From Asylum to Prison: Deinstitutionalization and the Rise of Mass Incarceration After 1945 by Anne E. Parsons (2018) Chapel Hill: University of North Carolina Press, 220 pp.

Reviewed by Christopher Santiago

During the second half of the twentieth century, antiinstitutional sentiment and mental health advocacy, along with changes in the psychiatric profession and shifting legal and political landscapes, combined to dramatically alter the mental health system in the United States. The result was deinstitutionalization – the downsizing and closure of state-run asylums and the release of thousands of people from confinement. Yet, "the asylum did not disappear", writes Anne E. Parsons in *From-Asylum to Prison*, "it returned in the form of the modern prison industrial complex" (p. 3).

Her book is part of UNC Press's *Justice, Power and Politics* series and co-winner of the Disability History Association's 2019 Outstanding Book Award. It tells the story of deinstitutionalization in the United States, focusing on events that occurred between 1945 and 1985 in Pennsylvania, the state that ran one of the country's largest mental health systems. It was during that period when the carceral state shifted away from psychiatric authority and asylums, toward the criminal courts, police, and prisons. Parsons argues that the swift expansion of the criminal legal system altered the process of deinstitutionalization, resulting in the overincarceration of people with psychiatric disabilities. Moreover, she asks what the history of deinstitutionalization can teach us about how to confront the crisis of mass incarceration today.

One of many factors that paved the way for deinstitutionalization was a change in how psychiatric disorders were treated. In the mid-twentieth century, mental health care was provided almost entirely on an inpatient basis. Laws allowed states to involuntarily commit people to asylums from which there were few legal avenues to secure release. In 1945, 190 state-run mental hospitals held 538,629 people, most of whom had been committed against their will and had no say in what treatment, if any, they received. Treatments common at the time included psychotherapy, electroconvulsive therapy, insulin comas, and psychosurgery. By the 1950s, new medications, such as the major tranquilizer Thorazine, became available. These new drugs opened the possibility for outpatient treatment with drug therapy and rehabilitation.

Negative publicity also spurred deinstitutionalization as popular media introduced Americans to the horrific conditions, riots, and scandals inside asylums. In 1946, for example, *Life* magazine and the journal *PM* ran articles exposing filthy, dilapidated, and overcrowded institutions such as the Philadelphia State Hospital at Byberry, where beatings and murders took place regularly. "Through public neglect and legislative penny-pinching", wrote Albert Q. Maisel (1946) in *Life*, "state after state has allowed its institutions for the care of the mentally sick to degenerate into little more than concentration camps" (p.102). Also, books such as Mary Jane Ward's *The Snake Pit* (1946), Ken Kesey's *One Flew Over the Cuckoo's Nest* (1962), and Sylvia Plath's *The Bell Jar* (1963) portrayed mental hospitals as prison-like settings where people languished while being forced to undergo unwanted, harmful treatments.

Channeling widespread outrage at institutional harms, public interest lawyers filed lawsuits that won civil rights for people during hospitalization. In the 1971 case of Dixon v. Attorney General, a federal district court in Pennsylvania declared the state's involuntary commitment law unconstitutional and ordered the release of people confined without due process from the Fairview State Hospital for the Criminally Insane. That decision led to the discharge of thousands of people from mental hospitals across the state. Similarly, in 1972, the United States Supreme Court held in *Jackson v. Indiana* that people with psychiatric disabilities could not be involuntarily committed without due process. That same year, in *Wyatt v. Stickney*, a federal court in Alabama recognized a constitutional right to treatment for people in mental hospitals.

Though the courts had granted individuals new rights regarding hospitalization, people in the community still lacked a right to mental health care. For that, they relied heavily on federal programs. In 1963, the Community Mental Health Act funded programs to build community-based care centres, making it possible for more people to receive mental health services outside of asylums. The newly created Medicare and Medicaid also played important roles in the transition from hospital to community care, as did the expansion of Supplemental Security Income and Social Security Disability insurance in the 1970s.

The confluence of new treatments, public outrage, activism, and changing laws resulted in a substantial reduction in the number of individuals confined to mental institutions. In 1950, about half a million

people were confined to psychiatric hospitals; by 2000 that number had fallen to about fifty thousand (Frank & Glied, 2006). At this point in the story, many accounts of deinstitutionalization claim that when adequate community mental health services failed to materialize, people released from asylums roamed the streets, ran afoul of the law, and landed behind bars. Parsons criticizes this oversimplified version of history for ignoring how law and order politics, increasingly punitive laws, the over-policing of African American communities, and the criminalization of people with mental disabilities steered the process of deinstitutionalization toward mass incarceration.

Her research reveals how policies that affected mental health care were closely intertwined with policies that drove mass incarceration, especially at the state level. In 1981, for example, Pennsylvania Governor Dick Thornburgh cut $267 million from the state budget, targeting the Department of Welfare and psychiatric hospitals for the largest cuts. At the same time, he announced a "war on crime", expanding police departments and the prison system. This reallocation of funds from welfare to law enforcement reflected a larger shift in the government's role from caring for people to policing them. It left individuals without the community-based mental health services and social supports they needed. As a result, more people with psychiatric disabilities were arrested and jailed rather than hospitalized.

As America's increasingly punitive criminal legal system grew, incarceration rates skyrocketed. By the twenty-first century, the United States held over two million people in prisons and jails. As the number of incarcerated people increased, so did the number of people with mental disorders behind bars. Money that should have funded community mental health was diverted to building not only new prisons, but also psychiatric wards within prisons. "The process of deinstitutionalization", ·Parsens writes, "was actually a reinstitutionalization in which prisons absorbed the functions of custodial mental hospitals" (p. 155). Many of the new prisons, especially in the Northeast and Midwest, were actually constructed on the sites of former asylums, repurposing their empty infrastructure and surplus land. *From Asylum to Prison* is the first book I am aware of to chart the literal conversion of mental institutions into correctional institutions.

The book is especially important because it uses history as a tool for solving social problems. According to Parsons, the "deinstitutionalization of the mental health system is a type of decarceration that activists can learn from as they promote prison abolition" (p.12). She provides three key lessons.

Firstly, human beings – especially people with psychiatric disabilities – should not be held in carceral spaces like prisons and asylums, which are notorious for their poor conditions and limited access to mental health care. Incarceration itself exacerbates mental illness. Parsons recommends that mental health advocates not only work to provide better mental health care for people behind bars, but also work to decarcerate prisons.

Secondly, decarceration cannot be driven by cost cutting. Social supports must be put in place for the well-being of people returning to their communities. People with psychiatric disabilities should have access to medical and mental health care, housing, and social services, which should be provided by the state "at the time of need rather than at the point of lawbreaking" (p.155).

Finally, in our efforts to decarcerate prisons and provide mental health care, we must be careful not to recreate confinement in other forms. This will require a change in the attitudes that led to overincarceration, especially the fear and discrimination that resulted in the criminalization of people of color and people with mental disorders. Parsons believes that public education campaigns are needed to accomplish this.

Extensively researched and written in clear, personcentered language, *From Asylum to Prison* is a necessary corrective for oversimplified histories upon which several misguided reform proposals that continue to rely on coercive confinement have been based. I recommend it to historians, abolitionist organizers, policy makers, and anyone involved with mental health or the criminal justice system.

REFERENCES

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