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ESSAY

# The Case to Bring Back the Asylum

A new generation of flexible, varied institutions would help reduce the vast numbers of mentally ill adults in jails and prisons



At Gould Farm in Massachusetts, residents garden, feed animals and run the farm's cafe and bakery. PHOTO: GOULD FARM

By *Howard Husock and Carolyn D. Gorman*

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**When Richard Quintero** broke into a Pizza Hut in High Point, N.C., early one morning in late March, he called 911 himself to let the police know. “Yes, this is Jesus Christ and I just broke into the Pizza Hut,” he said, according to a recording of the call. He then told the dispatcher that he was schizophrenic and kept getting kicked out of homes. When the police arrived, Mr. Quintero was cooperative but was still arrested on charges of felony breaking and entering and felony larceny. He spent time at a state prison before being found incompetent to stand trial and sent for a short-term stay at a state mental hospital.

Many in his situation, unfortunately, tend to stay behind bars: In the U.S. today, jails and prisons have become our mental asylums. The Bureau of Justice Statistics estimates that some 365,000 American adults with serious mental illness are behind bars and an additional 770,000 are on probation or parole. A 2017 Justice Department study estimates that some 37% of all prison inmates suffer some mental illness and that 26.4% of jail inmates suffer from a psychosis.

They are behind bars because, too often, they have nowhere to go. Two generations of policy have led to the mass closing of state mental hospitals. The extent of the resulting problems—for the seriously mentally ill in general, not just those in jails or prisons—is so widespread that a case is building to bring back the asylum, especially for those who pose a risk to others or themselves. But proponents aren’t advocating for a return of the inhumane places of the past. What’s needed is a new generation of flexible and varied institutions.

**It is difficult to imagine how ethically sound treatment of mentally ill prisoners can be delivered.**

To understand the problem, it helps to look back at the history of asylums. In 1840, Dorothea Dix, the former headmistress of a Boston school for girls, had completed a trip to England meant to help recover her health. Influenced by Quaker reformers there, she was exposed to the cause then known as “lunacy reform”—the idea that government had an obligation to care for the mentally ill.

Back in the U.S., Dix went on to survey and expose what was quickly understood to be a scandal: the confinement of the mentally ill in prisons. Dix successfully convinced states to invest in large-scale asylums, where those suffering from mental illness would be well cared for in impressive and expensive facilities. The construction and staffing of those state hospitals—which, in the early days, were often lofty, light-filled buildings with communal dining halls and sprawling grounds for outdoor exercise—became major state expenses.



Patients at an Ohio asylum circa 1946. PHOTO: JERRY COOKE/THE LIFE PICTURE COLLECTION/GETTY IMAGES

By the mid-20th century, the system had grown into a vast network of 322 state and county hospitals

holding more than 550,000 beds. But they had grown to encompass much more than housing the mentally ill. In an era before Social Security or long-term nursing care, they served as housing of last resort for those suffering with dementia, sexually transmitted diseases and other ills. “By becoming the dumping ground for all manner of people who could not care for themselves, the once-grand asylums deteriorated into snake pits and hellholes worthy of exposes,” says Jeffrey Geller, medical director of the Worcester Recovery Center and Hospital, one of the last surviving hospitals for the diagnosis and treatment of mental illness in Massachusetts. Overcrowding and less oversight created a much lower quality of care for patients. Work opportunities that taught valuable social skills disappeared under the guise of patient rights.

Today, we face the same problem that Dix found: that treatment for mental illness is fundamentally inconsistent with imprisonment. As Dominic Sisti, Andrea Segal and Ezekiel Emanuel of the University of Pennsylvania argue in a 2015 essay in the *Journal of the American Medical Association*, “It is difficult to imagine how ethically sound treatment of mentally ill prisoners can be delivered.” Many such prisoners are so difficult that they are held in solitary confinement. One advantage we have today is that mental illness can often be successfully treated with medication—but that may require supervision to ensure the patient is following the regimen.

As one option on a spectrum of possible settings, state hospitals would not require a huge number of facilities. In his 2013 book “American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System,” E. Fuller Torrey of the Treatment Advocacy Center, citing data from the National Institute of Mental Health, estimates that only 1% of the approximately 12.3 million people suffering from serious mental illness are a threat to themselves or others. That would mean facilities adequate to house a maximum of 123,000 people.

Nor would they have to be large, isolated institutions filled with beds. Experiments with new models have begun to emerge, including those modeled after Massachusetts’ Gould Farm, a “therapeutic community” operating since 1913 that is based in farming, where its 40-some residents feed animals, prepare meals, participate in fitness activities, maintain walking trails and run the farm’s cafe and bakery. “There are many different modalities,” says Dr. Sisti, who has promoted the asylum idea as part of a broader continuum of care in a series of panels and papers for the American Psychiatric Association. “Therapeutic communities, farmsteads, recovery campus settings. There should be a range of hospitals, as well, both public and private—but they should be within reach and affordable.” Not every patient would need a long-term stay.

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Bringing back the asylum would, of course, require public spending. Dr. Geller notes that Medicaid, since its inception in 1965, has barred the use of its funds to support inpatient

treatment in larger institutions—originally as a way to force states to continue to bear the expense of treatment. Instead, that policy, along with the deinstitutionalization movement, incentivized states to shift a huge portion of the cost of these hospitals to the federal government by encouraging patients to be served in small, community-based treatment centers, whether these services were sufficient or not. The mass closing of hospitals began, and the few inpatient beds left continue to decrease in number even today.

Dr. Geller proposes that public support for treatment work as a sort of a patient voucher—accompanying a patient in any treatment setting. He envisions patients moving from hospital to involuntary outpatient treatment to their own apartments in “supportive housing,” with the same level of funding following them wherever they go. He believes that state hospitals, run well, should not be “wildly more expensive than community treatment”—and can be crucial as treatment options.

Many of the asylums of the previous era still stand, often empty and eerie. We may not want to reopen those actual facilities—but it’s time to acknowledge that closing them has left a vacuum that must be filled.

—*Mr. Husock is vice president for research and publications and Ms. Gorman is project manager for mental illness policy at the Manhattan Institute.*

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