

Criminal Justice Reform: Lessons from the Deinstitutionalization Movement

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Today, a frequently expressed concern is that jails and prisons have become the nation's largest mental institutions. But how this shameful outcome came to be, and what lessons can be drawn for criminal justice reform are less commonly discussed.

As with other populations that are vulnerable to criminal confinement, people who have serious mental illnesses have been stereotyped as dangerous, morally weak and limited in their capacity (or their right) to be a part of the social mainstream. And although their essential issue is a *disability* -- such as schizophrenia or bipolar disorder -- and not criminal conduct, for decades the routine practice was to incarcerate people with serious mental illnesses in state psychiatric hospitals. Similar to the recent boom in constructing jails and prisons, during the late 1800s and into the mid-twentieth century, states across the country built huge, fortress-like mental asylums. These were generally located far from population centers and designed as isolated, self-contained communities. Depending upon one's perspective, they either offered people with serious mental illnesses a safe haven from the stresses of society, or they offered society protection from the purported dangers of mental illness.

By the 1950s well over half a million Americans with mental illnesses were segregated within these state institutions, the largest of which (Pilgrim State Hospital outside of New York City) housed almost 14,000 patients and proudly came to be listed in the Guinness Book of World Records as the world's biggest hospital. Most people who were admitted to state hospitals in this era were ultimately consigned to "back-wards," custodial settings for those who were classified as unresponsive to treatment. On these wards, people were offered little hope beyond a lifetime of institutional confinement.

Over the decades, those who were warehoused in state hospitals were subjected to indiscriminate seclusion and physical restraint and harmful treatments, including lobotomies (brain surgery), electric shock therapy, and medications with horrible side effects. For the "crime" of having a disability, these people were also subjected to the devastating effects of being deprived their freedom and other basic rights. Their social identities became little more than case numbers in massive public systems. And when they died, thousands of these people were buried in unmarked graves on the grounds of the hospital.

To fully appreciate the parallels between people with serious mental illnesses and other groups now vulnerable to incarceration in criminal justice settings, it is important to understand the common denominator: all are degraded populations without a significant political voice, and all are seen as risks to society and burdens on the public coffer. Among the primary reasons for creating psychiatric back-wards was the desire to segregate people who were regarded as "hopelessly insane" and to do so by spending as little as possible. In the 1950s, when the nation's state hospital population was at its peak, the average expenditure per patient day of care was \$2.70. Nevertheless, because of the sheer size of these institutions, states spent lots of money in the aggregate on maintaining their psychiatric hospitals. Across

the nation, state hospitals were often the largest employers in town. Pilgrim State Hospital, for instance, at one time employed over 4,000 staff members. Although the people these institutions served may have lacked political power, the political importance of the institution itself could be very strong. In a real sense, state hospitals achieved the status of important industries whose impact was felt on local economies and in state politics. This industry was constructed around the premise that state custody of large numbers of people with serious mental illnesses was necessary.

Beginning in the 1960s, a number of factors converged to change this institutional culture. The expense to states of supporting their massive institutions became prohibitive. For example, in New York as elsewhere, mental health had become the largest state agency, accounting for about one-third of the entire state budget. Additionally, new federal programs—Medicaid and Medicare—enabled states to shift significant costs borne by their mental health systems if people were transferred to nursing homes and similar settings. New antipsychotic drugs that held the promise of dramatic improvements in clinical symptoms came on the market too. And as an outgrowth of the mounting civil rights movement, many people began to critically examine the legal basis for trampling the liberties of Americans with mental disabilities.

Capping this picture, in the Community Mental Health Services Act of 1963, Congress laid out a vision of an ambitious new approach to mental healthcare, whereby clinics and services located in the community would offer a whole array of innovative services that would allow people with serious mental illnesses to live successfully outside of state hospitals. “Deinstitutionalization” and services in “least restrictive settings” became the hallmarks of public mental health across the nation. The promise was that state funds that had been invested in institutional warehousing would follow people into the community to support these goals and that state psychiatric hospitals would serve a transitional role as new models were implemented.

From a strictly numerical perspective, deinstitutionalization was a huge success. By 2002, the number of the nation’s state hospital beds was only about 10% of the 560,000 beds in 1955, and this figure continues to drop. States now spend more on community services than on psychiatric hospital care. And many individuals with serious mental illnesses now live successfully, integrated within their communities.

Much has changed, except for one very key factor: notwithstanding the ambitions of deinstitutionalization, people with serious mental illnesses remain stigmatized socially and politically. The promise to fulfill the aspirations of the community mental health movement quickly faded. Despite some pockets of success, far too frequently the innovative services and supports to promote community living never materialized. Instead, assembly-line discharges to private for-profit institutions, other marginal living arrangements or sometimes even to the streets allowed hospitals to rapidly downsize. Funds that were supposed to have been reinvested in community mental health were diverted to initiatives, such as road building, that had far more political influence. And reminiscent of the political power once associated with state hospitals, the nursing home industry and other congregate-care businesses have emerged as power players with state and federal legislators.

Lacking access to essential services and basic supports, people with serious mental illnesses became vulnerable to arrest, often for minor infractions associated with unemployment, homelessness or their untreated disabilities. For a variety of reasons (notably that the living arrangements to which state hospitals discharged people tended to be located where crime and drug use were rampant), substance abuse problems became commonplace, adding yet another risk factor for arrest. Once in custody, people

with serious mental illnesses also often have a very hard time complying with institutional rules, resulting in longer periods of incarceration than would otherwise be associated with their criminal charges. All told, these factors culminated in today's shamefully high representation of people with serious mental illnesses in the nation's jails and prisons, estimated at between 200,000 to 300,000 people.

The popular, simplistic view is that people with serious mental illnesses who are now incarcerated or at risk of incarceration need once again to be confined in hospitals or other institutions. In some quarters, the deinstitutionalization movement and the capacity of people with serious mental illnesses to live in the community are being questioned. The scientific evidence is quite different. As is documented in recent reports by the U.S. Surgeon General, a presidential commission on mental health and elsewhere, a broad selection of evidence-based services and supports could fulfill the vision of successful community living for most people with serious mental illnesses, but the political will to make these services available continues to be lacking. In short, the widespread incarceration of people with serious mental illnesses is a symptom of neglect, not of the actual capacities of the individual or of our knowledge of the tools they need to be successful. Also noteworthy is that appropriate community services would prove to be *less* expensive than incarceration or institutional confinement. To make such a rational investment, though, would require going up against the industries -- governmental and private -- and the political interests that benefit from the status quo.

An enormously important tool in challenging this reality is the Americans with Disabilities Act (ADA). Enacted by Congress in 1990, the ADA is a civil rights law designed to promote the integration of people with disabilities -- including serious mental illnesses -- within the community mainstream. In its landmark *Olmstead* decision of 1999, the U.S. Supreme Court held that the unwarranted institutional confinement of people with serious mental illnesses is a form of discrimination under the ADA. These legal tools are now being used to challenge the various factors that put people with serious mental illnesses needlessly at risk of incarceration and that prolong their confinement in jails, prisons and other segregating institutions.

While the full impact of the ADA is still unfolding, the story behind the shameful incarceration rates of people with serious mental illnesses holds critical lessons for many disenfranchised populations that are vulnerable to incarceration. Essential is an understanding of what happens to devalued, socially powerless groups and how politics and financial interests can trump good public policies, the rational use of government funds, and the basic rights of fellow citizens. Advocates for reforms within criminal justice systems should be mindful of these lessons.