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Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illnesses in the Criminal Justice System?

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Abstract Although there is broad consensus that people with serious mental illnesses (SMI) are overrepresented in correctional settings, there is less agreement about the policy trends that may have created this situation. Some researchers and policymakers posit a direct link between deinstitutionalization and increased rates of SMI in jails and prisons, a phenomenon described as *transinstitutionalization*. Others offer evidence that challenges this hypothesis and suggest that it may be a reductionist explanation. This paper reviews claims from both sides of the debate, and concludes that merely increasing access to state psychiatric hospital beds would likely not reduce the number of people with SMI in jails and prisons. A more nuanced approach is recommended for explaining why people with SMI become involved in the criminal justice system and why developing effective strategies to divert them out of jails and prisons and into community-based treatment is needed to improve both their mental health and criminal justice outcomes.

Keywords Deinstitutionalization · Mentally ill offenders · Incarceration · Correctional institutions · Community mental health services · Jail · Prison

Introduction

The popular account of why people with serious mental illnesses (SMI) are overrepresented in jails and prisons is usually structured as follows: deinstitutionalization, combined with inadequate funding of community-based treatment for individuals in need of mental health services, has led to the criminalization of mental illness and attendant increases in incarceration rates (Earley 2006). This represents a return to the conditions that psychiatric institutions were originally designed to alleviate (Earley 2006). Indeed, the mainstream assumption that the state psychiatric hospital and criminal justice systems are functionally interdependent (Steadman et al. 1984)—a phenomenon described as *transinstitutionalization*—is commonly accepted. The policy question one might reasonably derive from this account, however, is rarely posed: Would increasing the number of state psychiatric beds (i.e., reinstitutionalization) reduce the number of people with SMI in jails and prisons?

The answer to this question depends on whether the transinstitutionalization hypothesis is an appropriate causal inference, and this matter is subject to disagreement. Many researchers and policymakers believe that the closing of state psychiatric hospitals effectively placed thousands of people with SMI on the street with nowhere to go and inadequate community treatment options. Jails and prisons became de facto treatment facilities (Stephey 2007) because transferring people from structured long-term inpatient services to lower levels of care (or no care) in the

Points of view or opinions expressed in this article are those of the author and do not represent the official position or policies of the Council of State Governments Justice Center or its members.

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community is not effective for the majority of people leaving these facilities (Lamb and Weinberger 2005b). Some conclude that increasing the availability of state psychiatric hospital beds would thus prevent most people with SMI from coming into contact with the justice system altogether.

Critics of the transinstitutionalization hypothesis suggest that formerly institutionalized individuals and currently incarcerated people with SMI are clinically and demographically distinct populations, and that other factors (such as high arrest rates for drug offenses, lack of affordable housing, and underfunded community treatment) better explain the influx of people with SMI into jails and prisons (Osher and Han 2002). These observers argue that increasing the availability of state hospital beds would have a marginal impact on prevalence in jails and prisons. To invest in reinstitutionalization, they suggest, would represent an expensive misallocation of resources because most of the people with SMI in jails and prisons today could indeed succeed in community settings (excluding, of course, those who truly belong in jail and prison based on the nature of their offenses) with the proper services and supports.

The Scope of the Problem

Though researchers disagree about the transinstitutionalization hypothesis and potential solutions to the problem, there is broad consensus that people with SMI are overrepresented in the criminal justice system and that correctional facilities are not ideal treatment settings (Council of State Governments 2002). Recent prevalence estimates suggest that 14.5% of men and 31% of women booked into jails have SMI—rates 3 to 6 times those in the general population (Steadman et al. 2009). Findings are similar among prison populations (Ditton 1999; James and Glaze 2006; Pennsylvania Legislative and Budget Finance Committee 2007). It is also widely accepted that *involvement* in the criminal justice system for this group is more accurately described as *entrenchment*. They stay incarcerated longer, are less likely to be approved for community supervision, and are up to twice as likely to have their probation or parole revoked and return to jail or prison than others charged with similar offenses (see Prins and Draper 2009).

Acknowledging this problem, policymakers from criminal justice and mental health systems across the country are developing strategies to divert people with SMI from jails and prisons into community-based treatment when it is deemed appropriate based on the nature of their charges or offenses. The federal government has appropriated \$38.5 million from 2006 to 2010 for state and local grants to fund

these efforts under the Mentally Ill Offender Treatment and Crime Reduction Act of 2004, and a handful of states have followed suit with their own statewide grant programs (Council of State Governments Justice Center 2010; Florida Statute 2007). Jurisdictions have used this funding to establish law-enforcement-based interventions that divert people with SMI into treatment in lieu of arrest, problem-solving court models that mandate treatment in return for charge reduction or dismissal, enhanced transition planning from jails and prisons to the community, and specialized probation and parole supervision models to reduce recidivism rates for people with SMI following adjudication. (Osher and Steadman 2003; Prins and Draper 2009; Schwarzfeld et al. 2008; Thompson et al. 2008).

But despite all of this policy and programmatic activity, the scope, scale, and relative novelty of such interventions is such that overall rates of SMI in jails and prisons do not appear to be decreasing, given prevalence estimates obtained in the 1990s (for example, see Abram and Teplin 1991; Teplin 1990a, b, 1994; Teplin et al. 1996). As federal and state officials respond to the overrepresentation of people with SMI in the criminal justice system (in addition to unprecedented incarceration rates more generally: The Pew Center on the States 2008), their understanding of the role of deinstitutionalization may well influence the allocation of mental health and criminal justice resources.

Deinstitutionalization: Key Considerations

The public mental health system's shift from a nearly exclusive focus on psychiatric hospitalization to the nearly exclusive provision of community-based treatment (Council of State Governments, 2002) has been explored in depth elsewhere (for example, see Frank and Glied 2006; Geller 2000; Koyanagi 2007). Between 1955 and 1975, before the term *deinstitutionalization* had appeared in the literature, the percentage of treatment episodes that took place in state psychiatric hospitals dropped from 77 to 28% (Geller 2000; Frank and Glied 2006) and between 1955 and 2000, the number of state psychiatric hospital beds dropped from 339 per 100,000 to just 22 per 100,000 (Lamb and Weinberger 2005b).

But some scholars take issue with the term *deinstitutionalization*, and deny that such a process actually occurred (Geller 2000). Although there was a policy effort between roughly 1955 and 1980 to shift the locus of care from state hospitals to newly created community mental health centers (Geller 2000; Koyanagi 2007), this was achieved for only a small percentage of treatment episodes; what actually happened was a transfer of many patients from psychiatric hospitals to general hospitals and nursing

homes (Geller 2000; Frank and Glied 2006; Koyanagi 2007). This was facilitated by the arrival of Medicaid in 1965, which enabled states to shift a portion of the cost of mental healthcare to the federal government (Frank and Glied 2006). By 1980, 750,000 people with mental illnesses lived in nursing homes, representing 44% of the nursing home population (Koyanagi 2007). It was not until the 1990s that entire state institutions began to close, people with mental illnesses began to focus on their right to community integration, and more state-controlled mental health dollars were allocated to community care than to hospitals and nursing homes (Koyanagi 2007).

In addition, the population served by state psychiatric institutions in the past 20 years has become increasingly forensic (i.e., they have been referred by the criminal justice system). In the early to mid-1990s the proportion of public psychiatric hospital beds occupied by forensic patients had increased to between 41–61% in some states (Linhorst and Turner 1999). More recently, Manderscheid et al. (2009) found—for the first time since 1955—an increase in the census of state psychiatric hospitals, which agency staff attributed to the influx of forensic patients. The authors report that more than half of the beds in some state psychiatric hospitals are occupied by this population, and that new state hospitals have been built exclusively to serve them.

It is clear that deinstitutionalization plays a more complicated role in explaining the large number of people with SMI in jails and prisons than the common account described at the outset, and two distinct positions can be gleaned from the literature.

The Argument That Transinstitutionalization Is Real

As stated earlier, the rationale for increasing access to state psychiatric hospital beds to reduce the number of incarcerated people with SMI is that deinstitutionalization released a flood of people to inadequate community-based treatment, which led to a drastic increase in deviant behavior in the community to which the criminal justice system was forced to respond (Abramson 1972). Funding for community-based services promised in the early years of deinstitutionalization was slow in coming and some commentators have argued that even if funds were adequate, these types of services do not actually provide the level of care that a sizable minority of this population requires (see Pepper et al. 2000).

Lamb and Weinberger (2005b), proponents of increasing the availability of what they term “24-hour structured care,” suggest that jails and prisons, in effect, serve the role of psychiatric inpatient services. During the same period that the number of state hospital beds dropped from 339 per 100,000 in 1955 to 22 per 100,000 in 2000, the total

number of inmates (including those who had SMI) shot up from 209 per 100,000 in 1978 to 708 per 100,000 in 2000, or roughly 2 million people (Lamb and Weinberger 2005b). If, according to the national estimates used by the authors, the percentage of incarcerated people with SMI was approximately 16%, then over 300,000 people in jails and prisons had SMI in 2000 (Lamb and Weinberger 2005b). Lamb and Weinberger’s argument is that the number of incarcerated people with SMI in 2000 was equivalent to half of all people under local, state, and federal custody in 1978, and that it is unlikely that half of the jail and prison population at that time had SMI. They conclude that it is people with SMI who would normally be institutionalized (if beds were available) who are now entering the justice system (Lamb and Weinberger 2005b).

Two reasons cited for this transfer of individuals from psychiatric institutions to jails and prisons are particularly relevant to the current discussion. First, deinstitutionalization reduced the ability of the mental health system to provide intermediate and long-term care for people with SMI who frequently require acute psychiatric hospitalization (Lamb and Weinberger 2005b). In a different study, Lamb and Weinberger (2005a) show that, of individuals who were discharged from a locked intermediate care facility in California to lower levels of care in the community, more than half could not function in the community without repeated and lengthy hospitalizations or returns to the intermediate care facility. Another study in Vermont demonstrated that 87% of people released from a state psychiatric hospital were re-hospitalized for periods ranging from 3 months to 1 year (Deweese Pulice and McCormick 1997). Second, though there is evidence that community-based interventions such as intensive case management and assertive community treatment may be effective for some individuals with SMI, they are not sufficient to maintain all people with SMI in community settings (Lamb and Weinberger 2005b).

Thus, some commentators argue that there exists a group of individuals with SMI who are resistant to community-based treatment and who would otherwise reside in inpatient psychiatric facilities if enough beds existed. For this group, there is a functionally interdependent relationship between the criminal justice system and the mental health system and if it is a goal to reduce the number of these individuals in jails and prisons, 24-hour hospital care must be a readily available resource.

The Argument That Transinstitutionalization Is Spurious

Observers on the other side of the debate grant that the negative correlation between psychiatric hospital closures

and the prevalence of SMI in jails and prisons is undeniably strong, but argue that the relationship between these trends is more apparent than real. They suggest that arguments citing shifting hospital bed and inmate counts are conjectural and do not demonstrate a transfer of people with SMI from state psychiatric hospitals to jails and prisons. At least three reasons are cited for this misinterpretation.

First, these commentators argue that deinstitutionalization did not create a flood of people suddenly on the streets. As Steadman et al. (1984) note: “Although the *census* of state mental hospitals decreased dramatically between 1968 and 1978, the number of *admissions* declined only slightly.... Almost as many persons were admitted... they just did not stay as long” (p. 479). Further, as mentioned above, the introduction of Medicaid led many states to shift large numbers of people from state psychiatric hospitals to general hospitals and nursing homes. These individuals were still institutionalized, not in their communities unsuccessfully attempting to access treatment for behaviors that might draw the attention of law enforcement officers. Steadman and colleagues also demonstrated that decreases in the availability of state hospital beds were not reliably associated with increased admission rates to prisons for people who had prior psychiatric hospitalizations.

Other longitudinal studies that follow individuals released from state psychiatric hospitals have tracked discharges’ incarceration rates. For example, after the closing of a Philadelphia psychiatric hospital, 2% of discharges were arrested during the three-year follow-up period (Rothbard et al. 1999). Likewise, in Indianapolis, 4% of individuals discharged upon the closure of a large state psychiatric hospital were in jail or homeless after 24 months (McGrew et al. 1999). Re-hospitalization rates in these studies were 20–30 and 27% respectively (McGrew et al. 1999; Rothbard et al. 1999). A more recent study found that mental illness was not an independent risk factor for incarceration among veterans discharged from Department of Veterans Affairs inpatient services; the strongest predictor of incarceration was a diagnosis of a substance use disorder (Erickson et al. 2008). In the same study, the closure of 80% of psychiatric inpatient beds was not associated with increased incarceration rates among veterans with mental illnesses (Erickson et al. 2008). These findings are consistent with a 13-year longitudinal study of nearly 700 long-stay patients discharged from two psychiatric hospitals in London, England upon their closure in 1985 (Leff et al. 2000). After 5 years in the community, there were 24 recorded criminal incidents committed by 18 people—three of whom were imprisoned and four of whom were sent to secure units (Leff et al. 2000).

Second, comparisons of the clinical and demographic characteristics of state psychiatric hospital patients versus

incarcerated individuals show clear differences. The former tend to be predominantly white, middle-aged, and have diagnoses of schizophrenia (Erickson et al. 2008; Fisher et al. 2001; Manderscheid et al. 2009). The latter tend to be disproportionately African American, in their 20s and early 30s, and have diagnostic distributions similar to the general population (Teplin 1990a; b; Teplin et al. 1996; Pinta 2009; Trestman et al. 2007). These differences are striking because the characteristics of incarcerated individuals with SMI seem to be more consistent with shifts in the general composition of jails and prisons due to other social trends. Roughly 30% of men and 50% of women entering jail have substance use disorders and nearly $\frac{3}{4}$ of individuals with SMI entering jail have co-occurring substance use disorders (Abram and Teplin 1991; Abram et al. 2003; Center for Substance Abuse Treatment 2007; Teplin 1994), and rates of arrest for drug-related offenses have skyrocketed since 1980 (Federal Bureau of Investigation, annual), disproportionately affecting African Americans (King 2008).

The last point is important, because according to Frank and Glied (2006), incarceration rates of people with SMI have remained relatively stable over time and the share of incarcerated people with mental illnesses has varied primarily with increases in the overall incarceration rate (p. 124). Between 1990 and 2000, when incarceration rates increased overall, the share of people with mental illnesses in jails and prisons rose, but the proportion of people with SMI living with family or in the community remained relatively stable, at around 80% (Frank and Glied 2006, p. 123–124). The authors contend that increases in incarceration rates would have affected not only people with SMI who had been deinstitutionalized, but also those “who would not have been living in institutions even if deinstitutionalization had never taken place” (p. 128).

Third, there is broad consensus that community-based treatment works and that despite many challenges, setbacks, and slow systemic progress, the well-being of people with mental illnesses has increased substantially over the past 50 years (Frank and Glied 2006). The small group for whom community-based treatment is not effective represents only a portion of the people with SMI in jails and prisons; for most others, the problem may be that they do not have access to the high-quality services and evidence-based practices associated with better community outcomes (for example, Forensic Assertive Community Treatment and Integrated Dual Diagnosis Treatment), including reduced involvement in the criminal justice system (Steadman and Naples 2005; Mangrum et al. 2006; Cusack et al. 2010). Thus, increasing the number of inpatient psychiatric beds would have less of an impact on the prevalence of SMI in correctional facilities than increasing access to quality community-based services.

Discussion

In the debate summarized above, proponents of the transinstitutionalization hypothesis may be mistakenly drawing a causal connection between two merely correlated trends: the decline in availability of state psychiatric hospital beds and the rise in prevalence of SMI in jails and prisons. More specifically, they may (a) misinterpret deinstitutionalization as a flood of individuals who were released from state psychiatric hospitals only to be arrested and incarcerated, (b) conflate evidence that people released from psychiatric hospitals often require re-hospitalization with evidence that jails and prisons are serving that function (c) erroneously assume that people who require inpatient services are clinically and demographically similar to people with SMI who wind up in jails and prisons and (d) underestimate the effectiveness of high quality community-based treatment.

The evidence against the transinstitutionalization hypothesis is compelling because (a) most people released from state psychiatric hospitals do not appear to end up incarcerated, (b) the characteristics of people with SMI in jails and prisons differ from both the characteristics of people who were deinstitutionalized and the past decades' increasingly forensic state psychiatric hospital population, and (c) many agree that community-based treatment works for the majority of people with SMI.

This is not to say, however, that conclusive evidence currently exists on either side of the debate. More rigorous analysis to clearly define the causal relationship between deinstitutionalization and the overrepresentation of people with SMI in jails and prisons is certainly warranted (for example, retrospectively matching archival inpatient, arrest, and incarceration records). The arguments presented above should also not imply that the cases for and against increased access to inpatient services are irreconcilable. Indeed, the most important takeaway from this debate may be a fact that is often overlooked by policymakers working to address this issue: people with mental illnesses are not a homogenous population. Increased access to acute and intermediate psychiatric beds may, in fact, be necessary for a small but high-risk, high-cost group of people with severe mental illnesses who cycle through emergency rooms and the criminal justice system without obtaining the treatment they need (Pasic et al. 2005). For these individuals, shortages of 24-hour hospital care (and for this group and others with SMI, affordable housing more broadly) are indeed a problem.

Nevertheless, increased access to inpatient services may not be an optimal focus for a multi-systemic criminal justice/mental health policy strategy. The ramifications of casting too wide an inpatient net would not only be expensive, but would move away from the goal of full community integration of people with mental illnesses that

is the hallmark of the rights and recovery movement (New Freedom Commission on Mental Health 2003). Pragmatically, it might be argued, that reinstitutionalizing people with SMI who become involved in the criminal justice system is the lesser of evils, since treatment conditions in psychiatric hospitals are bound to be better than those in jails and prisons. This reasoning, however, addresses one problem by creating a new (but familiar) one, and avoids tackling the issues at the heart of the matter.

Broadly speaking, the popular account of current mental health policy is correct: people with SMI are being “locked up” in jails and prisons as was the case 200 years ago. Understanding why this is happening, however, is important for developing strategies to appropriately divert people with SMI out of jails and prisons and into the treatment they need to become productive members of their communities. The history of deinstitutionalization provides an intuitive but reductionist narrative about the reasons why people with SMI are overrepresented in correctional settings.

At the very least, policymakers and researchers should treat the transinstitutionalization hypothesis with caution and not as a presupposition. Failure to approach this issue with the nuance it requires may unwittingly imply expensive interventions that will benefit only a fraction of the population at issue. For the large remainder of people with SMI in jails and prisons, other causes of their involvement with the criminal justice system should not be ignored. In this regard, shifts in philosophy and ideology behind the concept of deinstitutionalization are still relevant. For the majority of this group, the key to staying out of hospitals, jails, and prisons may be a place to live, a job or some income support, a meaningful relationship or social network, quality healthcare, or linkage to treatment instead of frequent arrest for substance use disorders—fundamental needs that can best be redressed in the community, not psychiatric or correctional institutions.

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