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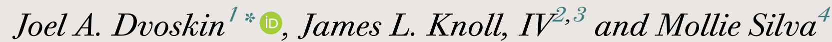
REVIEW ARTICLE

A brief history of the criminalization of mental illness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This article traces the history of the way in which mental disorders were viewed and treated, from before the birth of Christ to the present day. Special attention is paid to the process of deinstitutionalization in the United States and the failure to create an adequately robust community mental health system to care for the people who, in a previous era, might have experienced lifelong hospitalization. As a result, far too many people with serious mental illnesses are living in jails and prisons that are ill-suited and unprepared to meet their needs.

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Introduction

For a long time, mental illness was viewed not as a disease, but as a manifestation of evil spirits.[1] Confusion and apprehension have been the legacy view of mental illness, even as far back as ancient Greece. In 380 BC, Socrates wrote in *The Republic* that "The offspring of the inferior.... will be put away in some mysterious, unknown place, as they should be." During the middle ages, an obsession with evil in the form of witches became prominent. The official practice guidelines for detecting evil and witches, the *Malleus Maleficarum* (1486), assisted inquisitors in finding evil lurking amidst women, the socially disenfranchised, and those suffering from mental illness.[2] In 1494, theologian Sebastian Brant wrote *The Ship of Fools*, which detailed the phenomenon of sending away persons with mental illness aboard cargo ships through the canals of Europe and overseas. During the Renaissance (14th to 17th centuries) families were expected to care for relatives with mental illness, which often involved confinement in the home.[3] Lay concepts of evil often fuse with professional ethics of mental illness, and threaten to confound each other's ideologies.[4] Even today, there remains a deeply ingrained societal prejudice that persons with mental illness are "ticking time bombs, ready to explode into violence."[5] Thus, the primitive association between mental disorder and moral depravity has yet to be completely dissolved. The age-old concept that depravity is somehow involved in the origin of mental disease lingers in the shadows and waits to be resurrected.[6,7]

In 1656, the first Hôpital-Général was opened in Paris. These institutions were for the "insane" (sic), as well as those deemed to pose a threat to normality and progress. Within 3 years, the Hôpital-Général in Paris became home to more than 6000 people—approximately 1% of the French population. In London, the famous Bethlem Hospital began showing its patients off for a price in 1815. The hospital earned an annual revenue from this weekly event of almost 400 British pounds from 96 000 visitors who came (the equivalent today of a little more than 44 000 U.S. dollars).

Early in the 19th century, the idea of "moral treatment" came to the United States. According to Patricia D'Antonio of the University of Pennsylvania, "The moral treatment of the insane was built on the assumption that those suffering from mental illness could find a way to recovery and an eventual cure if treated kindly and in ways that appealed to the parts of their minds that remained rational. It repudiated the use of harsh restraints and long periods of isolation that had been used to manage the most destructive behaviors of mentally ill individuals. It depended instead on specially constructed hospitals that provided quiet, secluded, and peaceful country settings; opportunities for meaningful work and recreation; a system of privileges and rewards for rational behaviors; and gentler kinds of restraints used for shorter periods."[8]

Moral treatment led to the asylum movement, which was based on a belief that separation from the community, coupled with long periods of rest would allow the person

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to regain their senses and faculties.[9] It was not uncommon that a stay in an asylum lasted a lifetime, resulting in a severely restricted existence and limited exposure to life beyond the walls of the institution.[10]

Initially, the moral treatment philosophy and the asylums that practiced it were reserved for those who could afford this kind of care. In 1841, Dorothea Dix, while teaching in a Massachusetts jail, observed that a high number of inmates were not criminals, but people with mental illnesses. During the 1850s and 1860s, she traveled the country urging states to create public asylums, practicing moral treatment that would be available to people who could not afford private care. By the end of the 19th century, every state had such a public institution.[11] Unfortunately, those facilities quickly became incredibly large and overcrowded, resulting in conditions that were nothing like those envisioned by Dorothea Dix and other advocates.[12]

Clearly, the problem of criminalization of mental illness is not a new one. The reality that initially motivated Dorothea Dix to action (ie, the large numbers of people with mental illness in jails) is remarkably similar to the situation in which we find ourselves today, where the prevalence of mental illness in jails is significantly higher than for the population in general.[13,14]

From the Mid to late 1800s, public advocacy drew national attention to the plight of persons confined in institutions. Isaac Ray, founder of forensic psychiatry in the United States, advocated for clarification of civil commitment laws. Despite this, civil commitment laws were commonly misused, as in the 1860 case of Elizabeth Packard, who was committed to an institution for the insane based on an Illinois statute which allowed husbands to commit their wives for reasons other than mental illness. Many of the long-term civilly committed patients may not have been mentally ill at all. Most importantly, the effects of trauma were poorly understood. Women were especially vulnerable to psychiatric commitment when they rebelled against their husbands, including cases where the husband was physically abusive.[15]

From about the 1870s to 1920s, eugenics and biological theories of crime regarded habitual criminality as a form of intellectual disability.[16] Eugenic "segregation" in public institutions for "defectives" and "the feebleminded" was pervasive.

In the decades following the Civil War, there was a gradual return to more relaxed procedural standards and physician decision-making in terms of commitment. Psychiatric hospitalization was available only on an involuntary basis until 1881 when Massachusetts enacted the first state law that allowed persons to admit themselves voluntarily. However, the standards for admission were lax and subsequently began to receive greater scrutiny. In 1917, the Minnesota's Children's Code was enacted as a package of laws that affirmed the state's role as protector of disadvantaged children who were defined as "defectives," and thus a "public menace." The Code empowered probate judges to commit "defectives" (defined as feebleminded, inebriate, and/or insane) to state guardianship regardless of the wishes of parents or family. As wards of the state, committees could not vote, own property, or make their own medical decisions. By 1923, nearly 43 000 individuals were confined in custodial institutions for "the feebleminded." It was not until 1942 that the U.S. Supreme Court ruled that punitive sterilization was unconstitutional in *Skinner v. Oklahoma*, yet the decision left "eugenic" sterilization laws intact. By 1946, President Truman signed the National Mental Health Act—which created the National Institute of Mental Health (NIMH) and allocated government funds toward research into the causes of and treatments for mental illness.

In 1952, the antipsychotic effects of chlorpromazine (Thorazine) were discovered, and led to a much more optimistic view about the ability of doctors to treat the symptoms of psychosis. For a variety of reasons beyond the scope of this article, the promise of Thorazine exceeded its performance. The presence of severe and disfiguring side effects (especially tardive dyskinesia) led many people to resist taking this medication, and for those who did take it, the results were not always satisfactory. Nevertheless, the promise of this drug and its progeny ushered in an era of optimism that would help to fuel a movement to move people out of institutions and into the community.

That same year, the U.S. Government's Draft Act Governing Hospitalization of the Mentally Ill was published. The Draft Act proposed two criteria for involuntary commitment: (1) a risk of harm to self or others and (2) the need for care or treatment when mental illness rendered someone lacking in insight or capacity and therefore unable to seek voluntary hospitalization.

At about the same time, the treatment of people with "mental retardation" (now called developmental and intellectual disabilities) was decried as inhumane warehousing of people who posed little or no risk to public safety. The Willowbrook State School in Staten Island, NY, became a national symbol of disgrace. Among the many horrors uncovered at Willowbrook were physical violence, use of persons with intellectual disabilities for medical research without consent, understaffing, overcrowding, and a virtually complete lack of education and habilitative programs. Once these atrocities came to light, the residents of Staten Island filed a 1972 class action that was finally resolved by a consent decree in 1975. Not coincidentally, federal policy was changed by Willowbrook as well. For example, the Protection and Advocacy System for Persons with Disabilities was created in 1975, and in 1980, Congress passed the Civil Rights of Institutionalized Persons Act, which continues to hold various mental hygiene and correctional institutions accountable to this day.[17]

As the inhumane institutional conditions became clear to the public, public sentiment and eventual involvement

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of the Federal Courts made it clear that the conditions of confinement for committed psychiatric patients were going to become much more expensive. As a result, there were two powerful tides at work moving toward deinstitutionalization: human rights and money.

In 1960, attorney-physician Morton Birnbaum published a seminal article, "The Right to Treatment,"[18] advancing the "revolutionary thesis" that "each mental patient had a legal right to such treatment as would give him "a realistic opportunity to be cured or to improve his mental condition." Failing that, Birnbaum argued, the patient should be able "to obtain his release at will in spite of the existence or severity of his mental illness." Birnbaum saw right to treatment as a way to impel improved hospital treatment.[19] He advocated for a standard of care for state hospitals, which involved improvements such as better staffing ratios and ending overcrowding. He believed that such standards could be enforced (given) adequate federal funding.[20]

Change and intended reformation was the theme of this period, with Thomas Szasz publishing *The Myth of Mental Illness*,[21] and Erving Goffman publishing *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates.*[22] The 1960s to 1970s was a period of substantial sociocultural change in which civil rights took center stage. On an even grander scale, the attention to human rights occurred in the context of radical changes with regard to the civil rights of African Americans (and later other marginalized and disenfranchised groups). The Civil Rights Act of 1964 emphasized ideals of equal rights, freedom from government intrusions, the right to procedural protections when individual liberty was at stake, and outlawed discrimination on the basis of race, color, religion, sex, or national origin.[23]

Deinstitutionalization and the Decline of Civil Commitment

Thus began the process of deinstitutionalization in Western countries—the process of replacing long-stay psychiatric hospitals with less isolated community mental health services. Deinstitutionalization was driven by many factors, including:

- Socio-political movement for community mental health services.
- The advent of psychotropic medications.
- Class action lawsuits on behalf of institutionalized patients.
- The rising cost of constitutionally adequate inpatient care.
- Financial imperatives to shift costs from state to federal budgets.
- Civil rights movements that asserted constitutional rights for certain classes of people.

Civil commitment has dramatically decreased over the past 40 to 50 years. A 40-year review of case law in Oregon found that Oregon Court of Appeals rulings significantly contributed to a dramatic reduction in civil commitment.[24] Beginning in 1955, the state hospital population in the United States peaked at 550,000.[25] By 1980, it had fallen to 137,000 and to approximately 45,000 by the turn of the 21st century. Unfortunately, outpatient care did not replace inpatient care, and state mental hospitals were not successfully replaced by community based facilities. In the 1950s to 1960s, the process of replacing long-stay psychiatric hospitals with less isolated community mental health services began. In 1963, the Community Mental Health Act was passed to provide federal funding for community mental health centers in the United States and furthered deinstitutionalization. During this period, the pendulum of change swung away from the need for treatment (*parens patriae*) justification to a dangerousness standard. Washington, DC was the first to adopt a "dangerousness standard" in 1964, marking the shift from medical model of "in need of treatment" to a legal model of danger to self and/or others. Medicare and Medicaid were introduced in 1965, and provided federal funds to states for treatment of persons with mental Illness, but only if they lived in the community. This created an incentive to discharge patients to defer the cost of treatment to the federal government. Three years later, in 1969, the Lanterman-Petris-Short Act (LPS Act) was passed in California. The LPS Act endorsed voluntary treatment and repealed indefinite commitment, while including provisions for procedural protection in the case of involuntary interventions. It set a tone of reform that influenced commitment statutes across the United States.

Civil commitment saw its high-water mark set in 1972, and began its decline with two important cases, both of which took place in the early 1970s. In *Lessard v. Schmidt*,[26] the court drew strong comparisons between civil and criminal commitments. The standard of proof for civil commitment was held to be "beyond a reasonable doubt," and procedural safeguards similar to criminal commitment were mandated for Wisconsin. The U.S. Supreme Court then set the constitutional minimum standard of proof required for civil commitment at "clear and convincing" evidence. The net effect of all these changes was to reduce psychiatric hospitalization, as well as make it more difficult to involuntarily commit patients.[27]

The Role of Federal Courts

In the early 1970s, the federal courts became increasingly concerned about the unacceptable state of institutional care in some facilities. In *Wyatt v. Stickney*, Federal Court Judge Frank Johnson ruled that the conditions at Bryce (Alabama) State Hospital were so bad that they violated the due process clause of the constitution.[28]

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For example, at the time there was one psychiatrist at Bryce, serving approximately 5000 patients. Ironically, while Morton Birnbaum's goal was to drastically improve the conditions in state hospitals, other attorneys (eg, Bruce Ennis) working on the case had a very different goal: to make involuntary hospitalization prohibitively expensive. *Wyatt* was soon followed by similar suits in Louisiana, Minnesota, and Ohio.[29,30]

As Ennis and others hoped, the cost of involuntarily committing psychiatric patients skyrocketed, and the number of people housed in state hospitals began to decrease. As Birnbaum feared, however, there were not nearly enough facilities and services in the community to care for the people who were released.[1] As a result of these many forces, between 1955 and 1968, the residential psychiatric population in the United States dropped by 30%.[31] But the bright new reality promised by the Community MH Centers Act never materialized. Of the 1500 community mental health centers that were envisioned in the CMHC Act, only half were ever constructed, and most were not fully funded.[32]

The Theory of Trans-institutionalization

Trans-institutionalization is a term used to describe the proposed link between deinstitutionalization and increased rates of serious mental illness (SMI) in jails and prisons. It is based in part on the Penrose Hypothesis, which posits an inverse relationship between prison and mental hospital populations. If one of these forms of confinement is reduced, the other will increase. Penrose's hypothesis remains unresolved.[33] There are methodological problems with its study, including time points, politics, and legal reforms. Nevertheless, there is broad consensus that that people with SMI are overrepresented in correctional settings.[34] There is less agreement about what policy trends may have created this situation.[35]

The Penrose Hypothesis continues to be the subject of contentious debate.[36,37] Some 80 years after its formulation, the Penrose hypothesis has neither been rejected nor been confirmed.[38] Nevertheless, it appears to remain a credible hypothesis, not just in the United States, but in other countries as well.[39]

Investigation is ongoing, with different elements being studied to confirm or refute trans-institutionalization. For example, the term "compensation imprisonment" is used to describe a convicted person who is unable or unwilling to pay the requisite fine for a crime, resulting in a mandatory jail sentence. Compensation prisoners suffered disproportionately from SMIs, leading to trans-institutionalization and further criminalization.[39] Similarly, many people are detained in jail while awaiting trial simply because they cannot pay the required cash bail (https://www.law360.com/access-to-justice/articles/1180373/risk-assessment-tools-are-not-a-failed-minority-report-),[40] drawing a nearly straight line from poverty to incarceration. Whether trans-institutionalization or the Penrose Hypothesis is confirmed or not, there is general agreement that the correctional system was never intended to care for persons with SMI, and has had largely negative effects on this vulnerable population.

To be sure, for many of the folks who would previously have been hospitalized for life, their life in the community was better. Many were able to get psychiatric and psychological assistance from CMHCs, many were able to live with families, and many were able to maintain steady employment.[41] But for many others, life in the community resulted in a barrage of bad outcomes, including unemployment, homelessness, and victimization. More importantly for the purposes of this chapter, many of the people who would have formerly remained in psychiatric hospitals were now vulnerable to the vagaries of the criminal justice system.[42]

Fisher et al[43] found that "individuals with mental illness had significantly higher odds of having at least one arrest across all charge categories, often for misdemeanors."

The Growth of Incarceration

It is impossible to discuss the increase in incarceration rates for people with SMI without discussing the massive increase in incarceration rates in general throughout the United States. From 1970 until the present, there has been a sea change in the manner in which the United States has responded to fear of crime, especially crimes involving interpersonal violence and illegal drugs. The growth of American corrections has been astronomical, from about 200,000 in 1970 to 1.6 million today, this despite the lack of any significant change in the levels of violent crime during the same period. The reasons for this dramatic increase include: (1) political strategies to gain power by claiming to be "tough on crime"[44]; (2) a handful of high profile murders committed by recently released prisoners, especially Willie Horton[45]; (3) a misguided "war on drugs" that unsuccessfully sought to alleviate a perceived epidemic of addiction by incarcerating addicts[46]; and (4) a shift in criminal justice policies that removed discretion from judges, who exercised discretion in the light of day, to prosecutors who made charging decisions behind closed doors.[47]

The growth of corrections populations especially affected people with SMIs, many of whom had co-occurring substance abuse problems, and a high percentage of whom were living in communities of poverty.[48-50] Communities of poverty that have higher

[1] Unfortunately, in 1981 the Omnibus Budget Reconciliation Act consolidated federal funding, and shifted treatment costs back to states. As a result, the funding of community-based mental health services was significantly curtailed.

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levels of violent crime place people with mental illness in jeopardy of being victimized, and there has been substantial co-variation between victimization and violent offending that can land a person in jail.[51]

In 1986, Willie Horton, a convicted murderer serving a life sentence without parole, was allowed a weekend furlough from his Massachusetts prison. Instead of returning from his furlough, Horton committed a number of serious crimes, including armed robbery and rape, before being arrested in Maryland. It is widely believed that this incident effectively scuttled the 1988 presidential campaign of Michael Dukakis, who was the Governor of Massachusetts during this episode. "Tough on crime" (or more accurately, "Tough on criminals") had moved from a political slogan to an essential stance for anyone seeking elective office.

It is important to understand that all crimes are not equal. The relationship between SMI and crime is complicated and grossly misunderstood.[52,53] For example, use of the phrase "violent crime" is so vague as to be misleading. In some studies, it is considered a violent crime to push or shove a family member, just as it is considered a violent crime to take someone's life. What we now know is that the majority of crimes committed by people with SMI are of the former type, pushing and shoving family and friends.[54,55]

It is a matter of wide consensus that the reduction in long-term psychiatric hospital beds dramatically increased the number of people with SMI who live in the community. It is equally clear that as the number of people incarcerated in the United States has risen, so has the number of inmates and detainees with SMI. What is less clear is the extent to which mental illness itself has become criminalized. Peterson, Skeem, Hart, Vidal, and Keith tested the criminalization hypothesis in a study of 220 parolees with and without SMI. Interestingly, they found that "a small minority (7%) of parolees fit the criminalization hypothesis," in that their crimes were the result of either psychosis or minor, "survival crimes" related to poverty. For both groups, crime was chiefly driven by "hostility, disinhibition, and emotional reactivity." They concluded, "Offenders with SMI manifested heterogeneous patterns of offending that may stem from a variety of sources. Although psychiatric service linkage may reduce recidivism for a visible minority, treatment that targets impulsivity and other common criminal needs may be needed to prevent recidivism for the larger group."[55]

Jeffery Draine came to a similar conclusion: "Conceptualizing mental illness too generally as a cause of criminal involvement is not useful for policy or service implications. Such a strategy decontextualizes the experience of people with mental illness from broader incarceration patterns in the United States. When the reasons for which people go to jail or return to jail are examined, it becomes clear that the key issues are social difficulties complicated by mental illness—but not caused by mental illness."[56]

Despite a great deal of rhetoric associating SMIs with violent crime, this alleged association is consistently belied by research data. That being said, there are other, predictable consequences of undertreated psychosis, including homelessness, living in distressed and often violent neighborhoods, unemployment, hunger, and victimization; all of which are well known criminogenic factors.[57–59]

It is important to distinguish between at least three types of crimes when discussing people with SMI. A small number of seriously violent crimes that truly endanger the public are committed by people with SMI.[60–62] Further, the characteristics, situations, and stressors that lead to those crimes are in most cases similar for people with or without SMI. For nondangerous acts, even those that are technically counted as violent (eg, pushing or shoving), the necessity of confinement, especially long-term confinement, is dubious, and there is little evidence that it is effective. Long stays in hospital or jail tend to disrupt those parts of a person's life that are working, so that they might lose a job or an apartment, making things worse instead of better.

Crimes of survival are especially vexing when managed by the criminal justice system. For example, a homeless person who has no address may be unable to get disability checks; when such a person steals food, not a single ostensible purpose of criminal justice is served by sending them to jail. There will be no deterrence; hungry people will beg or steal food if they have no other option. It would be kinder and infinitely cheaper to give them a box lunch every day than to lock them up in jail.

On the other hand, some people with SMIs do commit serious crimes of violence. For the relatively small number of people with SMI who pose a serious threat to public safety, at least some type of involuntary confinement—whether in psychiatric or correctional institutions—will continue to be necessary. Prior to deinstitutionalization, that would have likely meant a long stay in a psychiatric hospital.

But humane psychiatric hospitals are expensive, costing hundreds of thousands of dollars per bed to build and almost as much annually to operate. As local, state, and federal budget crises have exploded, governments are increasingly seeking ways to save money, and the threshold for hospital care has risen. Those who cannot gain access to inpatient hospital beds are now housed in large numbers in local jails and state prisons across the United States.

The solution does not mean a return to the vast expense of massive long-term hospitalization. A host of examples have proven that most people with SMI can live safely in the community if they have access to housing, necessities, as well as varying levels of support, structure, scrutiny, supervision, and services, but only to the degree that they are actually necessary. For example, the best

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community mental health care costs much less than a state hospital bed or a jail or prison bed for a person with a mental disability. One good example is Forensic Assertive Care Teams, which provide high intensity treatment and case management for people with SMI who have been involved in the criminal justice system.[63]

Corrections as the New Asylums

In 1974 and 1975, Robert Martinson published findings suggesting that treatment programs in New York State prisons had failed to reduce recidivism.[64] The Martinson Report helped set off a national debate over the report's implication that "nothing works." Ironically, "Martinson's intention was to improve prison rehabilitative programs, but not to give up on them. He thought that his well-publicized skepticism about rehabilitation would empty most prisons."[65] Instead, it was asserted that inmates must necessarily have the proper internal motivation and commitment to be able to benefit from programming which should not be mandatory. Finally, their release from prison should be based on an objective schedule, and not on an arbitrary, subjective determination as seen in indeterminant sentencing. Society turned to embrace new, more punitive correctional philosophies, which reflected public demands and concerns about safety. The Martinson report sparked the end of the "medical model" of corrections, and ushered in an era of explicitly punitive and retributive criminal justice policies.[66]

Diminishing liberal attitudes and increasingly conservative politics in the 1980s helped to usher in a renewed societal desire for punishing offenders and "getting tough" on crime. Society had lost faith and interest in promoting correctional rehabilitation. Rather, the "certainty" of a punitive model became attractive in as much as it appeared to ensure that offenders received their "just desserts." Indeterminate sentences were replaced by fixed determinate sentences, with the ultimate outcome being that incarceration rates increased significantly. Correctional facilities began to fill beyond their capacities and the United States' move toward mass incarceration had begun.[65]

It was during the era of the Retributive Model that the number of mentally ill persons in jails and prisons began dramatically increasing. Correctional facilities began to house mentally ill persons in record numbers, and became "the new asylums." Research conducted over the last two to three decades clearly shows that the rates of SMI, such as schizophrenia and mood disorders, are three to six times greater in the prison population than in the community at large.[67] The present-day dilemma is that jails and prisons were not prepared to provide services to the large numbers of mentally ill inmates in their facilities. The incarceration of large numbers of mentally ill persons has led to the challenge of providing quality psychiatric care within facilities that are oriented primarily toward security and custodial care. Caring for people with serious and disabling mental illnesses in corrections places a significant financial burden upon state governments, and is a poor long-term financial strategy.[68] Nevertheless, until adequate community resources and innovative alternatives (eg, jail diversion and mental health courts) are established in much greater numbers, mental health services in corrections will remain a pressing and obligatory duty. This duty is commonly ensured via litigation and class action lawsuits because correctional facilities tend to be reactive to deficiencies. As a result, change comes mainly through legal action. Individual cases may be litigated, or they may be settled with settlement agreements or consent decrees.[69]

Why Correctional Institutions Are Harmful to People with Mental Illnesses

The mental health system has been "re-created" inside U.S. jails and prisons at considerable cost and effort, to treat the rising numbers of inmates with SMI. Patients with SMI require competent, well-coordinated mental health treatment. Treatment in a correctional environment presents many unusual challenges and stresses. Unfortunately, if patients are to fare well in this new corrections-based mental health system, they must adapt to it. They must make its ways their own, and many of these customs are contrary to what most in free society would consider psychologically healthy. Patients with SMI, along with all inmates, must undergo a process of "prisonization," the success of which can be measured by how closely they can come to resemble other inmates in their attitudes and behaviors. As can be imagined, many of these new behaviors would be maladaptive upon re-entry into the community. Some of the effects of prisonization on inmates with SMI include:

- Overreaction to perceived "disrespect."[70]
- Reluctance to discuss problems.
- Preference for isolation (impaired ability to trust).
- Reliance on verbal threats or intimidation.
- Medication noncompliance.
- Manipulation to achieve goals.
- Increased disciplinary infractions.[71]
- Increased likelihood of restrictive housing.[72]
- Increased likelihood of recruitment into gangs.

During society's renewed interest in punishment and retribution over the past several decades, the lay public may sometimes have the misimpression that prison life is too comfortable and affords too many privileges to inmates. To the contrary, "Life, in even the kindest of prisons is truly punishing."[73] While the barbarous practices condemned by John Howard may no longer exist, life in today's prisons is neither privileged nor comfortable. At the very core of the

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experience of incarceration is the inescapable deprivation which is most punishing.[74] It is difficult for many in free society to conceptualize life in a "total institution," cut off from loved ones, friends, and other supports most may take for granted. In a total institution, one is removed from society, and utterly subject to an "administered" form of living.[75] Thus, it is not necessarily the deprivation of material possessions that produces the greatest suffering. Rather, it is the isolation from society and the lack of control over one's basic life circumstances which is most punishing.

Through prisonization, inmates adapt to an institutional way of life that requires less independent thinking, fewer complicated decisions, and less healthy interpersonal emotional connections. Due to the relentless structure and repetition, it is not uncommon for seemingly trivial circumstances to take on critical importance in the eyes of inmates. Clinicians must remain sensitive to this fact. The new generation of correctional mental health professionals must be fully cognizant of the fact that unwritten rules govern inmates' code of conduct. They must adapt not only to official prison rules, but also to the rules of the inmate subculture, the effects of which may have a direct impact upon the success of their treatment plans. For example, the phrase, "Do your own time" could almost be considered a sacred mantra among inmates. It refers to keeping one's affairs to oneself, and not interfering in the affairs of others. In doing so, inmates hope to spend their prison time with the least amount of interpersonal conflict, avoid disciplinary infractions, and steer clear of intraprison retribution. Other unwritten codes of inmate conduct involve avoiding displays of emotional "weakness," which ultimately encourages emotional isolation, even from fellow inmates. The code also demands that the inmate show primary allegiance to other inmates, and general distrust of correctional officers. "Ratting out" a fellow inmate to correctional staff may cost an inmate his or her life, or at the very least cause them to live an anxious, paranoid existence.

All of these learned behaviors are antithetical to living in treatment settings, or even one's family in the community, leaving offenders with more problems than they had before their incarceration.

Theories of Punishment

The basis of punishment may be generalized into four different underlying principles: rehabilitation, restraint, retribution, and deterrence.[76] Of note,only one of the four is ostensibly related to "bettering" the state of the offender.

Particularly, after the fall of the medical model, the notion of "rehabilitation" lost its appeal to many. Thus, the primary objection to rehabilitation is the assertion, perhaps premature, that it simply does not work. Supporters of this argument point to a wealth of data on the high degree of recidivism among offenders to bolster their claims. In addition, it can be persuasively argued that the very nature of the prison system runs counter to the goal of rehabilitation. For example, locking a criminal up with other criminals can be compared with requiring an individual who has engaged in terrorist attacks to associate only with other terrorists. The conclusion of this line of logic is clear: prisons increase rather than decrease the criminal propensities of inmates. Finally, some argue that it is unjust to use scarce public resources to rehabilitate individuals who have demonstrated their disregard for lawful behavior with recidivism.

Restraint refers to the act of removing offenders from society to prevent them from committing further crimes. The length of restraint will depend upon the danger that offenders appear to present to society, and whether they are amenable to some lesser form of restraint. Whether restraint should be coupled with rehabilitation and to what degree is a perpetual source of debate. Specifically, those arguing in favor of rehabilitation point out that confinement without meaningful rehabilitation merely defers criminal conduct until the inevitable release from restraint.

Retribution aims to literally "pay back" the harm to the offender who caused it. The obvious objection to retribution is that it is barbarous and not compatible with enlightened civilization due to the fact that it often involves doing some harm to the offender, either mentally or physically. Those in favor of retribution often argue from a moralistic standpoint, and/or a belief that institutionalized retribution is necessary to prevent private or personal retribution. Yet philosophical arguments aside, society has made itself abundantly clear in this matter—it demands some form of retribution.

Legal theorists generally speak of two types of deterrence—individual and general deterrence. Individual deterrence has as its goal precluding further criminal activity by that particular defendant who is before the court. The theory behind general deterrence is that punitive sanctions imposed on a single criminal will dissuade others with similar propensities. It is not uncommon for judges (who may be up for re-election) to proclaim they are handing down a particularly harsh sentence to "make an example" of one offender, and thereby serve as a "general deterrent" to others who might commit the crime at issue. Critics of general deterrence argue that most prospective criminals are more or less unaware of sentences that the courts are imposing. Further, even those who are aware do not tend toward thoughtful, cautious reflection on the risk/benefit ratios of their actions. The counterpoint is simply the reverse; that the certainty of harsh punishment does in fact influence their thinking to some degree, an argument frequently used in support of the death penalty.

In summary, decisions regarding punishment are extremely complex. Yet punishment alone as resolution

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to society's "crime problem" seems lacking. Indeed, this may be because in reality, it is inaccurate to say that the United States has a "crime problem"; rather, we have a number of very different people who engage in antisocial conduct for a number of different reasons, and to achieve a number of different outcomes.

The job of corrections is made more difficult by the fact that society appears to have abandoned the concept of formal rehabilitation, and is likely to express outrage when prisons subjectively appear to be too pleasant or comfortable. Conversely, society reacts with horror when riots, suicides, and prisoner abuse confirm appalling prison conditions. These sentiments constitute the essence of the conflicting message that society gives corrections: transform, but do not rehabilitate; cure, but do not treat; salvage, but do not restore.

Jails

Jails, sometimes referred to as County Houses of Correction, confine persons who are awaiting trial (pretrial detainees) or offenders (in most states) serving a sentence of (typically) one year or less.[70] Federal jails are often referred to as Metropolitan Correctional Centers, and house inmates who are serving short sentences or awaiting trial on federal crimes. In reality, there is no one standard type of jail due to the fact that they vary in size and function across the country.[71] They range from massive facilities in urban areas to small "lockups" or "drunk tanks" in sheriff's stations. Functions range from the initial stop for police after arrest to the last resort for people who are homeless or mentally ill. Since jail inmates are often "fresh off the street," intoxication and/or mental illness may be in the acute stages. The initial booking and admission to jail is frequently a stressful and traumatic experience for a new inmate. These factors are thought to contribute to the high rate of suicide seen in jails.

Jail populations are complex and varied, consisting of both sentenced and unsentenced offenders. Pretrial detainees and offenders serving a year or less make up the majority of jail inmates. Other jail inmates include: probation/parole violators, convicted but presentencing offenders, and offenders waiting for transfer to prison. The jail population is rather transient due to a high turnover among the population. The typical jail population turns over 20 to 25 times per year, vs the prison population which turns over once every 2 years.[72] The high turnover presents a challenge to mental health staff who may have little time to develop a rapport, treatment plan, or even discharge plans for the jail inmate.

Jails across the country have been sued over a variety of unconstitutional conditions, especially in regard to their inadequate mental health services. In a similar way, the U.S. Department of Justice Civil Rights Division has conducted many investigations of local jails, the vast majority of which result in settlement agreements (https://www.justice.gov/crt/rights-persons-confined-jails-and-prisons).

Prisons

Prisons are correctional facilities that confine offenders who are serving sentences in excess of one year. They are operated at both the state and federal levels. State prisons typically confine offenders who are found guilty of violating state criminal statutes. Federal prisons generally hold offenders found guilty of federal offenses such as tax fraud, international drug trafficking, or crimes involving federal property. Federal prisons are operated by the Federal Bureau of Prisons. Compared to jails, prisons generally house larger numbers of inmates. There are far fewer prisons in the country than jails. Prisons range from large high security complexes to smaller rural facilities or camps. By the time offenders arrive in prison, most have either spent time in jail, or have had some prior confinement.

Prisons across the country have been sued for a variety of unconstitutional conditions, frequently regarding inadequate mental health services.[77] State prisons now have a great deal more forced idleness, and far too many inmates with SMI still find their way into restricted housing, despite federal court cases in CA, NY, WI, MS, and many other states.

Prison Overcrowding

Beginning in the 1970s, state and federal prison populations began a steady increase with no reprieve. By 2005, 24 state prison systems were operating at or above their highest capacity, and the federal system was 40% over capacity.[78] The conditions caused by overcrowding resulted in a steady wave of litigation and consent decrees aimed at resolving the problem. However, the prison population has continued to soar, and has reached approximately 2.1 million in prisons and jails, with another 5 million in probation and parole programs.[79]

Prisons may struggle with overcrowding in different ways. For example, some prisons may attempt to double and triple bunk the usually small, 8×10 ft. cells intended to house single inmates. When limited cell space has been exhausted, it is common for inmates to be assigned to mattresses lining the hallways outside of cells. Some prisons are able to assemble prefabricated trailers or tents on the prison grounds for housing the population overflow. Those prisons unable to afford such amenities may have to resort to using gym, education or dayroom space for housing, which results in these services becoming nonoperational.

In addition, the close quarter living conditions that overcrowding produces facilitates the spread of

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communicable diseases such as Tuberculosis and Hepatitis.[80] Viral respiratory and gastrointestinal illnesses spread easily in poorly ventilated, crowded prison housing areas. Huey and McNulty[81] have theorized that overcrowded conditions may increase the risk of prison suicides. Thus, the adverse effects of prison overcrowding are manifold, ranging from basic health to basic institutional functioning.

In *Brown v. Plata* (2011),[82] the U.S. Supreme Court issued a five to four decision that is the court's most important decision impacting correctional health care at least since *Farmer v. Brennan*[83] in 1994. The Court upheld the lower courts' decision to require a total prison population not to exceed 137.5% of rated capacity within a 5-year period of time. This involved a reduction of some 46 000 prisoners, but California was allowed to transfer some inmates to local jails, provide for enhanced good time credits leading to a somewhat earlier release, or even build new facilities. In sum, the doors to California's prisons were not suddenly opened.

The overcrowding was linked to the cause of inadequate health care, including mental health care. Its relief, then, simply cleared the path to hiring adequate numbers of treatment staff, creating an adequate number of beds that were varied as to the conditions treated, and assuring reasonable access by eligible inmates to staff and bed space.

California's prison reduction, which decreased its census by 15,493 persons from 2010 to 2011, constituted the most significant prisoner reduction in the nation in that period. A "Realignment" plan, effective October 1, 2011, now promises to be the most ambitious correctional reform in the nation, and with a significant impact on health care. Realignment transfers significant numbers of convicted felons from the state prison and parole systems to the state's 58 counties. This includes nearly all drug and property crimes.[84] Jails accustomed to providing pretrial detention or relatively short-term incarceration now house offenders serving as many as 10 years, which means chronic health and mental health care is on the agenda, and despite some state funding, the jails seem remarkably unprepared as to physical plant, staffing, training, and culture. In short, jails and prisons are counter-therapeutic for people with SMIs.

As evidenced by overcrowding, the lack of programming, inadequate education, and mental health services, it is easy to see why it is frequently alleged that mass and long-term incarceration has been an ineffective way to change criminal behavior. Indeed, it has been argued that current criminal justice policies make offenders worse instead of better.[85] Dvoskin et al wrote:

> "An objective look at today's criminal and juvenile justice programs reveals the sad truth: If this were a boxing match, there would be an investigation, because it looks like we are trying to lose. In the United States, billions of dollars are spent annually on a punitive system that consistently fails to increase public safety. Given our policy of mass incarceration, generations of minority children are growing up without a father in their home. Money that could be spent on community development and the creation of jobs is being poured into the construction and operation of prisons."[85]

What Do We Do Now?

Whatever its etiology, there is little debate that the United States incarcerates a very large number of people with SMI, people whose mental health needs would be better served in mental health settings.[86] It is equally clear that there seems to be little about the experience of incarceration that reduces their likelihood of future crime. If the United States is to successfully reduce its reliance on jails and prisons as the locus of treatment for people with SMI, a number of changes will be needed.

First, the sheer number of incarcerations and detentions, especially for offenders who pose no significant threat to public safety, needs to be reduced. Reducing the number of inmates could free up more money for correctional programs that are aimed at criminogenic factors.

Second, for those inmates with SMI who truly need to be incarcerated, there must be an investment in adequate mental health care for the duration of their confinement. Even if mental illness was not the cause of the person's criminal behavior, untreated mental illness in jails and prisons will prevent inmates and detainees from participating in correctional and educational programs aimed at criminogenic factors. Substantial numbers of inmates with and without SMIs have experienced significant trauma. Evidenced-based therapies to address inmates' psychological and emotional problems should become a priority in corrections.[87]

Third, it is essential that law enforcement and mental health agencies be given more and better options for dealing with people in crisis. Unreasonably low rates of Social Security Disability payments mean that many people with SMI will remain homeless. People in crisis need a place to go that is safe, such as drop-in centers and crisis residences. When police officers have options other than jail or emergency rooms, they use them.[88–91]

Fourth, the all-or-nothing rhetoric about reopening vast, long-stay institutions is a waste of energy. Even if such institutions were a good idea, they would be prohibitively expensive. But that does not mean that we have enough inpatient beds to adequately respond to short-stay crises. The dearth of acute inpatient beds has nothing to do with the horrors of psychiatric "warehouses" of the past.

Fifth, the vast majority of incarcerated people will eventually be released. When prisons are overcrowded

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and lack adequate mental health care, the criminal justice system has arguably made them worse instead of better.

Sixth, the current system of prosecutorial discretion provides no incentives for prosecutors to drop charges in cases of incompetent misdemeanor or minor felony defendants. One of the authors (J.D.) served as an independent expert in a class action involving incompetent defendants who remained in jail waiting for a bed in a psychiatric center. In a shocking number of cases, the underlying crime was extremely minor (eg, driving without a license or stealing a sandwich), yet the person had been in jail for months waiting for an inpatient restoration bed, then spent months in an inpatient bed, before being returned to court to stand trial, whereupon they were released with "time served." The person who stole a sandwich because he was hungry lost his freedom for as long as a year, at a cost of more than $100 000 taxpayer dollars, all for the want of a $3 sandwich.

Finally, as Lamb and Weinberger have suggested, it is important to remember that the vast majority of incarcerated people, including those with SMI, will eventually be released into the community:

> "The long term consequences of society's choice to use the criminal justice system and corrections as the new asylums have undeniably arrived, and require a thoughtful, evidenced based approach by multiple stakeholders. The present-day reality is that large numbers of persons with SMI are being released in the community, and it is critical that they receive the public sector mental health care they need. Important options to consider for this population upon re-entry include: diversion and mental health courts; the expectation that the mental health system will not avoid such patients; the capabilities, limitations, and realistic treatment goals of community outpatient psychiatric treatment; the use of involuntary commitment (both inpatient and outpatient), appropriately structured, monitored, and supportive housing; and implementation of workable violence prevention plans."[92–95]

Conclusion

The role of SMIs (especially psychoses) in violent crime has been exaggerated in the media. Research has demonstrated that mental illness itself accounts for a small percentage of violent crime in the United States, and that people with mental illnesses often commit crimes for the same criminogenic reasons as people without SMI. That being said, the combination of deinstitutionalization and inadequate community mental health and housing resources have clearly placed huge numbers of people with SMI in jeopardy of coming into contact with the criminal justice system. Homelessness is especially pernicious, and contributes to poor clinical outcomes and increased likelihood of crime. As a result, we have hundreds of thousands of people with SMI in jails and prisons that are ill-suited to meet their mental health needs.

At least some solutions to this problem are clear[96]:

1. Jails and prisons should be reserved for those offenders who truly pose a serious risk to public safety.
2. Community mental health centers should be adequately funded, so that anyone who needs treatment for their SMI can have access to timely and competent care.
3. Communities must invest in short-, intermediate-, and long-term housing for people with SMIs.
4. Police officers and other first responders must be trained (eg, Crisis Intervention Teams and Mental Health First Aid) in how to identify and respond to symptoms of mental illness and emotional crisis, more importantly, communities must create user-friendly options for people in emotional crisis.
5. While there are excellent reasons to avoid a return to long-term hospitalization of large numbers of Americans, there must be an adequate number of beds (in a variety of more or less restrictive settings) to provide short-term and crisis stabilization of people with SMIs during periods of extreme exacerbation that might otherwise be likely to land them in jail or prison.
6. For those people with SMI who truly pose a serious risk, and whose crimes were not the direct result of their illness, jails and prisons must provide adequate mental health services.
7. For offenders who are diverted or returned to the community, treatment programs must attend to both mental health and criminogenic factors.[97]

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Disclosures

The authors declare no conflicts of interest.

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