



The Abandoned Legacy of Dorothea Dix

by Jordan Harris

*“Men of Massachusetts, I beg, I implore, I demand . . . Raise up the fallen;
succor the desolate; restore the outcast; defend the helpless.”*

- Dorothea Dix

Much about the world has changed in the 172 years since Dorothea Dix pled with the men of the Massachusetts Senate to aid the mentally ill. The condition of mental health treatment, which she had witnessed firsthand while visiting the East Cambridge Jail years earlier, had moved her to action. She committed the rest of her life to defending the helpless, and kick-started America’s moral treatment movement. In the century since her death, the Commonwealth of Massachusetts has rightfully exalted her to the status of a heroine, even as it has, like the rest of America, slowly dismantled her life’s accomplishments. Today’s policy prescriptions eerily mirror the ones that left Dix aghast, with prisons serving as de facto mental health facilities and both adequate treatment and justice nowhere to be found.

Much needs to be done at the intersection of mental health and criminal justice reform to reverse this course both nationally and in Massachusetts. There are two issues currently before state government that can point the Commonwealth in a different direction. The first concerns Bridgewater State Hospital which, following a series of hard-hitting reports by The Boston Globe and the Disability Law Center promised a handful of policy changes¹, but have yielded little transparency and seem no closer to fulfilling the long-desired goal of transitioning the facility to Department of Mental Health oversight. The second concerns the practice of solitary confinement, which has come under heavy scrutiny from activists and experts, and was picked up for review by the state legislature on October 15th, 2015.² The current status of both policy items does not match the ethos of Dix’s legacy.

Institutionalization, Deinstitutionalization

In 1840, a year before Dix began her advocacy work, the Treatment Advocacy Center and National Sheriff’s Association estimates that 20 percent of the nation’s jail and prison inmates were suffering from a form of mental illness.³ Many mentally ill inmates had neither the means nor the access to resources beyond the prison itself, with only one public psychiatric bed available for every 5,000 Americans in 1850. Dix’s work led states to dedicate more resources to institutionalized treatment. She is directly credited with the creation and funding of more than 30 state psychiatric hospitals.

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In 1880, just a few years before Dix's death, the United States conducted one of the most thorough surveys of the mentally ill in its history. It found that over 40,000 mentally ill people had been moved to "hospitals and asylums for the insane" and less than 400 remained in jails and prisons nationwide.⁴ A study in 1930 showed the low percentage remained constant, near 1 percent, with studies through 1960 showing the same approximate figure.⁵ From 1843, when Dix issued her plea to the Massachusetts legislature to "defend the helpless," through 1960, the United States virtually eradicated mental illness from jails and prisons, instead treating the afflicted as patients.

By the mid-20th century, the state institutions that had been founded at Dix's urging were plagued by decades of overcrowding, inadequate funding, and numerous failed treatment theories. The institutional process came under heavy scrutiny from academics, journalist, and others who were disgusted by the conditions inside psychiatric hospitals. Through the 1950s and '60s the United States, like many Western nations, began the process of deinstitutionalization. The process was predicated on the belief that community-based services and systems would be cheaper and more effective, and made possible in part by the growth of psychiatric drugs for treatment. Changes in civil commitment laws over the course of the decade, in a shift since labeled "a need for treatment model" to a "dangerousness model," requiring that the individual being committed must pose an immediate danger to himself or others, helped to accelerate the deinstitutionalization and change the role of individual states played. President John F. Kennedy saw the need to aid the move to community-based treatment from the federal level, and in 1963 he signed the Mental Retardation Facilities and Community Mental Health Centers Construction Act (CMHA).^{6,7} It quickly became clear that the CMHA failed to properly serve the needs of individuals coming out of state hospitals, leaving many without the post-discharge support they needed. Only half the community centers promised in the bill were ever built, and even those did not receive full funding.

Since the time of the CMHA, deinstitutionalization has led to the elimination of 90 percent of the psychiatric beds at state hospitals around the country. Today there is only one public bed for every 3,000 citizens in the United States, a drop from one bed per 300 people in 1955. Some of this gap has been filled by the growth of inpatient programs and general hospital psychiatric capacity, as well as private psychiatric beds. Many factors, regardless of their good intentions, have played a contributing role in the current state of mental health in correctional facilities, such as changes in mandatory minimum sentencing laws and the previously referenced changes in civil commitment standards. In 2000, the American Psychiatric Association estimated that 20 percent of prisoners in the United States experienced some form of mental illness. Human Rights Watch produced the same figure in 2003 based on interviews conducted in state and local prisons.⁸ In 2006, the Department of Justice conducted their own survey finding that 24 percent of jail inmates and 15 percent of state prison inmates "had at least one symptom of a psychotic disorder."⁹ In 2014, the number of mentally ill prison inmates in Massachusetts state facilities was estimated to be consistent with 20 percent national figure.¹⁰ In 2012, the Massachusetts Sheriffs' Association estimated that a whopping 42 percent of county jail inmates have some form of mental illness, and 26 percent have a serious mental illness.¹¹

Attempts to improve the system have led to numerous policy missteps, and failures to invest in the appropriate resources have created new issues and resuscitated old ones. Surveys conducted in various states by multiple organizations show that the percentage of mentally ill citizens in America's jails and prisons has returned to the same or a higher level than in 1840. It is as if Dorothea Dix, her heroic work, and her accomplishments which improved the lives of so many in Massachusetts and around the country, never existed.

Bridgewater State Hospital

Bridgewater State Hospital, which holds the unique position of being a hospital run by a Department of Corrections, has been a frequent source of shame for

the Commonwealth of Massachusetts. The hospital became a national target during deinstitutionalization thanks to its uniquely perverse practices when, in 1967, it was the subject of a documentary by Frederick Wiseman.¹² The documentary, *Titicut Follies*, showed guards humiliating and mistreating prisoners and exposed how both guards and doctors failed to administer proper treatments. The Commonwealth responded to the documentary not with a call to leadership or sweeping changes, but by trying to have the film banned from public viewing for over two decades. Before the film was set to be released at the 1967 New York Film Festival, Massachusetts moved to block the public showing, but was denied by the New York Supreme Court. Following the festival, the Commonwealth succeeded in blocking the documentary from being shown in Massachusetts, with the Supreme Judicial Court ordering the film to be restricted everywhere.¹³ It would be 24 years before a Massachusetts Superior Court justice would finally lift the ban.¹⁴ The years since have brought improvements in treatment, but none have prevented the inefficiencies and additional embarrassing scandals for the hybrid hospital-prison.

In the late 1980s, a string of deaths prompted national headlines at the hospital-prison, reported by *The New York Times* and a number of Nightline ABC episodes which called for change.^{15,16} The complaints levied in 1987 have a familiar ring nearly three decades later. The hospital-prison, according to reports, was too overcrowded to properly provide services. Nearly half the facility's patients hadn't been convicted of a crime but were instead civil commitments. Philip Johnston, the Commonwealth's Secretary of Human Services, reportedly promised that the patients without convictions would be moved by 1988, and raised the possibility of turning the facility permanently over to the Department of Mental Health.¹⁷

Like all other Massachusetts prisons, Bridgewater State remains overcrowded today. The facility has a design capacity of 227, but according to the Department of Correction's most recent report in 2013, it housed an average daily population of 346. The percentage of that population which has not been convicted of a crime, a group which was intended

to be moved by 1989, is now even higher. Patients not convicted of a crime make up a majority of the prison's population.¹⁸ In recent years, guards have been cited numerous times for failing to provide proper treatment and improperly using restraints on mentally ill patients, an issue at the center of Joshua Messier's 2009 death.¹⁹ Three guards involved with the death were fired and have since been charged with manslaughter. A pivotal 2014 report by the Disability Law Center concluded that guards are more concerned with punishment than patient care.²⁰

A recent change, though not dealing directly with Bridgewater State Hospital, provides a hopeful precedent. In July of 2015, as part of a supplemental budget item, Governor Charlie Baker allocated funds for the reopening of the Taunton State Hospital for the treatment of civilly committed women, formerly housed at MCI-Framingham.²¹ The move, which was first pledged by a state official in 1987, was a central part of the Governor's plan to combat opioid addiction and signaled a recognition that treatment could not properly be administered at a prison saying, "We think it's important that we find a way to get them treatment and not jail time."²² This recognition can and should be extended to Bridgewater State Hospital, which remains a black eye for Massachusetts, and a shame to the Commonwealth's legacy on mental health issues.

Solitary Confinement

Bridgewater State Hospital is only one part of the changes needed for Massachusetts to reestablish a positive legacy for mental health treatment. For the first time in many decades, state legislators have opened the door to significantly alter Massachusetts' solitary confinement policy and invited experts and advocates to testify on the issue before the legislature's Joint Committee on the Judiciary. Solitary confinement has increasingly become the focus of national and local attention in recent years. President Obama joined the conversation in 2015, speaking out against prolonged segregation as an effective method of rehabilitation.²³ It was the first time a U.S. President had taken a public position on the policy. Many correctional officers, judges, advocacy groups, and international

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rights organizations substantiate and share the President's position.

States generally do not release recidivism data on prisoners held in solitary confinement, which makes comprehensive studies very difficult. One of the most thorough and significant studies was published in 2006, led by federal Court of Appeals Judge John Gibbons.²⁴ The study showed a recidivism rate of 64 percent, more than 20 points higher than average, for those released directly from solitary confinement in prison and jails. Additionally, according to Gibbons' report, repeat offenders who had been held in solitary confinement were "much more likely to commit violent crimes."²⁵

Some prison officials have expressed concern with moving prisoners out of solitary units, fearing that prisoners reentering the prison population will lead to increases in violence and other behavioral issues. At least two states, Ohio and Mississippi, tested this hypothesis. Ohio reduced its confined population by 89 percent and Mississippi reduced its population by 85 percent.²⁶ Both have experienced noteworthy success, but Mississippi's shift provides an important example which allays specific fears some have expressed. The state's policy changes not only allowed the majority of prisoners in solitary confinement to rejoin the population, it altered the policies for those who remained in segregated units. The remaining prisoners were allowed to eat their meals together, and were given several hours a day outside their cell instead of the traditional one hour for exercise. Those remaining in solitary units were also given access to "educational programing and mental health treatment." Mississippi also changed the criteria for being placed in confinement, making the requirements stricter, and transitioning mentally ill prisoners into "intensive mental-health treatment."²⁷ The state provided officers with new specialized training on dealing with mentally ill prisoners. Despite concerns that the reduced solitary populations would lead to more violence and disciplinary issues there was instead a nearly 70 percent reduction in prisoner-on-prisoner violence, prisoner-on-staff violence, and instances where officers were required to use force.²⁸

In September, the Association of State Correctional Administrators joined the call to reduce or eliminate solitary confinement, citing its ineffectiveness in keeping prisons safe and properly transitioning prisoners.²⁹ As previously noted, in addition to dispelling the myth of increased violence in the absence of confinement, data suggest that solitary confinement has negative effects on recidivism, successful re-entry, and life outside prison. These effects are more dire for prisoners suffering from mental illness who weren't provided proper treatment.

Following the 2012 settlement of a US District Court case brought by the Disability Law Center concerning mentally ill prisoners being held in solitary confinement, the Massachusetts Department of Corrections vowed to change policies to ensure the mentally ill would not be placed in isolation.³⁰ To date, there is virtually no transparency on how this promise is being fulfilled or how changes have been implemented. It is unclear how effective the Department of Corrections has been in keeping those with mental illnesses out of solitary confinement. Nationally, Human Rights Watch estimates that between one-third and half of prisoners in solitary confinement or "seclusion" suffer from some form of mental illness.³¹

For over a century, some have concluded that solitary confinement not only punished the mentally ill but helped to exacerbate or lead to forms of mental illness without offering reform. Writing about a Philadelphia prison in 1890, Supreme Court Justice Samuel Freeman Miller concluded,

A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.³²

Federal Judge William Wayne Justice was even more blunt in a 2001 opinion, "[Solitary confinement] units are virtual incubators of psychoses—seeding illness in otherwise healthy inmates and exacerbating illness in those already suffering from mental infirmities."³³

In a June 2015 concurring opinion (*Davis v Ayala*), Supreme Court Justice Anthony Kennedy claimed that solitary confinement brought prisoners, “to the edge of madness, perhaps to madness itself.”³⁴ Some medical precedent supports William Wayne Justice and Anthony Kennedy’s opinion. In his groundbreaking 2009 *New Yorker* piece on solitary confinement, acclaimed Harvard Medical School Professor Dr. Atul Gawande noted that “EEG studies going back to the 1960s have shown diffuse slowing of brain waves in prisoners after a week or more of solitary confinement.”³⁵

Data remains limited in Massachusetts, where the state requires little to no transparency on the use of solitary confinement or the transition from seclusion. Activists have called the state’s solitary confinement policies one of the “strictest and most punitive policies in the country.”³⁶ The Commonwealth is one of only two states that, “allow prisoners to live in solitary confinement for up to 10 years because of disciplinary infractions,”³⁷ according to *The Boston Globe*. A group of Harvard students are currently working on a compiled report of Massachusetts’ solitary confinement policies to be released this year that promises important data.

Bills currently being reviewed in the state legislature seek to address some of these issues. A transparency bill introduced by Representative Russell E. Holmes, H. 1381,³⁸ could serve as a catalyst to monumental reform. The bill would require jails and prisons to make data regarding solitary confinement public, including the number of prisoners in segregation for both disciplinary and non-disciplinary reasons, the frequency of use of force by correctional officers against segregated prisoners, the racial composition of segregated prisoners, and their education level, among many other metrics. In all, H. 1381 calls for 15 data points that must be made publicly available every quarter. A bill introduced in the House and Senate calls for equally substantive reforms. The bill (S.1255, H.1475) would require a hearing every 15 days a prisoner is held in solitary confinement, and would prohibit several groups from being subjected to solitary confinement altogether, including the deaf, blind, pregnant women, or prisoners under the age of

18.³⁹ Additionally, it codifies the 2012 commitment to keep mentally ill patients out of solitary confinement, making the policy state law. The proposed legislation would allow prisoners in solitary confinement to have an hour of exercise a day, the ability to buy from the canteen, and access to educational programs, luxuries which are presently required for prisoners of war under the Geneva Conventions. State Representative David Rogers has a separate bill which prohibits solitary confinement for anyone under the age of 21.⁴⁰

It is promising that so many proposals are being seriously reviewed by the state legislature. The various proposals, if adopted, would represent one of the largest policy shifts in the nation on solitary confinement. Nonetheless, they would still leave many issues on the table. Chief among them is whether solitary confinement in any form is making our prisons safer or more effective at rehabilitating prisoners, and how the failure to transition perpetuates violent crime, substance abuse, and other medical issues once inmates are returned to society. Virtually no evidence upholds solitary confinement as a social net benefit. It is time to adopt policies that do more to keep our streets safe and promote a positive mental health legacy.

Recommendations

In pursuit of impactful change, the Legislature and Governor Baker should consider the following recommendations:

- 1) The Department of Corrections should develop a partnership with the Department of Mental Health which gives DMH influence over treatment operations, wider information sharing, and cross accountability in the functions of Bridgewater State Hospital. A partnership with the Department of Mental Health ensures improved delivery of services while respecting the delicate political balance that presently serves as a barrier to broader action. Many states provide replicable examples in which mental health departments effectively balance treatment and patient safety.⁴¹
- 2) The Department of Corrections should make public the guidelines established following the

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2012 Disability Law Center case which requires mentally ill patients to be placed in alternatives to solitary confinement. Making these guidelines public will allow for transparent oversight and help prevent mentally ill inmates from being placed in segregation. The Massachusetts Legislature, in codifying these commitments (S.1255, H.1475), should provide specific guidelines or use existing DOC guidelines, either of which should be public. Information such as demographic data and behavioral issues should be compiled and made public on a quarterly basis. An independent appeal board should be established to allow a hearing for prisoners who contend they should have been placed in one of the DOC's 29 alternative units.

the moral treatment movement, and ensure the proper legacy of the Commonwealth.

- 3) In addition to requiring a hearing every 15 days for each prisoner in solitary confinement, such as that offered in S.1255, H.1475, a mental health assessment should be conducted at each hearing, corresponding with the assessment given to prisoners upon entering the prison system. Prisoners should be moved to one of the DOC's 29 alternative units when they experience a change of status causing them to meet the established mental illness criteria.
- 4) The Department of Corrections should supply transparent information on a quarterly basis regarding solitary confinement, including demographic data and length of isolation. Additionally, recidivism statistics for prisoners once held in isolation should be collected and made public on a quarterly basis. Bills currently being reviewed by the Massachusetts legislature introduce a substantive and appropriate level of transparency.

Massachusetts can seize this opportunity to reestablish itself as the national leader in mental health treatment. Liberating Bridgewater State Hospital from DOC control will be an important and symbolic step. Promoting serious reform to solitary confinement will send a message that resonates nationally. These changes, which are within reach, would help open the door for broad shifts. Both would honor the memory of Dorothea Dix and the hundreds of others who led

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