

CRIPA, *Olmstead*, and the Transformation of the Oregon Psychiatric Security Review Board

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This commentary explores the relationship among the 1999 U.S. Supreme Court *Olmstead* decision; the Department of Justice, Civil Rights Division, in its application of CRIPA (the Civil Rights of Institutionalized Patients Act); and the application of both CRIPA and *Olmstead* to the question of individuals hospitalized in state mental institutions following commitment from criminal courts. Using Oregon as an example, the commentary illustrates the interplay between state and federal governments as *Olmstead* and CRIPA are expanded into the realm of criminal court commitments to state facilities and into the arena of community mental health services for deinstitutionalized persons.

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On June 14, 2006, the United States Department of Justice operating through its Civil Right Division (DOJ) notified the Governor of Oregon that it was initiating an investigation of the Oregon State Hospital (OSH) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA).¹ OSH is Oregon's largest state hospital, with a campus in Portland housing a small population of civil commitment patients and a larger campus in Salem housing a population of patients committed primarily by Oregon's criminal courts.

On January 3, 2008, the DOJ issued a letter finding OSH deficient in five areas, some of which concerned the treatment environment within the hospital, such as a lack of adequate nursing and psychiatric staff, the overuse of seclusion and restraint, and the resultant failure to protect patients from harm. The final section of the letter focused on the area of inadequate discharge planning.² This commentary discusses the DOJ, CRIPA, and the application of the *Olmstead*³ decision to individuals committed to state

hospitals following criminal court commitments, to the degree that it substantially changed the structure and function of the Oregon Psychiatric Security Review Board (PSRB). The heart of this matter lies in the first sentence of the section of the CRIPA letter dealing with discharge planning. Citing the *Olmstead* decision the CRIPA report states:

Within the limitations of court-imposed confinement, federal law requires that OSH actively pursue the timely discharge of patients to the most integrated, appropriate setting that is consistent with the patient's needs [Ref. 2, Section E].

“Within the limitations of court-imposed confinement” is very meaningful in this context because the OSH population is almost entirely court committed. On June 24, 2011, 73 percent of OSH's population originated in the criminal courts, with 108 (25%) patients committed as incompetent to stand trial (IST), leaving 316 (75%) insanity acquittees committed to the jurisdiction of the PSRB. Thus, the DOJ, with knowledge that the OSH predominantly serves Oregon's criminal courts, introduced *Olmstead* as critical for the State of Oregon to consider as it developed its plans to respond to the need for discharge planning. Although the commentary focuses on the state of Oregon, I believe that the

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problems identified here have great relevance for other states.

Olmstead v. L. C. by Zimring

Olmstead is a 1999 Supreme Court decision based on a section of the Americans with Disabilities Act (ADA), which focused on the rights of disabled persons receiving services in public institutions. The case involved two developmentally disabled women who had been voluntarily admitted to one of Georgia's state hospitals. Eventually, the hospital's treatment staff determined that each could be cared for in the community, but the two remained in the hospital. The suit was brought against the state of Georgia because of the state's failure to provide community care for these women.

Justice Ginsburg, writing for the majority stated:

Specifically, we confront the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions. The answer, we hold, is a qualified yes. Such action is in order when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities [Ref. 3, p 587].

Olmstead provided the key legal framework regarding the question of release of institutionalized persons from state facilities. The decision rapidly became the central focus of the action agenda of national and state disability rights organizations. State hospital beds, which had been on a rapidly decreasing pathway from the highs of the mid-1950s,⁴ continued to decrease following the decision, although on a less steep trajectory.⁵

In 2003 the *Olmstead* decision had an impact on Oregon's state hospitals. At that time, the state entered into a settlement agreement with Disability Rights Oregon in a class action lawsuit alleging that the state had failed to provide community resources necessary to allow members of a class of "civilly committed adults" to be treated in the community. The settlement applied to Oregon's state hospitals and to those who "had not been discharged within 90 days of the ready-to-place determination of their Treatment Team."⁶ In the settlement, the state agreed to develop the additional community resources necessary to accommodate the class.

The 2008 U.S. presidential election greatly influenced the policies of the DOJ. In the last month of

the Bush administration, the Civil Rights Division reached CRIPA settlements with six states. These settlements were criticized as being weak.⁷ In 2009, on the 10th anniversary of *Olmstead*, President Obama issued a proclamation launching the Year of Community Living, which focused on increasing the availability of community options for disabled persons. The President stated:

The *Olmstead* ruling was a critical step forward for our nation, articulating one of the most fundamental rights of Americans with disabilities: Having the choice to live independently . . . I am proud to launch this initiative to reaffirm my Administration's commitment to vigorous enforcement of civil rights for Americans with disabilities and to ensuring the fullest inclusion of all people in the life of our nation.⁸

Following the President's proclamation, the DOJ issued a technical assistance guide to help individuals understand their rights and "to assist state and local governments in complying with the ADA." This document states that the DOJ "has made enforcement of *Olmstead* a top priority" which "reaffirms its commitment to vindicate the right of individuals with disabilities to live integrated lives under the ADA and *Olmstead*."⁹

This technical assistance document also recognized the role of a federally created "independent protection and advocacy system" to protect the rights of persons with disabilities. The representative of this system in Oregon is Disability Rights Oregon (DRO).¹⁰

On October 10, 2010, the DOJ and the state of Georgia signed a comprehensive agreement pertaining to patients in its hospitals for the mentally ill and developmentally disabled.¹¹ The settlement expanded the CRIPA agreement, made in the final week of the Bush administration, which focused on improved hospital conditions in Georgia's state facilities. Based on *Olmstead*, the new agreement focused on the significant expansion of the state's community mental health services with the goal of rapid deinstitutionalization of those patients ready for discharge. The parties also agreed that the state would develop stronger community crisis services to avoid future hospitalization.

Soon after the Georgia settlement, the DOJ wrote a letter to the state of Oregon expanding its CRIPA investigation to determine how the state was complying with the *Olmstead* decision.¹² This letter added emphasis to the portion of the original 2008 DOJ-

CRIPA findings letter that dealt with hospital discharge.

The Oregon Response

The State of Oregon responded to the DOJ investigation by developing plans to rectify deficiencies cited in the DOJ's findings letter. The state's responses are detailed in two documents: the first, its response to each of the major DOJ findings,¹³ and the second, a chronology (from January 2004 through February 2010) outlining the major interactions between the state and the DOJ.¹⁴ The 2007 Oregon legislature took significant steps to improve OSH by authorizing the development of two new state hospitals. The first, opened in early 2011, is a 600-bed hospital located on the OSH campus in Salem, and the second is slated to be built in Junction City just north of Oregon's second largest city, Eugene, to be opened in 2013. In addition to new hospital construction, the 2007 legislature authorized significant increases in OSH staffing for both nurses and psychiatrists and approved funding for an extensive program improvement plan.

From 2007 to the present time there have been problems in OSH's implementation of its improvement plan, including a patient's death in 2009 that resulted in a second DOJ visit and an additional letter of concern. However, the state has made a genuine effort to address the findings outlined in the CRIPA letter. The chronology cited above indicates that in 2008 the DOJ and the state were in the process of negotiating a possible settlement agreement. An entry dated April 15, 2008, noted that the state "agrees to every substantive term in the USDOJ's proposal, but disagrees on two points: filing of the agreement in federal court; and including community issues in the scope of the agreement."

The Psychiatric Security Review Board

The 1977 Oregon legislature created the PSRB, and it began functioning on January 1, 1978. From that date to the present, the PSRB has been responsible for the monitoring of all persons found guilty except for insanity³ by Oregon's trial courts who continue to be mentally ill and dangerous. Guilty except for insanity is Oregon's term for the insanity verdict. It has the same consequences as not guilty by reason of insanity in other jurisdictions.

Table 1 Legal Status of OSH Populations in 2008 and 2011

	9/20/2008	6/24/2011
Civil commitment		
Portland	90	73
Salem	34	0
Criminal Court Commitments		
Incompetent to stand trial	105	108
Psychiatric Security Review Board	354	316
Geropsychiatric units	99	84
Totals	682	581

Over the years, I along with others have written extensively about the functioning of the PSRB^{15,16} and about the case law related to it.¹⁷ It is beyond the scope of this commentary to describe the PSRB in detail. That will be the subject of a forthcoming empirical summary of the Board's activities from its inception in 1978 to 2012. In brief, the PSRB has the following features; a five-member board, replacing approximately 85 trial court judges making decisions about the hospitalization or release of insanity acquittees; a jurisdictional limit to the time that an individual can be under the board's jurisdiction¹⁸; an extensive system of monitored conditional release based on individualized conditional release plans; and the option for prompt revocation of conditional release. The PSRB also has the statutory responsibility to discharge an insanity acquittee at any time during the jurisdictional time period if they find at a hearing that an individual is no longer mentally ill or dangerous.

It is important to understand the scope of the PSRB program at the time that the 2011 Oregon legislature considered the two bills that would significantly alter the PSRB's enabling statutes. On the last day of 2011, the PSRB had 731 insanity acquittees under its jurisdiction. Of these, 318 (44%) were hospitalized at OSH, and 413 (56%) were on conditional release, with 403 (98%) residing in various living situations in Oregon. In 2011, Oregon judges committed 60 new insanity acquittees to PSRB jurisdiction, 6 (10%) after misdemeanor offenses. During this year, 70 individuals were discharged from PSRB jurisdiction: 47 (67%) because PSRB jurisdiction had lapsed, 17 (24%) after board findings that they were no longer mentally ill or dangerous, and 7 (10%) who died in 2011. There were no suicides, and no serious crimes reported for those on conditional release. During the year, 27 individuals had their conditional releases revoked. Finally, in 2011, the PSRB conducted 696 hearings, of which

312 (45%) were administrative reviews. It should be clear from this very brief review that the PSRB was responsible for a very large number of insanity acquittees with a slight majority on conditional release.

The 2011 Oregon Legislature

The Legislature concluded its session on June 30, 2011. Faced with insufficient revenues and heavy budgetary demands, the legislators made significant changes in the laws governing admissions to its psychiatric hospitals to reduce hospital census and perhaps to bring the DOJ investigations to a conclusion. It enacted two bills: HB3100 and SB420.¹⁹

Oregon generally has a deliberative legislative process that attempts to involve interested parties in the crafting and amending of bills. HB3100 is the product of just such deliberation. The bill has three components. First, it authorizes the Oregon Health Authority to develop a certification process for psychiatrists and psychologists who are participating in the evaluation of individuals for competency to stand trial or for criminal responsibility at the time of the crime charged. Second, the bill removes misdemeanor insanity acquittees from PSRB jurisdiction, but does allow judges to commit misdemeanants to the state hospital following successful insanity defenses if they remain mentally ill and a "substantial danger to others."¹⁹ Finally, the bill provides for the hospitalization of those found IST only if the trial court determines that as a result of mental disease or defect they are dangerous to self or others, and as long as there are no services available for them in the community. Without a finding of dangerousness, those found IST are to be treated in the community.

The legislative process that led to the introduction of SB420 was atypical. In the midst of the legislative session and very close to the deadline for hearings on bills, the Chief Justice of the Oregon Supreme Court was asked by the Oregon Health Authority (OHA) (the parent agency of the mental health division) to convene a group to discuss further legislation involving the PSRB. As I understand it, the group was made up of representatives from the Governor's Office, OHA, and the Attorney General's Office, and a group of state legislators led by the Chair of the Senate Judiciary Committee. Also invited was the Executive Director of DRO and a representative from the Oregon District Attorneys Association. There were no representatives of other affected groups, such as

the PSRB itself or the Oregon Psychiatric or Psychological Associations.

After several meetings, the group introduced a bill aimed solely at the PSRB. The Senate Judiciary Committee held a hearing that lasted six minutes. Without further debate, the Senate Judiciary Committee passed the bill and sent it to the Joint Ways and Means Committee for consideration of its potential fiscal impact. During the legislative process, OHA was not required to define the problems that it was trying to address.

The bill proposed to transfer the responsibility for all hospitalized insanity acquittees from the PSRB to the OHA, limiting the PSRB's authority and responsibility to those who are conditionally released. This change would amount to cutting PSRB's authority roughly in half. OHA would have complete jurisdiction over the hospitalized insanity acquittees and would have the power to release or discharge these individuals conditionally. Jurisdictional authority would pass between the PSRB and the OHA, depending on whether the person was in the hospital or community. SB420 placed the hospital superintendent in the key position of initiating conditional release or discharge. The bill required OHA to hold hearings for hospitalized insanity acquittees in lieu of the PSRB or a trial court judge and to follow all of the current law in considering conditional release or discharge. OHA would thus be placed in the position of both initiator of release and arbitrator of the release decision.

At the end of the legislative session, SB420 was on the fast track to approval. Only one amendment was considered. The Portland District Attorney proposed an amendment that would maintain PSRB jurisdiction over hospitalized insanity acquittees who had been charged with the most serious crimes. To get sufficient votes for passage of the bill, proponents agreed to an amendment that divided the crimes leading to the insanity verdict into Tier 1, the most serious crimes, and Tier 2, those crimes that were not Tier 1. With the new amendment, the bill had sufficient support to pass. The new bill went into effect on January 1, 2012, and at the end of that month, there were 734 insanity acquittees in Oregon. PSRB had 609 individuals under its jurisdiction in the hospital and in the community, whereas OHA had the responsibility for 125 hospitalized Tier 2 insanity acquittees.

Discussion

HB3100 and SB420 went into effect on January 1, 2012. As noted earlier, the provisions of HB3100 had been agreed to by a variety of interested parties. The development of a certification process for psychiatrists and psychologists responsible for forensic evaluations had long been advocated by the Oregon Psychiatric Association as a means to upgrade the quality of evaluations for competency to stand trial and criminal responsibility.

The provision in HB3100 to remove misdemeanor insanity acquittees from the PSRB's jurisdiction does allow judges the authority to commit directly misdemeanor offenders who mount a successful insanity defense. Once in the hospital, these patients can be discharged by hospital physicians without a requirement that they return to court. These changes were introduced to reduce the hospital length of stay for misdemeanor insanity acquittees. If this provision is used in Oregon courts, the result may be an increased number of patients committed to the hospital, albeit for shorter times.

The last section of this statute requires a finding of both dangerousness and lack of community resources before a person found IST can be hospitalized. Since community resources designed to restore competency to stand trial are currently limited, this change in the law will not, in the near term, substantially reduce the number of those committed as IST. However, some individuals will be found not to be dangerous and will be allowed to remain in the community. New tracking and treatment systems will be needed to avoid the loss of individuals within the community, who may appear years later, perhaps with new charges and with earlier charges still unresolved. This concern was raised by the Oregon District Attorneys Association without effect on the final law.

SB420 presented an entirely different set of circumstances. By placing total responsibility for hospitalized insanity acquittees in the hands of the OHA, the Legislature clearly intended to reduce PSRB's authority. The only effective opposition to this bill came from the Oregon District Attorneys. Their concerns led to a final amended version of the bill creating Tier 1 and 2 insanity acquittees. Why did the Legislature directly aim to reduce the authority of the PSRB, an institution that it had supported for 34 years? The evidence seems to point in two

directions: the unresolved DOJ CRIPA-*Olmstead* investigation and significant opposition to the construction and staffing of a new state hospital in Junction City.

On February 11, 2011, the state published its *Olmstead* Plan.²⁰ The plan promises to achieve the goal of independent living for hospitalized individuals by "reducing the length of stay at OSH," and by promoting their living independently in the community. The plan also focuses on preventing their future "hospitalization at OSH." This plan set the stage for the rapid development of SB420.

As stated above, on December 30, 2011, there were 318 PSRB clients at OSH, more than 50 percent of the hospital's census, and the largest group of hospitalized patients in the institution. The PSRB controlled conditional release or discharge decisions for this group, independent of the hospital's administration. PSRB clients represented the largest target for potential census reduction based on the application of the state's *Olmstead* plan. As originally drafted, SB420 provided the authority for the OHA to gain control of the hospital course and eventual release of all of these individuals. By accepting the separation of insanity acquittees into Tiers 1 and 2, the OHA got what it could from this 2011 Legislature.

However, this attempt by OHA to control the release of insanity acquittees is highly inconsistent with past decades in the evolution of insanity defense law.²¹ Recall the language of the 2008 CRIPA investigation findings letter on hospital discharge:

Within the limits of court-imposed confinement, federal law requires that OSH actively pursue the timely discharge of patients to the most integrated, appropriate setting that is consistent with patient needs [Ref. 2, Section E].

The 2011 DOJ settlement with Delaware²² makes the same point about "court-imposed confinement." In defining priority populations, the Delaware settlement agreement covers, "People who are currently at Delaware Psychiatric Center, including those on forensic status for whom the relevant court approves community placement."

In Oregon, there is no court that imposes confinement for insanity acquittees. Once an individual is committed to the jurisdiction of the PSRB, it has the sole authority to determine whether the person is hospitalized, conditionally released, or discharged. When the PSRB came into existence in 1978, it assumed the responsibility that had been exercised by

the courts. SB420 broke with the past and substituted the OHA and OSH for the PSRB in relation to hospitalized Tier 2 patients. Substituting OHA for both court and petitioner for release is a highly unusual legal arrangement. It opens the OHA to many potential problems, not the least of which is a conflict of interest between census reduction and cost containment and the responsibility for protection of the public (which was articulated in the original PSRB statute and remains in the current statute). However, by attempting to place all release decisions in the hands of the OHA, the hospital superintendent, and the treatment team, the language of SB420 directly parallels the language of the *Olmstead* decision. This relationship between SB420 and *Olmstead* may explain the reason that OHA sponsored this bill, viewing it as an approach to settle the DOJ's CRIPA investigation.

The DOJ settlements with Georgia and Delaware will most likely serve as models for a possible settlement in Oregon. In addition to giving OHA authority over the discharge of Tier 2 individuals, a settlement agreement probably will also focus on the further development of community mental health services designed for the management and treatment of forensic patients in the community (both those found IST and PSRB clients on conditional release). A focus on forensic community services would be necessary in Oregon, since the bulk of OSH's patients are referred by the criminal courts.

There is another theme at work in Oregon, one that reflects national trends in regard to state hospital facilities. Portions of both HB3100 and SB420 reflect significant opposition by community mental health advocates to the construction and staffing of a new hospital in Junction City. The opposition came from a coalition concerned with the costs of a new hospital and from those ideologically opposed to any new hospital construction (see Ref. 12). In the end, the 2011 Legislature appropriated token planning money for the second hospital and greatly reduced the number of beds planned for this facility. Beyond the scope of this discussion, but also clearly relevant, is that it is entirely possible that very soon Oregon will be left with the 600-bed OSH as its only state facility. My colleagues and I have written about the shortage of psychiatric beds, both nationally and in Oregon.²³

The argument against the construction of new state facilities is most often cast in either/or terms,

hospital versus community. Yet we know that both general hospital and state hospital inpatient beds and a robust community mental health system are necessary for a modern mental health system. Both in Oregon and nationwide, as the number of state hospital psychiatric beds has decreased, voluntary hospitalization is greatly attenuated, civil commitments decrease, and criminal court commitments increase, as does the flow of the chronically mentally ill into jails and prisons.^{24–26} This outcome should not be the unintended result of the deliberations of the Oregon Legislature or of a potential agreement between the DOJ and the state. The DOJ should not be involved either directly or indirectly in facilitating this shift of seriously mentally ill persons into the criminal justice system.

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