Rethinking the Carceral through an Institutional Lens: On prisons and asylums in the United States

Séminaire GERN "Longues peines et peines indéfinies. Punir la dangerosité" (Paris, 21 mars 2008)

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Introduction

The classic texts of social theory tell a consistent story not only about the rise and (in some cases) fall of discrete carceral institutions, but also of the remarkable continuity of confinement and social exclusion. This pattern is reflected in the writings of Erving Goffman on Asylums (1961), Gerald Grob on The State and the Mentally Ill (1966), David Rothman on The Discovery of the Asylum (1971), and Michel Foucault (1961). In Madness and Civilization, Foucault traces the continuity of confinement through different stages of Western European history, from the lazar houses for lepers on the outskirts of Medieval cities, to the Ships of Fools navigating down rivers of Renaissance Europe, to the establishment in the seventeenth century of the Hôpital Général in Paris—that enormous house of confinement for the poor, the unemployed, the homeless, the vagabond, the criminal, and the insane.

The leading social theorists of the 1960s identified a continuity of spatial exclusion and confinement between the asylum and the penitentiary. Erving Goffman’s essays are a good place to start. Goffman located the asylum within the space of what he called “total institutions”—a class of institutions that includes prisons, jails, sanitaria and leprosaria, almshouses for the poor and infirm, army barracks, boarding schools, and monasteries (Goffman, 1961, 4-5). These total institutions, Goffman explained, are marked by a “basic split” between a group of inmates removed from the outside world and a staff that is integrated with that outside world (1961, 7):
A total institution may be defined as a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life. Prisons serve as a clear example, providing we appreciate that what is prison-like about prisons is found in institutions whose members have broken no laws. This volume deals with total institutions in general and one example, mental hospitals, in particular (1961, xiii).

3 It is the continuity—and discontinuities—between the different “total institutions” that Goffman explored in his work, tracing the contours of the asylum inmate’s world and the inmate’s relation to the supervisory staff, and in the process producing a manual on the structure of the self.

4 David Rothman similarly explored total institutions but from the perspective of social history. He too located the asylum squarely in a shared space with the prison, the sanitarium, the orphanage, and the almshouse. The question Rothman posed was: “Why in the decades after 1820 did [Americans] all at once erect penitentiaries for the criminal, asylums for the insane, almshouses for the poor, orphan asylums for homeless children, and reformatories for delinquents?” (1971, xiii). It is this “revolution in the practices toward the insane” that Rothman sought to explore and explain—a revolution that encompasses institutionalization writ large (1971, 128). Institutions, Rothman observed, became places of “first resort, the preferred solution to the problems of poverty, crime, delinquency, and insanity” (1971, 131). In remarkably Durkheimian fashion, Rothman’s answer turned on social and moral cohesion—on the perceived need to restore some form of social balance during a time of instability at the birth of the new republic. In this quest for stability and social cohesion, the invention of the penitentiary, the asylum, and the almshouse—as well as houses of refuge, reformatories, and orphan asylums—represented an ordering of spatial exclusion necessary to appease apprehension of the unknown. It produced, again, a continuity of confinement.

5 In Madness and Civilization, Foucault also documented the continuity from the lazar homes for lepers on the outskirts of villages in the Middle Ages to the all encompassing houses of confinement in the seventeenth century, to the birth of the asylum in the modern age:

Leprosy disappeared, the leper vanished, or almost, from memory; these structures remained. Often, in these same places, the formulas of exclusion would be repeated, strangely similar two or three centuries later. Poor vagabonds, criminals, and “deranged minds” would take the part played by the leper..... With an altogether new meaning and in a very different culture, the forms would remain—essentially that major form of a rigorous division which is social exclusion but spiritual reintegration (Foucault, 1961, 16).

6 Goffman’s “total institutions” were all reunited in the establishment in 1656 by Louis XIV of the Hôpital Général in Paris (Foucault, 1961, 65). Once an arsenal, a rest home for war veterans, and several hospitals, the new Hôpital Général served as a house of confinement for the poor, the homeless, the unemployed, prisoners, and the insane—those who sought assistance and those who were sent there by royal or judicial decree. In the space of several months, one out of every hundred inhabitants of Paris would find themselves confined in these institutions. What characterized the house of confinement was precisely its indiscriminate nature: “the same walls could contain those condemned by common law, young men who disturbed their families’ peace or who squandered their goods, people without profession, and the insane” (Foucault, 1961, 66).
An outpouring of critical work in the 1960s and 70s, from the Left and from the Right, portrayed the mental hospital as an inherently repressive institution, on par with the prison. Drawing on the writings of Thomas Szasz, especially, *The Myth of Mental Illness* (1961), as well as on the works of Goffman, Rothman, Foucault, and Michael Ignatieff, these critical writings contributed to the idea of continuity in confinement. From this perspective, mental illness was “an abstraction designed to rationalize the confinement of individuals who manifested disruptive and aberrant behavior” and the asylum’s primary function was to “confine social deviants and/or unproductive persons” (Grob, 1983, ix-x).

Surprisingly, this literature never made its way into the empirical social science research on the incarceration revolution in the United States of the late twentieth century. With the marked exception of a few longitudinal studies on the interdependence of mental hospital and prison populations, as well as a small subset of the empirical research on the causes of the late-twentieth century prison explosion, no published empirical research conceptualizes the level of confinement in society through the lens of institutionalization writ large.

Uniformly, the empirical research limits the prism to rates of imprisonment only. None of the research that uses confinement as an independent variable—in other words, that studies the effect of confinement (and possibly other social indicators) on crime, unemployment, education, or other dependent variables—including mental hospitalization in its measure of confinement. Moreover, none of the binary studies of confinement—in other words, research that explores the specific relationship between confinement and unemployment, or confinement and crime, or confinement and any other non-mental-health-related indicator—uses a measure of coercive social control that includes rates of mental hospitalization. Even the most rigorous recent analyses of the prison–crime relationship use only imprisonment data. Though a tremendous amount of empirical work has been done on long-term crime trends, structural covariates of homicide, unemployment, and the prison expansion, none of this literature conceptualizes confinement through the larger prism of institutionalization, and none of it aggregates mental hospitalization data with prison rates.

Little of the social theorizing made its way into the measurement of coercive social control for purposes of empirical research, data collection, and statistical analyses. The one exception, naturally, involves the few studies of the interdependence of mental hospitalization and prison populations. This research specifically explores whether the deinstitutionalization of mental hospitals in the 1960s fed prison populations, contributing to the rise in incarceration in the following decades. But other than this specific body of literature, the link between the asylum and the penitentiary has essentially been ignored.

This is the product, in part, of the balkanization of research on systems of social control. Criminologists and sociologists of punishment have turned most of their attention recently—and justifiably—to the massive prison build-up. Historians of mental health systems, in contrast, have had their own remarkable trend to explain: the massive deinstitutionalization of mental health patients. The focus of their research predominantly has been to analyze the shift to deinstitutionalization, and much of the research has explored alternative explanations to the traditional humanitarian gloss. But the two research interests seem not to have intersected.
It is also, in part, an accident of history. Much of the longitudinal research into structural covariates of homicide and the incarceration–crime relationship was conducted using pre-1980 data during a period of perceived stability of imprisonment—for instance, the important work of Alfred Blumstein on the stability-of-punishment hypothesis,19 research on the prison–crime nexus,20 leading studies on covariates of homicide,21 and research of the National Research Council’s Panel on Deterrent and Incapacitative Effects (Blumstein, et al., 1978). The shock of the incarceration explosion in the 1980s and 1990s led most researchers—including Blumstein (1995, 388)—to revise their earlier findings on the stability of punishment, and triggered an outpouring of new research on the effect of incarceration on crime, this time using 1990s data (Spelman, 2000, 97). But the temporal disjuncture obscured the role of mental hospitalization: By 1999, the number of persons in mental hospitals was so relatively small that the rate of mental hospitalization seemed insignificant (APA, 2004).

Lack of attention to the link between the asylum and the penitentiary also reflects the wide gulf between critical social theory and quantitative research. Whatever the explanation, though, the result is striking: no published empirical research conceptualizes confinement through the lens of aggregated institutionalization. The criminology has failed to connect the prison to the asylum.

For instance, Alfred Blumstein, in his account of crime trends in the introduction to The Crime Drop in America—generally perceived as an authoritative compilation on recent crime trends—never addresses aggregated institutionalization (Blumstein, Wallman, 2000, 1-12). With regard to the sharp increase in crime in the 1960s, Blumstein hits on all the usual suspects—the baby-boom generation, political legitimacy, economics (Blumstein, Wallman, 2000, 4)—and includes later the usual explanations for the 1990s crime drop—changing drug use patterns, decreased gun violence, New York-style policing, the federal COPS program, and increased incarceration (Blumstein, Wallman, 2000, 4-5). Notably absent in all of this, though, is the relationship between mental health and prison populations.

More recently, Steven Levitt, in his review of the empirical literature on crime, Understanding Why Crime Fell in the 1990s: Four Factors that Explain the Decline and Six that Do Not (2004), identifies the prison-population build up as one of the four factors that explains the crime drop of the 1990s. Levitt estimates that the increased prison population over the 1990s accounted for a 12% reduction of homicide and violent crime, and an 8% reduction in property crime—for a total of about one-third of the overall drop in crime in the 1990s (Levitt, 2004, 178-79). When Levitt extends his analysis to discuss the period 1973–1991, however, he sticks to the prison population exclusively and does not even consider the contribution of the declining mental hospital population (Levitt, 2004, 183-86).

This is remarkable, simply astounding. It is astounding because the empirical data on mental hospitalization reflect extraordinarily high rates of institutionalization at mid-century. Simply put, when the data on mental hospitalization rates are combined with the data on prison rates for the years 1928 through 2000—combined to create a measure of what we might call aggregated institutionalization—then the incarceration revolution of the late twentieth century barely reaches the level of aggregated institutionalization that the United States experienced at mid-century.
Aggregating mental hospitalization and imprisonment rates into a combined institutionalization rate significantly changes the trend line for confinement over the twentieth century. We are used to thinking of confinement through the lens of incarceration only, and to referring to the period prior to the mid-1970s as one of “relative stability” followed by an exponential rise—and I include myself here. As a literal matter, this is of course right. If all we are describing is the specific variable in our study and the source of the data, then indeed the observations are relatively stable over the five decades. But the truth is, what we are trying to capture when we use the variable of imprisonment is something about confinement in an institutional setting—confinement that renders the population in question incapacitated or unable to work, pursue educational opportunities, and so forth. And from this larger perspective, the period before 1970—in fact, the entire twentieth century—reflects a very different trend and reveals extraordinarily high levels of institutionalization at mid-century. At the national level, if we include data on mental institutions (including all institutions for those deemed mentally ill), the contrast between the mid-century and 2001 is in fact even more pronounced: during the 1940s and 50s, the United States consistently institutionalized in mental hospitals and prisons at rates above 700 persons per 100,000 adults, reaching peaks of 778 in 1939 and 786 in 1955.

In this Article, I explore the continuity of spatial exclusion and confinement in the United States from the high rates of mental hospitalization in the mid-1930s to the high rates of imprisonment at the turn of the twenty-first century. The potential implications are wide ranging and particularly salient for sociological, criminological, and economic research into the institutionalization of citizens and punishment theory more generally. My purpose in this Article is not to develop or test hypotheses about the actual relations between institutionalization writ large and other factors like crime, unemployment, or education. Instead, my goal is more limited: to reconnect social theory to empirical research; to take seriously the writings on the asylum from the 1960s and 1970s and to allow those writings to inform our empirical research; and to provoke us all—myself included—to rethink confinement through the lens of institutionalization.

1. Collecting the Data

Naturally, the first task is to collect state-level data for each state in the United States over the 20th century, and I confess that as soon as I began that task—the very moment I came across what was for me the first volume describing the population in mental hospitals—I knew that I was on to something. By chance, it was the Patients in Hospitals for Mental Disease, 1923. I had others in my hands, from 1928, 1929 and 1930, 1933, and those thick library-bound collected series 1938—1941 and 1941—1945. But this first 1923 volume—a volume that anticipated the annual series which would begin in 1926 with the “first annual enumeration of patients in State hospitals for mental disease”—somehow caught my attention.

The volume had a humble cover. Green soft cardboard. The title was printed in simple block letters at the top of the page: PATIENTS IN HOSPITALS FOR MENTAL DISEASE. A few lines below: 1923. In the bottom right corner, in smaller block letters, above a simple insignia of a boat and an eagle, was marked: DEPARTMENT OF COMMERCE, and below it, BUREAU OF THE CENSUS. In small letters, a stamp that a librarian must have pressed on the cover. “Gift of U.S. Govt.”
That’s all. Nothing fancy. A soft-cover volume, bound by the library in an elegant 1920 binding, with a leather spine and a marble front and back. The price, marked on the inside cover page, was 35 cents. A modest volume indeed.

But inside, as I turned the pages, I discovered a treasure of data, of numbers, of categories, tables, maps, and graphs. No, I must be more precise. This modest volume demands more precision. 124 text and detailed tables. 13 maps and charts. 83 pages of analysis of the statistics. A half-inch thick compilation of every possible detail regarding the population of mental patients.

In these pages, I discovered that five men were readmitted to the State Hospital for the Criminal Insane in Waymart, Pennsylvania, during the year 1922 (BC, 1923, 101, table 64); that 107 women born in Scotland were admitted for the first time to hospitals for mental disease during 1922, representing 89.6 per 100,000 of the same nativity in sex, which incidentally compares well to the 399 Austrian women, comprising 159 per 100,000, admitted for the first time that same year (BC, 1923, 23, table 8); that 4,492 patients in state hospitals, including two federal hospitals (the Asylum for Insane Indians in South Dakota and St. Elizabeths in the District of Columbia), or 2 percent of the total state hospital population on the books—including residents and those on parole or otherwise absent—suffered from “involuntary melancholia,” which includes “slowly developing depressions of middle life and later years which come on with worry, insomnia, uneasiness, anxiety, and agitation, showing usually the unreality and sensory complex but little or no evidence of difficulty in thinking” (BC, 1923, 44 table 28; 41).

The mental population of 1922 and 1923 was dissected in every conceivable way, along every possible dimension, through every imaginable category. Listen to this random—random, I assure you—sample from the tables in the volume:

Text Table 39.—Intemperate use of alcohol among first admissions to hospitals for mental disease during 1922, by country of birth and by sex. . . . 64
Text Table 55.—Color or race and psychoses of ex-service patients in hospitals for mental disease on January 1, 1923, and of first admissions and readmissions during 1922 . . . . 85
Detailed Table 81.—Marital condition of first admissions to hospitals for mental disease during 1922, by sex, color or race, nativity, and parentage, for the United States . . . . 144
Detailed Table 124.—Expenditures of State hospitals for mental disease, for maintenance and other purposes, during 1922, with per capita cost of maintenance, by individual institutions. . . . 252

The populations, the movements, the first admissions, the readmissions, the transfers, the deaths of every mental patient, categorized by diagnosis, of every public and private mental institution in every state, including county and city and VA hospitals, each institution listed separately, including those residents in the hospitals as well as, separately listed, those on parole or otherwise absent, by gender, by race, by nationality, by psychoses, by age, by marital status, by country of birth, by time spent in the hospital, by number of times admitted, in raw numbers and in percentage distributions. Over 250 pages of materials—in minute detail. A mesmerizing wealth of numbers and categories that signaled one thing: this population mattered to us. This population needed to be understood, analyzed, categorized—which is not surprising because it was such a big population, consisting in 1923 of 267,617 patients or 245 per 100,000 population. This was a huge number of people, which would double to 513,894 by 1938.
The Bureau of the Census performed annual enumerations beginning in 1926, and produced these detailed pamphlets scrutinizing the population. Even during the war years, the compilation and analysis and dissection did not suffer. Starting in 1947, the task of enumeration and analysis was turned over to the National Institute of Mental Health, part of the U.S. Public Health Service, which continued to issue these detailed analyses. Beginning in 1952, the yearly pamphlets were divided into four separate parts. The category of hospitals enumerated also changed over the years, as did the enumeration by type—whether “in residence,” on “parole,” “in family care,” “on trial visit,” or otherwise.

Interestingly, the last volume I could find in the series was from 1967. After 1967, it was simply impossible to find any volumes at all. After that, it seems, we no longer needed to know this population. Not surprisingly, this coincided with deinstitutionalization. After a few more unsuccessful attempts, I resorted to the phone call and spoke with the statisticians in the survey department of the National Institute on Mental Health who compile the data. She explained that the “Series A publications”—those were the four part publications that began in the 1952—stopped in 1970. Starting in 1970, her department began tracking only state and county mental hospitals. Professor Steven Raphael at the School of Public Policy at Berkeley had used those data to compile a state-level dataset on state and county mental hospitals for the period 1967 through 1996 for a study he conducted in 2000, and generously shared his data with me. With some additional reports from 1997 through 2001, I was able to complete the datasets.

Things could not have been more different when I began collecting the prison data. Today, state and federal prison populations are well enumerated, dissected, and documented in the most accessible manner by the Bureau of Justice Statistics of the Department of Justice. All kinds of breakdowns are readily available and the data can all be downloaded easily from the Internet in electronic and pdf format. No need to get out of your chair. No need to go to the library. Books, printed materials—those are things of the past. In a matter of a few minutes browsing the web, anyone can locate a downloadable spreadsheet that offers, in Excel format—ready to paste into any statistics program—the state-by-state breakdown of state and federal prisoners, in raw number and rates per 100,000, for the entire period 1977 through 2004. The accessibility is remarkable. In relation to today’s technology, it is the simplest and easiest, readily accessible, effortless trove of data.

The trouble is, getting data prior to 1977 is not as easy or as reliable. I spoke with the statistician at the Bureau of Justice Statistics who co-authored the original modern dataset and updated it to 2004, and she explained to me that the earlier enumerations are neither reliable, nor consistent—and certainly not available in electronic format. There were documents issued since 1926 on a yearly basis with annual counts of state and federal prisoners, and I collected those—thin pamphlets, first compiled by the Census Bureau along the lines of the mental health population breakdowns, though much less detailed and with far fewer tables. These were, after all, much smaller populations. The data are there, but are a lot less well analyzed and dissected.

On reflection, it almost seems as if we could run our quantitative analyses using, instead of population numbers, an index of the accessibility and availability of data on the populations. We could regress the number of pages and tables dedicated to each; the amount of data available in the most technologically advanced format for the period (35 cent printed monographs in the early 20th century, Excel spreadsheets in the early 21st century).
century); the amount of detail and number of categories, the breakdown of the data, the number of observations. The raw number of pages of tables and analysis. We practically do not need to look at the population numbers, the availability of data itself tells a whole story. And that story, very simply, is that the institutionalized population that we supervise, dissect, categorize, and analyze has changed. It was mental hospital patients, but is now prison inmates. This is a story that may tell itself, simply, from the data collection. In what follows, though, I offer a more detailed description of the data collected and used in this study.

2. Compiling the Dataset

Mental Health Populations. A complete list of the data sources for the mental health populations is attached as Appendix A to my article, « From the Asylum to the Prison: Rethinking the Incarceration Revolution - Part II: State Level Analysis, » University of Chicago Law & Economics, Olin Working Paper No. 335 (March 2007) (http://papers.ssrn.com/sol3/papers.cfm?abstract_id=970341). Using those sources, I created three different variables to capture mental health populations. The first variable, which I will refer to as “Insti1,” consists of patients in residence at state, county, and city hospitals. This is the most limited and narrow count, but also the most consistent because, after 1967, it is the only reliable data available. It was consistently measured from 1922 to 2001. The data are obtained from official reports compiled by the Bureau of the Census and, later, the National Institute of Mental Health and the Center for Mental Health Services. For the period 1967 to 1996, I relied on the electronic dataset provided by Steven Raphael, who compiled the data using the same reports; for every year that I had the reports, I compared and ensured that the data were correct.23

The second variable, which I will refer to as “Insti2,” consists of all patients in residence at all mental health institutions. These include not only state, county, and city mental hospitals, but also psychiatric wards in general hospitals and VA hospitals, psychopathic hospitals, private mental hospitals, public and private institutions for “mental defectives and epileptics” and for “the mentally retarded.” One important reason to include all these institutions is that it is meaningful when the census begins enumerating these different categories of institutions: it reflects that there are a lot of people there, that they have achieved enough critical mass that they need to be counted. That is a meaningful marker and it captures well the larger notion of mental health institutionalization.

The third and final mental health variable, which I refer to as “Insti3,” expands the second variable to include, as well, patients on parole from the institutions. The category of parole covers a number of different statuses, ranging from trial leaves of absence, to extramural or family care, and even to escaped patients. Here too, one reason to include these patients in a separate variable is that they are numerous and important enough, in the eyes of those conducting the census, to count as supervised and to be measured.

In order to get a sense of the different mental hospitalization variables, the figure 1 plots all three variables over time: (1) first, the rate of patients in residence institutionalized in state, county, and city mental hospitals (Insti1); (2) second, the rate of patients in residence in all mental health institutions (Insti2); and (3) third, the rate of patients in residence and on parole in all mental health institutions (Insti3).
Figure 1: Different Rates of Institutionalization in Mental Institutions in the United States (per 100,000 adults)

35  *Prison Populations.* The data on prison populations are compiled from the Census Bureau report titled “Prisoners in State and Federal Prisons and Reformatories [Year]: Statistics of Prisoners Received and Discharged During the Year, for State and Federal Penal Institutions.” These reports were prepared by the Bureau of the Census on a yearly basis beginning in 1926. For the period beginning 1977, the data are available directly from the Bureau of Justice Statistics (BJS, 2005a).

36  *Jail Populations.* Data on jail populations are sparse and not reliable for the period before 1970, the year that the Law Enforcement Assistance Administration (LEAA) conducted the first state-by-state census of jails (Cahalan, 1986, 73, 76). Prior to that, there were decennial Census Bureau counts for 1880, 1890, 1940, 1950, and 1960, but even those Census counts were not entirely reliable.\(^24\) Since 1970, the data are more reliable, but they remain extremely spotty. The Bureau of Justice Statistics conducts census counts of jails every 5 to 6 years, and those census counts produce state-level data. These censuses are supplemented by the annual survey of jails which is a sample and does not allow for state-by-state estimates.\(^25\) As a result, since 1970, jail inmate counts by state are available only for 1978, 1983, 1988, and 1993 (BJS, 1997); as well as 1999 (BJS, 2001); in addition, there is a mid-year 2005 state-by-state estimate of jail inmates (BJS, 2005b). There are national trends from 1990 to 2005, but those are for the nation, not for the states.

37  Using the available data, I have compiled the best existing state-level data for jail populations. Those consist of the following: (1) Census Bureau data for decennial years 1940, 1950, and 1960, as well as Census Bureau counts of prisoners and jail inmates for 1923 and 1933 (Cahalan, 1987, 76, 78); (2) LEAA census data for 1970 (Cahalan, 1987, 76); and (3) the Bureau of Justice Statistics jail inmate counts for 1978, 1983, 1988, 1993, 1999 and 2005. For missing years, I have linearly interpolated—for 1922, extrapolated—the data.
3. National Level Findings Based on State-level Data

The state-level data collection revealed numerous types of mental institutions at mid-century, including institutions for “mental defectives and epileptics” and “the mentally retarded,” psychiatric wards in VA hospitals, as well as “psychopathic,” city, and private mental hospitals. When I include only residents of the institutions in the national level data (using the Insti2 dataset), the comparison to our current imprisonment rate is stark: in the period between 1935 and 1963, the United States consistently institutionalized (in these mental institutions and prisons) at rates above 700 per 100,000 adults—with highs of 778 in 1939 and 786 in 1955.

If I include residents (residents only and not persons on parole) from all those mental institutions, the national-level trends look like the figure 2.

Figure 2: Rates of Institutionalization for Residents in All Mental Institutions and State and Federal Prisons in the United States (per 100,000 adults)

These figures do not include jail populations because, as noted in the previous section, data on jail populations are extremely sparse and not reliably measured until 1970; and after 1970, there are only six state-level censuses (1978, 1983, 1988, 1993, 1999, and 2005). Nevertheless, when I use those jail counts, linearly interpolate missing years, and include those in the overall national trend, the figure looks something like this. Again, only recently does the prison revolution of the 1980s and 1990s approach the earlier levels of aggregated institutionalization from the 1940s and 50s.
Since I do not have reliable state-level figures for prisoners on parole, in all future analyses, especially regressions, I will use the Insti2 dataset, which does not include mental health patients on parole. I have included Insti3 here—in addition to Insti2—for information purposes only.

4. Implications, Questions, and Directions

Rethinking confinement through the lens of institutionalization puts the incarceration revolution of the late twentieth century in a different light. If hospitalization and prison rates are aggregated, the United States is only now beginning to reach the levels of institutionalization that were commonplace from the mid-1930s to the mid-1950s. Naturally, this tells us nothing about the proper amount of confinement in society, nor should it alter our perception or evaluation of the incarceration revolution of the late twentieth century. What it does underscore, more than anything, is how much institutionalization there was in the 1930s through 1960s. Perhaps, then, it is the continuity of confinement—and not only the most recent exponential increase in imprisonment—that we need to study empirically and explain.

The potential implications are significant for sociological, criminological, and economic research on the relationship between incapacitation and crime, education, employment, and other social indicators. Rethinking confinement through the lens of aggregate institutionalization also significantly impacts research in punishment theory more generally, such as studies that have attempted to operationalize and test the central insights of the Frankfurt School—specifically, Georg Rusche and Otto Kirchheimer's suggestion in *Punishment and Social Structure* that penal strategies are shaped by systems of economic production and fiscal policies (1939, 7). A review of that literature suggests that there is empirical plausibility to the Rusche–Kirchheimer hypothesis (Chiricos, Delone, 1992, 431). To date, though, the research has focused only on imprisonment rates.
For instance, in *Unemployment, Imprisonment, and Social Structures of Accumulation: Historical Contingency in the Rusche–Kirchheimer Hypothesis* (1999), Raymond Michalowski and Susan Carlson refine the test of the Rusche–Kirchheimer hypothesis by periodizing the analysis. Drawing on recent theories about shifts in social structures of accumulation (SSAs) in the United States during the twentieth century, the authors break down the years between 1933 and 1992 into four periods: (1) a period of economic exploration from 1933 to 1947 marked by high levels of structural unemployment, labor conflict, and worker displacement, that led to the emergence of social institutions (welfare state policies and labor accords) that have come to be known as Fordist (Michalowski, Carlson, 1999, 224); (2) a period of economic consolidation from 1948 to 1966 marked by increasing economic output, upward trends in real wages, and decreasing unemployment (1999, 224-25); (3) a period of decay from 1967 to 1979 marked by increasing unemployment, eroding labor accords, and the oil crisis of 1973 (1999, 225-26); and (4) a period of renewed economic exploration from 1980 to 1992 marked by significant displacement of young men, a shift away from social welfare strategies, and the growth of the service industry, that some have called the beginning of the post-Fordist period (1999, 226).

Using only imprisonment rates, the authors find a weak, though statistically significant, impact of unemployment on prison admissions during the first period (exploration) (1999, 237-38); and a strong impact of unemployment on prison admissions during the third period (decay) (1999, 238). The trouble is, both of those periods are marked by stability of incarceration but instability of institutionalization. Using aggregated institutionalization data, the first period is characterized by a dramatic increase in the institutionalized population, and the third period is marked by an exponential decrease in institutionalization. In other words, things look very different if we conceptualize confinement through the larger prism of institutionalization. Studies of the relationship between education, incarceration, and crime, also would be significantly affected.

### 4.1. Interdependence of the Populations

One important question, though, has to do with the difference in the populations between the prison and the asylum. The fact is, the demographics of the populations were and are extremely different. Although there may be some overlap at the margin, it is hard to believe that the same people who were deinstitutionalized would end up in prison. The continuity thesis is, in this sense, shocking to our sensibilities about the “insane” and the “criminal.” This raises the question of the interdependence of the two populations, an area that has received some research attention.

In a 1984 study, Henry Steadman, John Monahan, and their colleagues tested the degree of reciprocity between the mental health and prison systems in the wake of state mental hospital deinstitutionalization. They used both a comparative and longitudinal approach. Their study randomly selected a total of 3,897 male prisoners and 2,376 adult male admittees to state mental hospitals from six different states, half from 1968 and the other half from 1978 (Steadman, Monahan, 1984, 478). They gathered full institutional histories for arrests, imprisonment, and state mental hospitalization for each inmate and then compared the system overlap between 1968 and 1978 (1984, 478). They were able, thus, to measure the extent of cross-institutionalization—the change in the number of prisoners with prior mental health contacts, as well as the change in mental health patients with criminal records.
Regarding the number and proportion of prison admittees with one or more prior mental hospitalizations, Steadman and Monahan found significant variation between the six states. Texas experienced a huge increase. California and Iowa had increases as well, but New York, Arizona, and Massachusetts experienced proportional declines. Naturally, it was a period of rapid expansion in the prison population, with prison admissions up 42.4% for the six states from 1968 to 1978. During that period, the overall number of prisoners in the six states with prior hospitalization almost doubled, up 97.3%. Consolidating their tables, and calculating total figures, their findings can be summarized as follows:

<table>
<thead>
<tr>
<th></th>
<th>Prison admittees with prior hospitalization</th>
<th>Prison admittees with prior hospitalization</th>
<th>Expected 1978 number using 1968 percentages</th>
<th>Difference: actual versus expected (in %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NY</td>
<td>741</td>
<td>797</td>
<td>9.3</td>
<td>1,037</td>
</tr>
<tr>
<td>CA</td>
<td>1,099</td>
<td>1,777</td>
<td>9.5</td>
<td>1,111</td>
</tr>
<tr>
<td>AZ</td>
<td>35</td>
<td>39</td>
<td>2.2</td>
<td>60</td>
</tr>
<tr>
<td>TX</td>
<td>18</td>
<td>1,004</td>
<td>8.4</td>
<td>35</td>
</tr>
<tr>
<td>IA</td>
<td>64</td>
<td>153</td>
<td>16.7</td>
<td>71</td>
</tr>
<tr>
<td>MA</td>
<td>54</td>
<td>139</td>
<td>9.0</td>
<td>194</td>
</tr>
<tr>
<td>Total</td>
<td>1,981</td>
<td>3,909</td>
<td>10.7</td>
<td>2,517</td>
</tr>
</tbody>
</table>

Because three states (New York, Arizona, and Massachusetts) experienced relative declines—that is, taking into account the increase in the prison population—Steadman and Monahan concluded from these data that there was little evidence of movement from the mental hospitals to prisons: “the percentage of former patients among the ranks of prison admittees decreased in as many study states as it increased” (1984, 483). Thus, “[l]ittle evidence was found to support the idea that mental hospital deinstitutionalization was a significant factor in the rise of prison populations during the period [from 1968 to 1978]” (1984, 490).

On the other side of the equation, Steadman and Monahan did find evidence that mental hospitals were becoming more “criminal.” Holding constant the changes in total mental hospital admissions for the six states—which were down 9% from 1968 to 1978—the number of mental hospital admittees with one or more prior arrests increased by an average 40.3%, and the number with a prior imprisonment increased on average by 60.4%. “In all study states but Iowa, the actual number of hospital admittees with one or more prior arrests is substantially higher (from 11.7% to 99.9%) than would be expected from total admission trends” (1984, 486).

My interpretation of their prison data is less sanguine. Although the state-by-state breakdown is even, the aggregated numbers tell a different story. The number of inmates with prior mental hospitalization is more than 50% higher than would have been expected given the prison growth. To be sure, it does not account for all of the prison expansion. In this sense, Steadman and Monahan are undoubtedly right: the evidence

Champ pénal/Penal field, Séminaire du GERN "Longues peines et peines indéfinies. Punir la dangerosité" (2008-2009)
does not show that deinstitutionalization explains the prison explosion. It does not establish direct transfer from the asylum to the penitentiary. But there may be significant overlap and, over time, more substitution. The proportion has increased by more than half. It is consistent at least with some interdependence. The real question is, how much?

Steven Raphael tackles this question using an econometric model in his paper *The Deinstitutionalization of the Mentally Ill and Growth in the U.S. Prison Populations: 1971 to 1996* (2000). Raphael tests the relationship between mental hospitalization and prison populations using state-level data for the period 1971 to 1996. What he finds, across his six different models, is that the mental hospitalization rate has a statistically significant and robust negative effect on prison rates (2000, 8-9, 10-11). Moreover, the magnitude of the effect is large; and ranges from a low of a seven-person decline to a high of a two-person decline in mental hospitalization resulting in a one-person increase in the prison rate (2000, 9). Translated into actual population numbers, Raphael’s findings suggest that deinstitutionalization from 1971 to 1996 resulted in between 48,000 and 148,000 additional state prisoners in 1996, which according to Raphael, “accounts for 4.5 to 14 percent of the total prison population for this year and for roughly 28 to 86 percent of prison inmates suffering from mental illness” (2000, 12). What we also know is that, at the close of the twentieth century, there was a high level of mentally ill offenders in prisons and jails in the United States—283,800 in 1998—representing 16% of jail and state prison inmates (Ditton, 1999).

The problem with these empirical analyses, though, is that again they take too literally the official categories of the “mentally ill” and of the “criminal.” The diagnosis and documentation of mental illness needs to be problematized, as does the guilty verdict. The studies in effect put too much credence in the official labels. These categories are not natural and do not have independent validity and objective signification. The question is not, how many people with mental illness are in the criminal justice system? Rather, the question should be, has the criminal justice system caught in its wider net the type of people at the margin of society—the class of deviants from predominant social norms—who used to be caught up in the asylum and mental hospital? The real challenge is to deconstruct both the categories of the “insane” and of the “criminal” simultaneously.

The first is easy. With regard to the asylum, we are all constructivists today. We all accept the claim that criminality was medicalized in the early twentieth century. As Liska and Markowitz suggest, correctly, “During the first half of the 20th century, psychiatrists medicalized social problems, successfully arguing that the cause of many social problems, like crime, lies in the psychological malfunctioning of people and that the solution lies in their treatment by medical specialists in treatment centers” (Liska, et al.,1999, 1747). Or as William Gronfein explains:

> In Goffman’s words, “part of the official mandate of the public mental hospital is to protect the community from the danger and nuisance of certain kinds of misconduct.” Publicly supported insane asylums represented an uneasy, albeit surprisingly successful, marriage between asylum and prison, a fact that was of particular importance in contributing to their long-term growth (Gronfein, 1985, 194 [citing Goffman, 1961, 352]).

We all agree that the category of the “insane” was created in modern times to capture the deviant and marginal. But in order to make sense of the larger trend in institutionalization, we need to view the “criminal” through the same prism. Is it possible that the category of the present-day criminal does the same work that used to be
done by the category of the insane? Might it capture the same class of norm violators, the same kind of deviants?

4.2. Differences in the Populations

Certainly there are important demographic differences. The gender distribution, for instance, was far more even in mental hospitals than in prisons. In 1966, for example, there were 560,548 first-time admissions to mental hospitals, of which 310,810 (55.4%) were male and 249,738 (44.6%) were female (USHEW, 1969). In contrast, new admittees to state and federal prison were consistently 95% male throughout the twentieth century (Cahalan, 1986, 66). There were also sharp differences in racial and age compositions, which I discuss next. But within the demographic group—within the set of male inmates, for instance—could the categories have served the same function, at least roughly? Steadman and Monahan gesture at this in their study, suggesting that the relationship between the mental health and prison systems may be indirect, “mediated by community reaction towards all types of socially marginal groups when the societal tolerance level for deviance is exceeded” (1984, 479). This is one direction for research to pursue.

And how does race figure into the equation, since it is such an important part of the incarceration expansion—since the prison has become, as Loïc Wacquant suggests, the last of our peculiar institutions (Wacquant, 2001, 98-99)? There is some evidence to suggest that the proportion of minorities in mental hospitals was increasing during deinstitutionalization. From 1968 to 1978, for instance, there was already a demographic shift among mental hospital admittees. In Steadman and Monahan’s data, for instance, the proportion of non-whites increased from 18.3% in 1968 to 31.7% in 1978: “Across the six states studied, the mean age at hospital admission decreased from 39.1 in 1968 to 33.3 by 1978. The percentage of whites among admitted patients also decreased, from 81.7% in 1968 to 68.3% in 1978” (Steadman, Monahan, 1984, 479). There was a less stark shift in prison admissions data, though the direction of change was the same: “Across the six states, the mean age of prison admittees was 29.0 in 1968 and 28.1 in 1978. The percentage of whites among prison admittees was also relatively stable, decreasing only from 57.6% in 1968 to 52.3% in 1978” (Steadman, Monahan, 1984, 479).

At the national level, though, the racial shift in prison admissions began well before 1968. In fact, throughout the twentieth century, African Americans have represented a consistently increasing proportion of the state and federal prison populations. Since 1926, the year the federal government began collecting data on correctional populations, the proportion of African Americans newly admitted to state prisons has increased steadily from 23% in 1926 to 46% in 1982 (BJS, 1991, 5). It reached 51.8% in 1991 and stood at 47% in 1997 (BJS, 1997, 10, tab. 1.20).

In 1978, African Americans represented 44% of newly admitted inmates in state prisons (BJS, 1991, 5). That same year, minorities represented 31.7% of newly admitted patients in mental hospitals—up from 18.3% in 1968. Is it possible that, as the population in mental hospitals became increasingly African American and young, our society gravitated toward the prison rather than the mental hospital as the proper way to deal with at-risk populations? This too would require further investigation.
4.3. Future Directions

In the end, the findings raise more questions than they answer. To be sure, they help formulate the right questions to pose; but they represent only the beginning of the conversation, not the end.

The first question, naturally, has to do with these enormous differences in the demographic profile of the two populations—mental health and prison. And it is not only the differences, but also the gradual changes in the demographic composition of the two populations that need to be explored. The mental hospitalization population was far more evenly distributed along gender lines, was an older population, and tended to be more white. But the demographic distributions changed over time, and this gradual change calls for explanation.

Related to this first point is the question of the length of detention of the different populations. I have measured census data—the stock of populations. But I have not investigated the flux of the populations and this may present important differences in the populations. Thanks to Bruno Aubusson de Cavarlay et René Lévy for this insight.

A second question is how these aggregated data would affect the incarceration-crime nexus. For anyone who has spent time looking at longitudinal data on homicide in the United States, the aggregated institutionalization trend from Figure 2 is shocking: it reflects a reverse mirror image of national homicide rates. This is visually represented in Figure 4, using vital statistics data from the National Center for Health Statistics.

Figure 4: Institutionalization and homicide rates (per 100,000 adults)

The relationship between aggregated institutionalization and homicide rates in Figure 4 is remarkable, at least at first glance. I have conducted other research to explore the relationship in more depth and, to my surprise, I have found that, even holding constant the leading structural covariates of homicide (poverty, demographic change, and unemployment), there is a large negative relationship between institutionalization and...
homicide that is statistically significant and robust. Naturally, the correlation does not begin to explain the relationship. But what this does suggest is that we may need to revisit all of our empirical studies on the incapacitation thesis.

A third question is comparative. The United States today has an extraordinarily high rate of imprisonment, especially compared to other Western or industrialized countries. (It has the highest rate and raw number of inmates in the world, but the contrast is even more shocking with peer countries, naturally). One immediate question that comes to mind is whether Western or industrialized countries with currently low prison populations use their mental health systems as an alternative form of social control.

My preliminary research suggests that the answer is no, at least as to the present. So, for instance, among countries in the European Union, the highest rate regarding the number of beds in psychiatric hospitals per 100,000 inhabitants in 2000 was in the Netherlands, which had a rate of 188.5. Other highs were posted in Belgium (161.6), Switzerland (119.9), France (113), and Finland (102.9). The average for the 25 European Union countries in 2000 was 90.1, down from 115.5 in 1993 (Eurostat, 2008). These figures are, indeed, higher than the corresponding prison rates for the same countries, which stood in 2006 at 128 per 100,000 persons in the Netherlands, 91 in Belgium, 83 in Switzerland, 85 in France, and 75 in Finland. But they certainly do not come close to the rates of aggregated institutionalization in the United States. These are preliminary findings, and I do need to conduct more research on these comparative figures. The Russian Federation, for example, has a prison rate of 611 per 100,000 (Walmsley, 2006, 5), which, when combined with mental health institutionalization, may offer some competition to the United States.

On a related issue, there is evidence that in the past some European countries used institutions other than the prison more than they do now to control those deemed deviant—in other words, that the trends identified in the United States may bear some resemblance to trends in Europe. The Republic of Ireland, for example, had much higher rates of institutionalization in a wide range of facilities, including psychiatric institutions and homes for unmarried mothers, at mid-century—in fact, eight times higher—than at the turn of the twentieth century (O’Sullivan, O’Donnell, 2006, 27-48). In Belgium, the number of psychiatric hospital beds per 100,000 inhabitants fell from 275 in 1970 to 162 in 2000; in France, it fell from 242 in 1980 to 111 in 2000; in the UK, from 250 in 1985 to 100 in 1998; and in Switzerland, from 300 in 1970 to 120 in 2000 (Eurostat, 2002). Again, this requires more research, but there may be an intriguing parallel—a parallel that may raise further questions about the novelty of our culture of control.

Conclusion

Today, the categories of “mental illness” and “criminality”—and the corresponding populations of the mental hospital and the prison—seem so distinct, so different, so particular. With the exception of the 7% to 16% of prison inmates who are suffering from mental illness (Ditton, 1999, 1), it seems so wrong and confused to mix the categories. It seems almost insulting to aggregate the two populations into one variable. But is it? Will later generations question our inability to see the continuity of spatial exclusion and confinement? Will they object to the balkanization of research on forms of social control? Will they reexamine our categories?
I suspect they will. It may be time, then, to rethink the category of confinement through the larger lens of institutionalization and to begin to trace that broader history of institutional incapacitation in twentieth century United States. Of course, the story may be even more complicated. Perhaps I have not even begun to scratch the surface of institutionalization. After all, Goffman included the military in the set of total institutions (Goffman, 1961, 5). Should we add the armed forces as part of our institutionalization count? Also, in the mental health area, many of the persons who were deinstitutionalized moved into private facilities. As William Gronfein writes, “many former patients have been ‘transinstitutionalized’ rather than deinstitutionalized, moving from state-supported asylums to privately run nursing homes or board-and-care homes.” Should we include nursing homes as well? And how about universities? How exactly should we define institutionalization? Where do we place the contour of the total institution?

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Champ pénal/Penal field, Séminaire du GERN "Longues peines et peines indéfinies. Punir la dangérosité" (2008-2009)
NOTES


2. See Rothman, 1971, 133 (observing that the goals of the asylum system was to create a “new world of the insane [that] would correct within its restricted domain the faults of the community
and through the power of example spark a general reform movement” and noting that that “broad program had an obvious similarity to the goals of the penitentiary”).

3. Foucault, 1961, 66 (« Il ne faut pas oublier que peu d’années après sa fondation, le seul Hôpital général de Paris groupait 6000 personnes, soit environ 1 % de la population. »)

4. Ignatieff, 1978, 210 (“The persistent support for the penitentiary is inexplicable so long as we assume that its appeal rested on its functional capacity to control crime. Instead, its support rested on a larger social need. It had appeal because the reformers succeeded in presenting it as a response, not merely to crime, but to the whole social crisis of a period . . . .”).

5. See Grob, 1983, ix (1983) (stating that 1960s “revisionist scholars” thought “mental illness was not an objective description of a disease within the conventional meaning of the term; it was rather an abstraction designed to rationalize the confinement of individuals who manifested disruptive and aberrant behavior”).

6. See, e.g., Grabosky, 1980 (examining the interrelation between prison and mental hospitalization rates 1930–1970); Liska et al., 1999 (examining the reciprocal relationship between the mental health system and the criminal justice system); Steadman, Monahan, 1984 (employing both a comparative framework and a longitudinal framework to analyze the relationship between mental hospital and prison populations).

7. See, e.g., Pfaff, 2004 (unpublished working paper, on file with author); Raphael, 2000 (finding that mental hospitalization rates have significant negative effects on prison incarceration rates).

8. See, e.g., DeFina, Arvanites, 2002 (investigating the effect of prison incarceration rates on crime by using per capita imprisonment rates); Levitt, 2004, 177–79 (examining the rising prison population as a factor in the reduction of crime during the 1990s).

9. See, e.g., Blumstein, Moitra, 1979, 377–89 (examining trends in imprisonment rates by state, noting “[t]he data also exclude prisoners in . . . mental institutions, and other forms of incarceration”); Bowker, 1981, 208 (deriving imprisonment rates by using the number of prisoners in state and federal institutions and examining the relationship between crime and incarceration rates); Chiricos, Waldo, 1970, 203-06 (using state prison data in an examination of the relationship between certainty and severity of punishment and crime rates); Levitt, 1996, 323 (using prison overcrowding litigation as a variable to analyze the effects of prison population on crime); McGuire, Sheehan, 1985, 77 (deriving imprisonment rates by using the number of “individuals confined in state and federal institutions” and examining the relationship between crime and incarceration rates).

10. E.g., DeFina, Arvanites, 2002 (analyzing the effect of imprisonment on seven criminal offenses using annual state-level data); Levitt, 2004; Levitt, 1996; Marvell, Moody, 1994, 127 (investigating the relationship between state prison population and crime rates).


12. See, e.g., Land, 1990, 922 (explaining that the current empirical literature on the structural covariates of homicide rates contains inconsistent findings across time periods and geographical units, and that a reestimation of the regression model greatly reduces these inconsistencies).


14. See, e.g., Blumstein, Wallman, 2000, 1-12 (noting the enormous expansion of the prison population); Levitt, 2004, 178–79 (examining the link between increased punishment and lower crime rates); Marvell, Moody, 1994, 109 (suggesting that regression analysis is a better tool for estimating the impact of increased imprisonment on crime rates); Spelman, 2000, 125 (concluding that increased incarceration was an important contributing factor to the reduction of violent crime in recent years).

15. See supra notes 5 and 6 and accompanying text.
16. See Liska, et al., 1999, 1744 (“The last decade has witnessed a plethora of social control studies, ranging from imprisonment to psychiatric hospitalization. Unfortunately, research on each of these two forms tends to be isolated from the other, and research on the relationships between them is limited.”).

17. See, e.g., Gronfein, 1985, 192 (“State hospital populations have declined substantially since the mid-1950s, falling by more than 75% from 1955 to 1980.”).

18. Gronfein shows that the structure of reimbursement policies that came into effect with the passage of the federal Medicaid program was the decisive factor in moving toward deinstitutionalization—and not, as many tend to think, the mere policy choice, nor the funding of community mental health centers. Gronfein, 1985, 193. But see Aviram, 1976, 576 (“In an attempt to account for variations in the decline trends for inpatients in mental institutions between and within states during a 15-yr period, we found an association between the pattern of decline and change in administrative policies and programs.”); Rose, 1979, 434-35 (discussing various factors scholars have proposed as influencing deinstitutionalization, such as a humane new concept of mental health, fiscal motives, and the role of psychotropic drugs).

19. See Blumstein, Moitra, 1979, 389 (“In examining the trends in the per capita imprisonment rates in the forty-seven states, it has been noted that almost half, twenty, are trendless, i.e., stationary, and that the trends in the remainder are small, i.e., less than 2% of the mean per year in all cases. These findings are thus consistent with the general homeostatic process previously observed in the United States as a whole and in other countries.”).

20. See, e.g., Bowker, 1981, 206 (extending a previous analysis that reported a positive relationship between crime and imprisonment); Chiricos, Waldo, 1970, 200 (extending prior research by examining three points in time instead of one and by examining changes in prior rates of crime); McGuire, Sheehan, 1985, 73–74 (extending prior research by accounting for “lag structures and interdependencies characterizing the relationships”).

21. See, e.g., Land, et al., 1990, 922 (demonstrating “that the empirical literature on the structural covariates of homicide rates contains inconsistent findings across different time periods and different geographical units”).

22. See Harcourt, 2007a, 166-167 (noting that the shift from rehabilitation in the 1950s to incapacitation in the 1980s and 1990s can be traced to the popular rise of actuarial methods in predicting and controlling criminality); Harcourt, 2001, 4 (describing the dramatic increase in incarceration from the 1970s to the 1990s).

23. A detailed list of the exact sources for the first variable, Insti1, is attached as Appendix B to my article « From the Asylum to the Prison: Rethinking the Incarceration Revolution - Part II: State Level Analysis, » University of Chicago Law & Economics, Olin Working Paper No. 335 (March 2007) (http://papers.ssrn.com/sol3/papers.cfm?abstract_id=970341). There were few missing observations, but for those few, I interpolated values. I complete list the state/year observations that were interpolated is attached as Appendix C to the same article.

24. For instance, in 1970, the Census reported 129,189 inmates in jail, whereas the first Department of Justice LEAA count that same year reported 160,863 inmates in jail—24.5% higher than the Census count (Cahalan, 1986, 76). In addition, between 1904 and at least 1940, the Census counted only jail inmates who were sentenced (Cahalan, 1986, 73-74). The 1923 special report, “Prisoners, 1923,” also excluded inmates who were not sentenced and omitted certain jails that were believed not to contain sentenced jail inmates (Cahalan, 1986, 73). All that data, including the 1933 “County and City Jails” report, excluded jail inmates who had not been sentenced yet (Cahalan, 1986, 73).


26. This includes not only studies of incapacitation and deterrence, but also research that studies the influence of crime rates on incarceration rates. Much of this work uses data from the
early 1970s. See, e.g., Ouimet, Tremblay, 1996, 109, 111 (comparing crime rates to imprisonment levels across states and time periods). Here too, aggregating mental hospitalization rates would have a significant effect.

27. See, e.g., Donohue, Siegelman, 1998, 21 (analyzing the tradeoff between investment in early education social programs, such as Head Start, and crime); Jacobs, Lefgren, 2003, 1561 (analyzing the short-term effects of school on juvenile crime); Lochner, 2004, 827-28 (comparing longitudinal data on education and employment with incidence of incarceration); Lochner, Moretti, 2004,156 (studying the relationship between state compulsory schooling laws and the probability of incarceration).

28. Another problem with their analysis is that the reduction in mental health care starting in the 1960s may itself reduce the number of mental health contacts for individuals who end up in prison. Measuring the interdependence of the two populations based on prior mental hospitalization will not capture mental illness properly if there is less and less care that leaves traces on the general population.

29. There are troubling reports concerning mental health institutionalization in Russia. See Murphy, 2006.

30. Gronfein, 1985, 193. Gerald Grob notes that “much of the decline in the number of patients in mental hospitals was more apparent than real. During the 1960s the number of mental patients in chronic nursing homes rose precipitously as states attempted to reduce their expenditures by taking advantage of new federal programs” (Grob, 1983, 317). So, for instance, whereas mental hospital populations decreased sharply and rapidly from over 500,000 in 1963 to under 370,000 seven years later in 1970, “the number of individuals with mental disorders in chronic nursing homes increased from 221,721 to 426,712 (of which 367,586 were aged sixty-five or older)” (Grob, 1983, 317).

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