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The autonomy of individuals experiencing mental health challenges has been under a series of calculated, multi-pronged attacks over the last year. In August 2025, President Trump declared[1] a public safety emergency in Washington, D.C. to remove the encampments of homeless residents and "fight crime," despite violent crime rates being at a 30-year low.[2]

One month later, local officials in Utah announced[3] plans to construct a sprawling detention camp to house individuals experiencing homelessness and dealing with substance misuse concerns, in response[4] to the Trump Administration's executive order[5] "Ending Crime and Disorder on America's Streets." Those "sanctioned"[6] to go, civilly committed, or court-ordered to receive mental health treatment would not be able to leave the encampment voluntarily.[7] Utah officials have threatened that unhoused people who refuse detention could face jail time. The threat of further displacement via incarceration looms for those who are noncompliant.

More recently, on January 23, 2026, nine states filed a joint complaint[8] with the Health and Human Services Department (HHS), claiming that staff in the Biden Administration interpreted[9] the integration mandate set forth by Section 504[10] of the Rehabilitation Act of 1973 too broadly,[11] and seeking to reduce its scope.[12] The integration mandate states that any entity receiving HHS funding has to serve individuals with disabilities in the most integrated setting available (i.e., in their communities instead of inside an institution, or at a site that provides co-located services).

Alongside the multi-pronged push to loosen restrictions on forceful institutionalization and build a treatment camp, the Trump Administration is planning to cut $10.7 billion from the Department of Housing and Urban Development's 2027 fiscal budget.[13] With those cuts comes a shift regarding their approach to housing assistance, toward transitional housing that requires work and treatment for substance misuse, under the guise of promoting "self-sufficiency" and restoring "accountability."[14] House and Senate Appropriations subcommittee members from both sides of the aisle expressed concern about the administration's plans, citing that up to 170,000 more people will be at risk of homelessness.[15]

These are just three examples of a coordinated effort to further criminalize and displace a population that has long been forced to the margins of society. Though many advocates and lawmakers alike agree that the contemporary mental health systems in the U.S. are not meeting the needs of the nation's residents, doubling down on carceral, short-term interventions will only repeat the mistakes of the past and worsen the ongoing mental health crises in the U.S. and globally.[16] Some policymakers may feel like more autonomy and supportive housing-based models have led to our current dire circumstances, but a

brief overview of the historically contingent ideologies, policies, and practices meant to address the growing burden of mental health challenges in this country reveals a long history of neglect and unsupported community mental health programs.[17]

CRUEL BEGINNINGS: 1773-1949

People experiencing mental health challenges have been thrown in jails and asylums as early as 1773.[18] Growing cities and weakening social support systems meant that the demand for long-term solutions regarding the growing population of people struggling with their mental health was also rising. Public agencies began building mental hospitals in the early 1800s.

During that time, mental health care was proctored from a lens of "moral treatment."[19] This was expressed as a desire for specially built hospitals that provided opportunities for work and recreation, rewards for behavior deemed rational, and limited use of restraints. For those who could afford it, long periods of rest and separation from one's community were believed to be key to recovery. The committed often found that their stay extended for the rest of their lives. Individuals who couldn't afford an asylum stay often ended up in jail.

In 1854, President Pierce vetoed a bill to push the federal government to provide land grants for the construction of state mental hospitals.[20] He feared federal expansion into the domain of states and local government, and worried that if the federal government assumed responsibility for the care of one population it would eventually have to do so for all impoverished Americans.[21] This move blocked the federal government's involvement in mental health for decades. Individual states had to fill in the gaps, but most were hampered by limited budgets and growing public sentiment that people were not responding to the mental health treatments available.[22]

The latter half of the 19th century brought overcrowded asylums and jails, as well as new scrutiny of civil commitment laws.[23] Advocates lamented the harsh conditions of confinement and the institutional incapability to properly provide care. Women were particularly vulnerable to being institutionalized by their husbands, for dubious reasons, who could weaponize state statutes against them. Voluntary psychiatric hospitalizations only became available after 1881, when Massachusetts became the first state to allow an individual to admit themselves.

By the beginning of the 20th century, the eugenics movement had begun to gain popularity in the U.S., and its insistence on biological explanations for intellectual disabilities that led to criminalized behavior found a wide audience.[24] Individuals deemed "defective" or "feeble-minded" were often segregated within public institutions. By 1923, almost 43,000 people were warehoused in custodial institutions built specifically for those considered societally "undesirable," including people with mental health challenges and the destitute.[25] In 1907,

Indiana became the first state to enact compulsory sterilization laws for those populations; many other states subsequently passed similar laws.[26] The U.S. Supreme Court ruled the practice was unconstitutional in 1942's Skinner v. Oklahoma decision,[27] but some states still have sterilization laws on their books.[28]

In 1946, President Truman signed the National Mental Health Act, which set aside government funds to establish the National Institute of Mental Health in 1949 and conduct research into the causes of mental health challenges.[29] Through this act, the federal government took more responsibility for improving mental health on the population level and facilitated the creation of a feedback loop regarding mental health research and treatment between local, state, and federal agencies. This move was partly inspired by the number of World War II recruits who were unable to serve due to psychiatric reasons.[30]

DRUG-INDUCED HOPE AND UNSUPPORTED DEINSTITUTIONALIZATION: 1955-1968

In 1955, the number of people in public psychiatric hospitals peaked at around 559,000,[31] roughly 0.3 percent of the total U.S. population at the time.[32] At the same time, Congress passed the Mental Health Study Act, which established the Joint Commission on Mental Illness and Mental Health.[33] This commission was tasked with investigating and assessing available resources and methods for diagnoses and mental health treatment. Commission members released a report in 1961 based on their findings; in it, they called for training and hiring more staff to support individuals suffering from mental health challenges, and for the construction of community mental health clinics as the main line of defense against prolonged or repeated institutionalization.[34]

The movement against institutionalization was influenced by many factors, including the hope that came with Thorazine, the first antipsychotic drug approved by the Food and Drug Administration in 1954.[35] The medication soon became widely used in asylums, despite having severe side effects.[36] The Civil Rights[37] and Disability Rights[38] movements carried that momentum into the 1960s; in 1963, President Kennedy signed the Community Mental Health Act, which provided federal funding for community mental health centers and research facilities.[39] Kennedy had a larger vision: that the government could help people with mental health struggles through medication and supportive housing.[40] However, his assassination meant that this vision would remain unrealized. Most of the money was reappropriated for the ongoing war[41] in Vietnam; less than half[42] of the community mental health centers proposed by the Community Mental Health Act were built, and most of those were not fully funded.

By the middle of the decade, perspectives on how to treat mental health issues had shifted. Instead of centering the individual's perceived need of medical intervention, a dangerousness standard, or a measure of whether an individual should be involuntarily treated if they are deemed likely to cause lasting damage to themselves or others, was more often used.[43] Washington, D.C. was the first to adopt this standard in 1964.[44]

It was with the passage of Medicare and Medicaid in 1965 that states were further incentivized to close psychiatric hospitals. Federal funds would be provided to care for people experiencing mental health challenges, but only if they were in nursing homes, general hospitals, or elsewhere in the community.[45]

Two years later, the passage of the Lanterman-Petris-Short Act made involuntary institutionalization much more difficult and pushed for due process protections and the right to quick psychiatric evaluation and treatment when possible.[46] At the same time, advocates fighting for better conditions within psychiatric hospitals led to an increase in the cost of care. By 1968, the population in state psychiatric hospitals dropped 30 percent, to just under 370,000.[47] These events and legislation were some of the key moments in what came to be known as the deinstitutionalization movement, which continued for several decades.[48]

IMPRISONING THE PROBLEM: 1970S-PRESENT

The decline in involuntary commitments and rising cost of care led to tens of thousands of people with severe mental health challenges being released from public psychiatric hospitals starting in the 1970s.[49] Few of these former patients had means of accessing consistent care again, especially if they had been hospitalized for years.

At the same time, shifting labor demands in large cities saw a decline in manufacturing jobs and an increase in low-paying service work that could not absorb the returning "surplus" workforce.[50] A rise in policing and higher arrest rates in non-white neighborhoods ensured that residents suffering from the structural consequences of uneven development (unemployment, low-wage jobs, drug use, and family dysfunction) did not get in the way of transforming those neighborhoods into financial districts that could generate value for international markets.[51]

"Tough on Crime" policing[52] and the War on Drugs[53] begun by President Nixon and continued by President Reagan further criminalized and racialized the stigma surrounding the relationship between mental health challenges and substance misuse.[54] This situation was only worsened by the consequences of the U.S. military giving soldiers heroin and other opioids to reduce stress and pain during the Vietnam War.[55] Discrimination against Black people and people struggling with substance misuse was significantly exacerbated by the convergence of deinstitutionalization, the War on Drugs, and the lasting effects of the Vietnam War.

Many people who were deinstitutionalized wound up homeless or incarcerated.[56] Early studies found that people experiencing mental health challenges were three times more likely to be arrested than the general public after being released into the community. Most of those arrests were for nuisance crimes like loitering or trespassing, or crimes motivated by hunger.

The perceived need by political figures and public sentiment to incarcerate more and more people took money away from health and welfare programs, instead directing funds toward policing and facilities to warehouse people. Money was also needed to hire psychiatrists to work within the mental health wards of jails and prisons. In a morbid twist of fate, some of the abandoned state mental hospitals were transformed into correctional facilities.[57] Between 1990 and 2005, a new prison was built approximately every 10 days; during that same period, over 1.4 million people were imprisoned in the U.S.[58]

Reagan's War on Drugs was bolstered[59] by the Sentencing Reform Act of 1984,[60] which limited judges' discretion in sentencing, and the Anti-Drug Abuse Act of 1986[61] that imposed high mandatory minimum sentences for drug offenses, specifically penalizing crack cocaine usage because of its association with Black users.[62] President Clinton's Violent Crime Control and Law Enforcement Act of 1994 continued this trend, allocating billions for new prisons and created three-strikes laws.[63]

Incarceration and Psychiatric Hospitalization Population in the U.S. 1950-2025

	1955	1960	1970	1980	1990	2000	2010	2020	2025
Psychiatric Hospitalizations (State and County)	559,000	535,540	337,619	132,164	90, 572	56,716	43,854	50,868*	36,542**
Incarcerated (Jail and Prison)	288,862	346,015	357,282	493,815	1,148,702	1,933,503	2,266,832	1,691,600	1,660,000

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* Combined population from number of clients who received services in public psychiatric hospitals and general hospitals (N-MHSS 2020)

**Data not provided for hospitalizations at county level

These policies and laws have created an inverse of the psychiatric hospital era.[64] The incarcerated population jumped from approximately 360,000[65] at the beginning of the 1970s to around 2.3 million today.[66] This has happened despite a steady decline in reported violent crime over the last three decades.[67] In 1976, 171,000 people were in state psychiatric hospitals.[68] In 2025, there were 36,542.[69] As a result, the largest providers of inpatient psychiatric care in the U.S. are the Cook County Jail, Los Angeles County Jail, and Rikers Island.[70]

APPLYING LESSONS FROM THE PAST

Walking through just a brief history of individuals criminalized for their struggles with mental health reveals a closed circle: confinement in jails and asylums led to offloading in resource-stricken communities with underfunded community-based centers and state

hospitals.[71] And now, with the proposed treatment and work camp in Utah, we're back to confinement.

Researchers have consistently shown that carceral settings should not be the first line of defense. Involuntary commitment doubles the risk of suicide, overdose, and violence upon release.[72] Additionally, both jails and prisons disrupt connections to networks of social support, employment and housing. The experience of confinement is in itself traumatic and a catalyst for worsening physical *and* mental health.[73] Jail stays are also usually short-term, making it difficult to provide meaningful mental health care. And each year within a prison shortens life expectancy by two years.[74] Hundreds of thousands of people are impacted by these harms; forced hospitalizations currently mirror incarceration rates.

One in five adults in the U.S. are impacted by mental illness, yet the people who will suffer the most from plans like Utah's will be people who are already marginalized.[75] Many of those one in five struggle with housing; an estimated 67 percent[76] of the 771,000 people[77] (an all-time high) currently experiencing homelessness are also living through mental health challenges, and approximately 44 percent struggle with substance misuse.[78]

Additionally, non-white people, and Black people in particular, are overrepresented[79] in jails and prisons, where they are unlikely to receive appropriate care, despite this being the one place where care is constitutionally mandated.[80] Approximately 43 percent and 44 percent of people incarcerated in local jails and prisons, respectively, have been diagnosed with a mental health condition.[81] Yet almost two-thirds of people incarcerated in federal prisons reported not receiving any sort of menta health care while imprisoned.[82]

NOW IS THE TIME TO ACT

The proposed treatment camp in Utah; efforts to make involuntary commitment easier to achieve; and cutting funds for housing assistance may become the model for dealing with the mental health crisis in the near future. While exacerbating the crisis itself, these measures also erode communities and support systems that allow people to maintain dignity and agency.[83] Instead of repeating the mistakes of the past, we can build a future that doesn't punish individuals for societal failures. Doing so means diverting funds away from punitive initiatives toward:

Making a physical health screening part of routine mental health screening, especially when involuntary psychiatric hospitalization is being considered.

Individuals with serious mental health challenges are more likely[84] to have co-morbid physical conditions and less likely[85] to have them diagnosed, which can lead to a misdiagnosis of their mental health challenges and improper treatment.

Providing supportive, long-term housing:

Take a housing-first approach that ensures people have shelter while receiving voluntary treatment and wraparound services like work placement, legal support, child care, and education.[86]

This approach is also cost-effective: the health system spends up to $1,000,000 per person annually for treatment that generally consists of repeated emergency room visits and trying non-curative and potentially harmful medications.[87] Conversely, the cost of providing supportive housing is $25,000-$36,000 per year.[88]

Employment programs:

Employed individuals are more likely to report a higher quality of life, greater self-esteem, and fewer psychiatric symptoms than if they are not working.[89] Having a job is also crucial to maintaining and sustaining house and health care in the U.S.

Funding a community-based mental health system[90] staffed by trained specialists, without police[91] or the threat of incarceration for non-compliance:

Building a new mental health system would have to acknowledge and address the targeted[92] economic extraction and political divestment of Black and brown communities that have made predominantly non-white neighborhoods more vulnerable to surveillance and policing.[93]

Because of this organized abandonment,[94] Black and Hispanic individuals are less than half as likely as their white counterparts to receive outpatient mental health care.[95]

This includes providing services for youth that maintain their agency in the treatment process.[96]

Additional measures include:

- Holding jails and prisons accountable for human rights violations and medical neglect.
- Eliminating cash bail: individuals with serious mental health conditions often make less than $10,000 a year, and any bail costs could lead to prolonged and unnecessary incarceration.[97]
- Maintaining the provisions set out by Section 504 of the Rehabilitation Act.[98]
- Enacting legislation to further protect individuals from involuntary hospitalization.
- Incorporating people with lived experience into conversations regarding state- and federal-level medical intervention policies.

The paradox of seeking harsher, more explicit carceral interventions to address the current mental health crisis is that ample research, in addition to an analysis of historical

shortcomings, demonstrates that both forced treatment *and* incarceration are physically and mentally harmful. They also reduce an individual's agency when everyone should be able to maintain their autonomy in making decisions about their health care. That is why advocates fought so hard against forced confinement and involuntary commitment in the first place. Continuing to rely on punitive mental health interventions will reinforce the systems of value and hierarchy created and maintained by their use and perpetuate the stigma of mental health challenges and poverty. Building and fully supporting community-based mental health systems will reduce the human and economic costs of criminalizing mental health conditions.

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