a 1989 survey given by the Robert Wood Johnson Foundation, 58 percent of respondents cited ““lack of discipline”” as a potential cause of mental illness.¹¹⁴ The policy goals of the 1980s, welfare and crime, reflected these emerging themes about citizenship. Welfare had to be scaled back because individuals were responsible for themselves, and crime had to be heavily policed in order to ensure that unruly citizens were brought in line.

The rise of neoliberal economic and political rationality during this decade led to the dismantling of key aspects of the welfare state. On the whole, the 1980s was characterized by retrenchment from the powerful role the federal government had played in social service

¹¹² Ibid, 59.

¹¹³ Michelle Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* (New York: The New Press, 2010), 46.

¹¹⁴ Andrew B. Borinstein, “Public Attitudes Toward Persons with Mental Illness,” *Health Affairs* 11, no. 3 (1992): 189, accessed September 2014, doi: 10.1377/hlthaff.11.3.186.

provision in decade's prior.¹¹⁵ Neoliberalism provided a theoretical framework within which policymakers could work to change the way social services were provided.¹¹⁶ During the Reagan years in particular, there were significant cuts in federal funding for a host of domestic programs. For the services that were provided at the same level as they had been in previous decades, devolution and privatization were instituted to reduce costs, foster choice among clients, and develop competitive social service environments.¹¹⁷ This entailed increasing reliance on public-private partnerships. During the 1980s, the federal government contracted out a variety of services that would otherwise have been produced by a government agency.¹¹⁸ In addition to reducing costs and promoting competition, these partnerships were intended to increase both efficiency and quality. Private organizations would be much more successful than bureaucratic institutions at serving the public's needs. The shift from public to private provision of services put more of the burden to seek out services on the individual. Failure to obtain needed services, then, was not the fault of the government, or society at large.¹¹⁹

The neoliberal ideology that predominated during the 1980s laid the foundation for how we think about mental health policy. One of the most significant consequences of this ideology was the end of federal funding to CMHCs. The Omnibus Budget Reconciliation Act of 1981 replaced categorical funding for CMHCs with smaller block grants. In line with the neoliberal value of decentralization, the law shifted the financial burden from the federal government to the states.¹²⁰ Today, publically funded CMHCs play a very small role in treatment, and the federal block grant to state mental health agencies is the only remaining source of discretionary funds to

¹¹⁵ Yeheskel Hasenfeld and Eve E. Garrow, "Nonprofit Human-Service Organizations, Social Rights, and Advocacy in a Neoliberal Welfare State," *Social Service Review* 86, no. 2 (2012): 304, accessed February 2015, doi: 10.1086/666391.

¹¹⁶ Hasenfeld and Garrow, "Nonprofit Human Service Organizations," 302.

¹¹⁷ *Ibid*, 302.

¹¹⁸ *Ibid*, 302.

¹¹⁹ *Ibid*, 301.

¹²⁰ *Omnibus Budget Reconciliation Act*, Public Law 97-35.

these agencies.¹²¹ The shift to block grants in the 1980s introduced competition into the realm of mental health service provision and put a greater burden on non-profit and for-profit human service organizations to administer services that were previously administered by government agencies. Social rights were less emphasized in this highly privatized and deregulated service environment. Instead, mentally ill persons became consumers whose rights were contingent on their desirability as such.¹²² Local organizations were subject to funding formulas and other universal standards. According to Fording, Soss and Schram (2007), such a structure can give local authorities and organizations an incentive to limit benefits and reduce costs, which indeed happened in the 1980s. Since the overall goal was not to increase value necessarily but rather to fulfill certain performance standards, these organizations were not given any incentive to ensure that the care they provided was in line with consumer needs. These changes set up a system in which the mentally ill became consumers in a “market” instead of recipients of public services.

Ironically, although the federal government took a step back from social service provision in the 1980s, it became extensively involved in the criminalization of behavior. Michael Foucault, a French philosopher, termed such governmentality “the conduct of conduct.”¹²³ Instead of government serving as an unbiased overseer of the general safety and welfare of its citizenry, it becomes a regulator of individual behavior. Almost paradoxically, given the fact that neoliberalism is associated with the free market and state retrenchment, citizens are encouraged to act in a certain fashion, to be entrepreneurs. In other words, an individual is expected to use existing institutions for his or her own benefit instead of crafting these institutions to achieve the greatest public good.¹²⁴ This organization of citizens’ behavior

¹²¹ Frank and Glied, *Better But Not Well*, 88.

¹²² Hasenfeld and Garrow, “Nonprofit Human Service Organizations,” 307.

¹²³ Brown, “Neoliberalism and the End of Liberal Democracy,” 23.

¹²⁴ Erkulwater, *Disability Rights*, 7.

is not achieved in a traditionally oppressive way but rather through laws and social policy that elevate individual choice, liberty and accountability. Political Scientist Wendy Brown calls it “control achieved through formation.”¹²⁵ Concepts such as freedom and equality are reconstructed to mean something very different than they had in decade’s prior.

Neoliberal governmentality steered incarceration policy during the 1980s. Drug arrests skyrocketed as a direct result of Reagan’s “War on Drugs,” and incarceration emerged as the primary method of social control.¹²⁶ Between 1980 and 2000, the United States penal population increased from 300,000 to 2 million. Today, that number stands at 2.2 million. From an economic point of view, states paid \$9 billion for correctional facilities in 1985 and \$50 billion today.¹²⁷ Contrary to popular belief, this exceptional growth in prison populations and costs has not been a result of an increase in crime but rather of a change in laws. Mandatory minimum sentencing laws, the creation of drug task forces, and three-strikes laws are just some of the methods used to round up more prisoners than ever before in the United States, making us the country with the world’s largest prison population.¹²⁸ Michelle Alexander uses the phrase “mass incarceration” to describe our present situation. Mass incarceration involves not only the criminal justice system itself but also the larger web of laws, rules, policies, and customs that control those labeled criminals both inside and outside the prison walls.¹²⁹ Loic Wacquant aptly describes the system as a “closed circuit of perpetual marginality.”¹³⁰

Neoliberalism, despite its rhetoric of individual rights, moved those with SPMI in the opposite direction of participatory parity. Through policies that simultaneously cut holes in the

¹²⁵ Brown, “Neoliberalism and the End of Liberal Democracy,” 23.

¹²⁶ Alexander, *The New Jim Crow*, 89-94.

¹²⁷ Richard A. Viguerie, “A Conservative Case for Prison Reform,” *New York Times*, June 9, 2013. Retrieved from http://www.nytimes.com/2013/06/10/opinion/a-conservative-case-for-prison-reform.html?_r=0.

¹²⁸ Alexander, *The New Jim Crow*, 89.

¹²⁹ *Ibid*, 13.

¹³⁰ Brown, “Neoliberalism and the End of Liberal Democracy,” 94.

social safety net and cracked down harder on those who required it, the 1980s further marginalized persons with SPMI. While it is true that mentally ill persons retained the civil “rights” achieved for them several decades earlier, they were never given the capabilities necessary to exercise these rights fully. As unsuccessful market actors, they seem to have been cast into our streets and jails, punished for finishing last even though they started far behind everyone else.

Moving Forward: Towards Participatory Parity

A shared safety net is when a state implements an accessible and comprehensive continuum of care between hospital-based care and community-based care to meet a service recipient’s needs.

–National Association of State Mental Health Program Directors (NASMHPD)

Introduction

Having made an argument for parity of participation as a normative requirement for mental health policy, and laid out the historical and political reasons why our system has yet to fulfill this requirement, I will now engage potential solutions to the situation in which we find ourselves. When I began my research, I was interested specifically in whether bolstering insurance coverage for mental illness, as federal parity legislation has done, would succeed in lowering rates of mental illness in the criminal justice system. We can now turn our attention to the MHPAEA and the role such legislation can realistically play in reducing rates of mental illness in our jails and prisons. There is a general consensus that parity under insurance will increase access to mental health services, and I do not dispute this. Based on the evidence I have presented about the current state of the mental health system, however, I do not think it achieves substantive equality for persons with mental illness.

Limitations of Mental Health Parity and the Need for Systemic Reform

Between the early 1990s and late 2000s, mental health advocates in Congress focused the majority of their energy on achieving parity for private insurance coverage of mental health care.¹³¹ Parity legislation seeks to equalize coverage for physical and mental illnesses. The MHPAEA does so by requiring insurers to impose the same financial requirements and treatment limitations on mental health care as they do on physical healthcare. This includes things like co-payments, deductibles and visit limits. The law does not require an insurer to cover mental health care; however, if it chooses to do so, the insurer must adhere to these rules.¹³² Legislation that ends discriminatory health insurance practices against persons with mental illness and substance use disorders is a step in the right direction in the quest for parity of participation. The passage of the MHPAEA symbolizes a large-scale shift in our country's conception of mentally ill persons, from second-class citizens to equal partners in social interaction. Even so, the law does not get to the root of the problem, that our society does not have substantive equality as a core value.

This law increases access to mental health services for those individuals who have insurance; however, the failure of states to expand Medicaid has left many low-income working adults without the ability to obtain coverage. In essence, parity helps the “haves” but does not touch the “have-nots.” Yet, the prevalence of mental illness is highest among those of the lowest socioeconomic groups.¹³³ Of the millions of low-income working adults who were not eligible for Medicaid prior to the passage of the ACA, 25 percent have a serious or moderate behavioral health condition. More than half of this 25 percent suffer from a SPMI, such as major

¹³¹ Congressional Research Service, *The Mental Health Parity Act: A Legislative History* (Washington, D.C.: United States Government Printing Office, 2007). Retrieved from <http://www.policyarchive.org/handle/10207/3088>.

¹³² U.S. Department of Labor. *The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*, Fact Sheet, 2010. <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html>.

¹³³ Frank and Glied, *Better But Not Well*, 15.

depression, bipolar disorder, severe panic disorder, or schizophrenia.¹³⁴ Therefore, for the population most affected by SPMIs, mental health parity does little.

Furthermore, mental health parity does not address the root of the problem: a broken mental health system. Community mental health was not inherently a bad policy. Its ultimate undoing stemmed from the failure of policymakers to integrate community mental health services and to recognize the extra constraints faced by mentally ill persons living in the community. As a result, the mental health system today does not provide adequate material resources to severely mentally ill persons, or reflect the unique needs of this population. First, although material resources exist, there is no clear bridge between all of the different types of services. As such, the system is difficult to navigate. Therefore, my first recommendation focuses on linking these services to one another through integrated treatment approaches. In addition, mental health policy does not reflect the unique needs of persons with severe mental illnesses. Although I do not in any way think we should fully replace community treatment services with inpatient care, I recommend increasing the number of inpatient beds in psychiatric hospitals to meet the current demand. I recognize that these recommendations are just a beginning in creating widespread change in the realm of mental health care and in achieving substantive equality; however, they are a start.

Recommendation 1: Improved Case Management for Persons with Severe Mental Illness

My first recommendation aims to integrate existing modes of mental health treatment through improved case management for persons with severe mental illness. The idea of case management originally developed following the establishment of Community Support Programs

¹³⁴ National Association of State Mental Health Program Directors, *The Waterfall Effect: Transformative Impacts of Medicaid Expansion on States* (Alexandria, VA, 2012), xv.

(CSPs) by the National Institute of Mental Health (NIMH) in the 1960s.¹³⁵ Influential models of case management for this population include Assertive Community Treatment (ACT) and Intensive Case Management (ICM). ACT is an intensive treatment model in which a multidisciplinary team provides community care for patients with a severe mental illness.¹³⁶ It was developed specifically for persons with severe or chronic psychosis, as well as for patients with high service use. Unique aspects of ACT include a team of clinicians who share a relatively small patient load, 24-hour coverage and at-home services. The effectiveness of ACT has been extensively studied and found to be effective at reducing hospitalizations, stabilizing housing, reducing the severity of symptoms, improving quality of life, and lowering overall treatment costs.¹³⁷ In addition, studies have shown that PACT greatly reduces inpatient use and promotes continuity of outpatient care.¹³⁸ Evidence also suggests that consumers can improve in an ACT program and then be transferred to less intensive services.¹³⁹ When combined with more specialized interventions, such as Integrated Dual Diagnosis Treatment (IDDT), ACT is associated with a decrease in nuisance acts and convictions.¹⁴⁰

¹³⁵ Kim T. Mueser, Gary R. Bond, Robert E. Drake, and Sandra G. Resnick, "Models of Community Care for Severe Mental Illness: A Review of Research on Case Management," *Schizophrenia Bulletin* 24, no. 1 (1998): 40. Retrieved from <http://schizophreniabulletin.oxfordjournals.org/content/24/1/37.abstract>.

¹³⁶ Gary R. Bond, Robert E. Drake, Kim T. Mueser, and Eric Latimer, "Assertive Community Treatment for People with Severe Mental Illness: Critical Ingredients and Impact on Patients," *Disease Management & Health Outcomes* 9 (2001): 147.

¹³⁷ Kim T. Mueser, William C. Torrey, David Lynde, Patricia Singer, and Robert E. Drake, "Implementing Evidence-Based Practices for People with Severe Mental Illness," *Behavior Modification* 27, no. 3 (2003): 396, accessed March 2015, doi: 10.1177/0145445503253834.

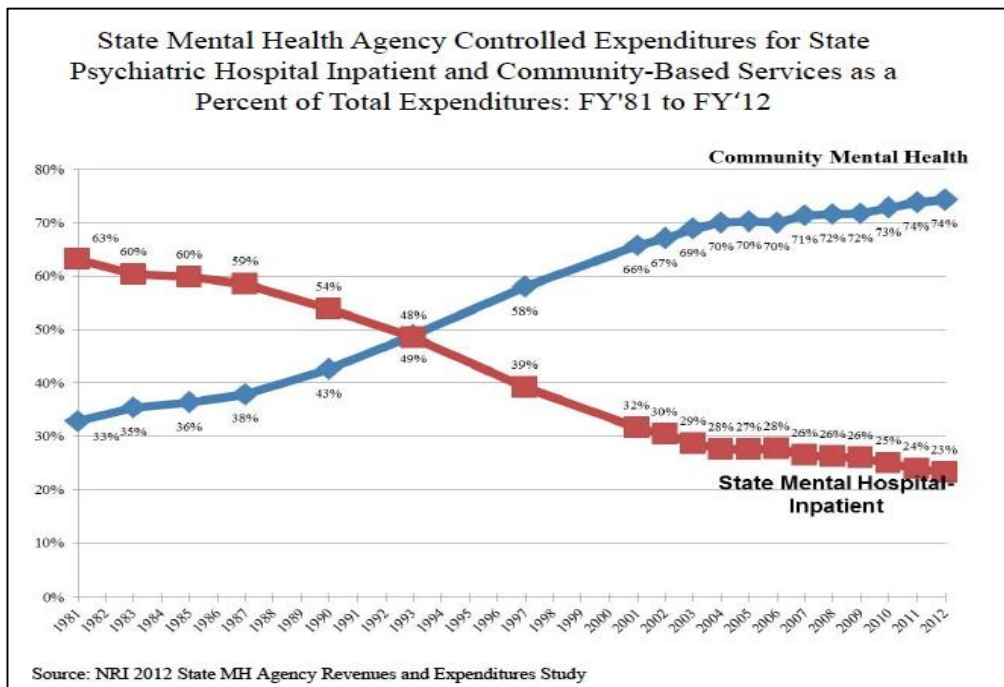
¹³⁸ Anthony F. Lehman, "Quality of Care in Mental Health: The Case of Schizophrenia," *Health Affairs* 18, no. 5 (1999), 57, accessed March 2015, doi: 10.1377/hlthaff.18.5.52.

¹³⁹ *Ibid*, 396.

¹⁴⁰ Anton B. P. Staring, E. Blaauw, and Cornelis L. Mulder, "The Effects of Assertive Community Treatment Including Integrated Dual Diagnosis Treatment on Nuisance Acts and Crimes in Dual-Diagnosis Patients," *Community Mental Health Journal* 48, no. 2 (2012), accessed April 2015, doi: 10.1007/s10597-011-9406-9.

Recommendation 2: Increase the amount of funding attached to the Mental Health Block Grant (MHBG) and alter the criteria to allow for its dissemination to state psychiatric hospitals.

My second recommendation attempts to bolster public mental health services by increasing access to acute inpatient care in state psychiatric hospitals. I am in no way advocating for an increase in the scope of inpatient care but rather for an increase in its availability for those who meet the criteria for admittance. This type of care is only appropriate for persons who cannot be safely and effectively treated in other, less restrictive settings.¹⁴¹ The demand for inpatient beds largely outstrips current supply. Between 1986 and 2005, inpatient care as a percentage of total mental health expenditures dropped from 42 to 19 percent. Conversely, expenditures on outpatient services and prescription drugs increased. The number of inpatient psychiatric beds across all states over a similar time period has decreased by 32.5 percent.¹⁴²



Source: National Association of State Mental Health Directors, 2013.

¹⁴¹ Haupt. *The Vital Role*, 23.

¹⁴² National Alliance on Mental Illness, *State Mental Health Cuts: A National Crisis*, Report, March 2011. http://www2.nami.org/Template.cfm?Section=state_budget_cuts_report.

The continued migration from inpatient to outpatient care can be traced to cost concerns held by states. Inpatient psychiatric care is expensive, totaling more than \$260,000 per patient annually in some states.¹⁴³ The continued criminalization of mental illness, particularly severe mental illness, however, indicates that outpatient treatment is not sufficient on its own. States are paying comparable amounts of money to handle the consequences of untreated mental illness. A 94-day incarceration costs \$30,258, and a 19-day stay in a general hospital costs just under \$32,000.¹⁴⁴

Specifically, I suggest that the federal government increase MHBG appropriations and allow this money to be used for inpatient care in state psychiatric hospitals. Currently, the MHBG constitutes the only federal source of discretionary funding for mental health care.¹⁴⁵ In fiscal year (FY) 2013, the mental health block grant accounted for just one percent of the total revenue received by State Mental Health Agencies (SMHAs), amounting to \$398.7 million.¹⁴⁶ It has grown very little over the past decade or so when taking into account inflation. In essence, this money represents an abysmally small portion of total funding for public mental health services, but it plays a crucial role in providing care to individuals without Medicaid or other insurance coverage.¹⁴⁷ Therefore, an increase in funding for the MHBG would benefit the population most affected by SPMI, the uninsured.

¹⁴³ Sisti, *Improving Long-term Psychiatric Care*, 244.

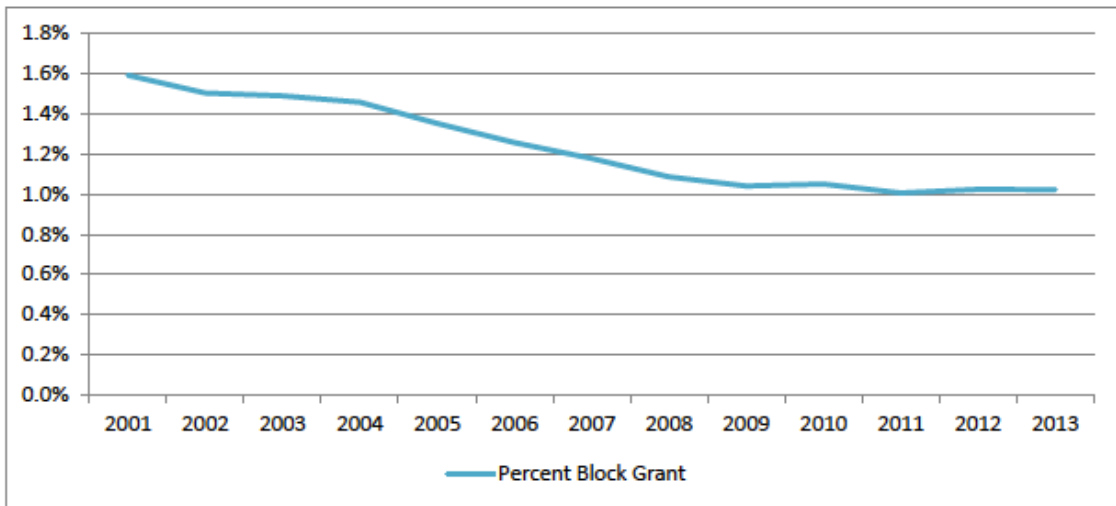
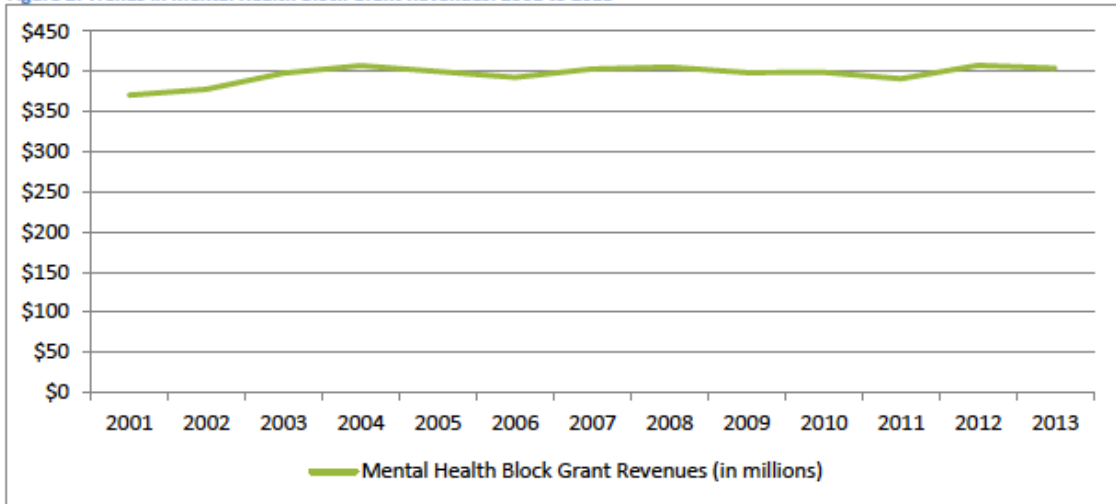
¹⁴⁴ Liz Szabo, "The Cost of Not Caring," USA Today. Retrieved from <http://www.usatoday.com/longform/news/nation/2014/05/12/mental-health-system-crisis/7746535/>.

¹⁴⁵ *Ibid*, 18.

¹⁴⁶ National Association of State Mental Health Program Directors, *State Mental Health Agency Revenues, State Fiscal Year 2013*, by Robert Shaw and Ted Lutterman (Washington, D.C., 2013), 15.

¹⁴⁷ *State Mental Health Agency Revenues*, 16.

Figure 2: Trends in Mental Health Block Grant Revenues: 2001 to 2013



Source: National Association of State Mental Health Directors, 2013.

In addition to the small amount of funding attached to it, my primary qualm with the MHBG is that it cannot be used to fund treatment in state psychiatric hospitals. Therefore, it makes up 0.0 percent of total expenditures of inpatient psychiatric care.¹⁴⁸ If the grant criteria were broadened to allow for its dissemination to inpatient psychiatric hospitals, states could utilize it to increase the number of inpatient beds and create more options for persons with severe mental illness. This, along with a greater focus on case management programs like ACT, should move persons with the most severe forms of mental illness closer to participatory parity.

¹⁴⁸ *State Mental Health Agency Revenues*, 22-23.

Conclusion

After spending months researching the history of mental health policy, I have concluded that there does not exist a one-size-fits-all approach to mental health treatment, particularly when thinking about treatment through a justice lens. Throughout history, mental health policy has hinged on the idea that one approach, whether that be care in hospitals or care in the community, is best. This tug of war between the two is evident in the ebb and flow of policy, between institutionalization and community care. One of the earliest solutions was to institutionalize this population, the assumption being that persons with severe mental illnesses were second-class citizens and unable to provide for themselves. Because of this, material resources had to be redistributed to them through mental hospitals, where they would live separately from the rest of society. Nearly 100 years later, policymakers swung in the opposite direction. Community-based treatment gradually came to be viewed as the best option for persons with mental illnesses, even severe forms of such, and superior in every way to inpatient care. The new thought was that mentally ill persons should be recognized as equal partners in social interaction and should have the right *not* to be forcibly treated. This switch from a focus on positive to negative rights has solidified over the years, to the point that inpatient care makes up an extremely small portion of mental health treatment. The ideal approach to mental health policy, however, falls somewhere in between these two extremes. Based on my research, this ideal, which combines recognition with redistribution, has yet to exist in the history of the United States.

My two recommendations moving forward are just a starting point in repairing the broken mental health system and achieving parity of participation for persons with severe mental illnesses. As I endeavored to convey through my discussion of community mental health and the neoliberal leanings of the 1980s, decades of opposing reforms layered on top of one another have resulted in a highly fragmented system. Connecting the pieces of the system through more

effective case management should make it easier to navigate, just as adding inpatient options should add some “exceptionalist” flavor back into mental health policy; however, neither of these recommendations addresses the root of the problem: the residual welfare state. If substantive change is going to occur for persons with the most severe forms of mental illness, our society is going to need to shift from reactionary to anticipatory policies. Instead of coming in after the market has failed to equitably distribute resources and recognize the particular nuances of certain groups, we should approach mental health treatment as a positive right. It is only through such a shift in mindset, from seeing all persons as neoliberal actors to collective citizens, that participatory parity for persons with the most severe forms of mental illness might be reached.

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