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Review Article

Aftermath of Deinstitutionalization: A Secondary Analysis of Crime, Deviance, and Mental Health in Industrialized Society

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Abstract

This secondary analysis synthesizes recent empirical research to examine the relationship between mental health, crime, and deviance through a sociological lens. Drawing on labeling theory, conflict theory, and governmentality perspectives, the analysis demonstrates that the criminalization of mental illness is fundamentally a social process rather than a consequence of psychiatric pathology. The study integrates findings from epidemiological research, criminal justice studies, and public health scholarship to show that structural disadvantage, institutional practices, and racialized social control mechanisms channel people with mental illness into carceral pathways. Findings indicate that diversion programs often function as net-widening mechanisms, that mass incarceration produces community-level mental health harms extending far beyond those imprisoned, and that the therapeutic and penal institutions have become increasingly entangled. The analysis concludes that addressing the criminalization of mental illness requires structural transformation of housing, healthcare, and social welfare systems rather than incremental criminal justice reform.

Keywords: sociology of deviance, mental health, criminalization, labeling theory, mass incarceration, racial disparities.

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Introduction

The intersection of mental health, crime, and deviance constitutes one of the most pressing concerns in contemporary sociological inquiry. Recent scholarship has increasingly recognized that the overrepresentation of people with mental illness in the criminal justice system is not an inevitable consequence of psychiatric disorder but a product of specific institutional arrangements and structural forces (Karunarathna, 2025; Downes et al., 2026). The sociology of crime and deviance provides essential analytical tools for understanding this phenomenon, offering frameworks that move beyond individual pathology to examine the social processes through which deviance is defined, labeled, and managed (Crawford & Novak, 2024; Downes et al., 2026).

Contemporary estimates indicate that more than two million people with serious mental illness are arrested and booked into jails and prisons annually in the United States (Karunarathna, 2025). This staggering figure reflects not the dangerousness of the mentally ill, the overall incidence of serious violence among those with psychiatric diagnoses remains extremely low, but the systematic failure of community mental health infrastructure and the expansion of carceral governance into domains previously managed by therapeutic institutions (Manor et al., 2025; Solomon & Petros, 2020). The three largest mental health facilities in the United States are not hospitals but the Rikers Island jail complex, the Los Angeles County Jail, and the Cook County Jail (Cockerham, 2024). This institutional configuration represents what this analysis terms the "carceral nexus": the entanglement of therapeutic and penal functions such that treatment and punishment become indistinguishable (Stitt, 2025).

This secondary analysis synthesizes recent empirical research to examine the sociological dimensions of the intersection between mental health, crime, and deviance. The analysis proceeds through four substantive sections. The first establishes theoretical foundations for understanding deviance and mental illness as socially defined phenomena. The second examines empirical evidence on mental illness prevalence in carceral settings, interpreting these figures as indicators of systemic failure. The third analyzes mechanisms of criminalization, including policing practices, diversion programs, and structural disadvantage. The fourth examines the spillover effects of mass incarceration for population mental health. The analysis concludes by considering implications for policy and for the sociological understanding of deviance.

Theoretical Foundations: Labeling, Conflict, and the Social Construction of Mental Illness

The sociological study of deviance begins from a foundational insight: deviance is not a property inherent in particular acts or conditions but a product of social definition (Scheff, 1966; Downes et al., 2026). What counts as deviant varies across time, place, and social context, and the processes through which certain behaviors or characteristics come to be defined as deviant are themselves worthy of sociological analysis (Crawford & Novak, 2024). This insight, articulated most forcefully in labeling theory, has profound implications for understanding the relationship between mental illness and criminality (Scheff, 1966; West et al., 2024).

Labeling theorists, drawing on the symbolic interactionist tradition, argue that deviance is produced through processes of social reaction (Scheff, 1966; Link et al., 1997). An individual engages in a primary deviant act; if this act is discovered and the individual is publicly labeled as deviant, secondary deviance may follow as the labeled person reorganizes their identity and behavior around the deviant status (Link et al., 1997; Moore & Tangney, 2017). Applied to mental illness, this framework suggests that diagnostic labels activate stereotypical associations that shape how individuals are perceived, treated, and ultimately how they come to understand themselves (Link et al., 1997; West et al., 2024). Research on juror decision-making has found that while diagnostic labels may have limited direct impact on verdicts regarding diminished responsibility, stigma associated with mental illness significantly shapes attributions of blame and dangerousness (Walkden et al., 2026). This suggests that the consequences of psychiatric labeling operate not primarily through formal legal categories but through the informal stereotypes that such labels activate (West et al., 2024).

The social constructionist perspective on mental illness does not deny the reality of psychological suffering or the utility of psychiatric intervention. Rather, it insists that the boundaries of what we call "mental illness" and the institutional responses to it are shaped by social forces that cannot be reduced to medical or biological determinants (Eisenberg, 1977; Crawford & Novak, 2024). The expansive diagnostic categories of contemporary psychiatry, the pharmaceutical industry's role in shaping treatment paradigms, and the cultural narratives that associate mental illness with dangerousness all contribute to the social production of mental illness as a particular kind of identity (Yakeley, 2026; Hickling, 2019). When this identity intersects with race, class, and gender, the consequences become especially severe: Black individuals, particularly Black men, are disproportionately diagnosed with psychotic disorders, subject to coercive interventions, and processed through the criminal justice system (Heyes et al., 2025; Yakeley, 2026).

Conflict theory offers a complementary perspective, emphasizing how power differentials shape the definition and management of deviance (Crawford & Novak, 2024; Piatkowska et al., 2024). From this view, the criminalization of mental illness reflects broader patterns of social stratification: those with the least power, the poor, the unhoused, the racially marginalized, are most likely to have their mental distress managed through punitive rather than therapeutic means (Stitt, 2025; Piatkowska et al., 2024). The "criminalization of illness" documented in recent scholarship is thus not a neutral response to dangerousness but a manifestation of structural inequality, whereby the state's coercive apparatus is deployed most readily against those whose social position renders them expendable (Yakeley, 2026; Stitt, 2025).

The Prevalence of Mental Illness in Carceral Settings: Empirical Evidence and Interpretation

If mental illness were primarily a cause of criminal behavior, we would expect to find high rates of untreated psychiatric disorder among incarcerated populations. The evidence bears out this expectation, but in ways that require careful sociological interpretation (Fazel et al., 2025; Emilian et al., 2025). Recent systematic reviews examining prevalence of severe mental illness among people in prison across multiple countries have found that depression affects approximately 12.8% of incarcerated

individuals, while any psychosis affects 4.1% (Emilian et al., 2025; Fazel et al., 2025). Schizophrenia spectrum disorders are present in 3.6% of the prison population, with bipolar disorder at 1.7% (Fazel et al., 2025). These figures substantially exceed community prevalence rates for comparable diagnostic categories (Emilian et al., 2025).

The treatment gap within carceral institutions is equally significant. The identification of mental illness does not ensure its treatment, and the vast majority of incarcerated individuals with mental illness receive no treatment at all (Cockerham, 2024; Gido, 2026). The prison thus functions less as a therapeutic institution than as a warehouse for populations that the community mental health system has failed to serve (Stitt, 2025; Cockerham, 2024). This failure is not accidental but the predictable consequence of deinstitutionalization policies that reduced psychiatric bed capacity without adequate investment in community-based alternatives (Manor et al., 2025; Taylor Salisbury et al., 2022). Research examining the relationship between psychiatric bed availability and incarceration rates across Latin American countries found an inverse relationship: as psychiatric beds decreased, incarceration rates increased (Siebenförcher et al., 2022). This pattern suggests that the carceral system has absorbed populations that the mental health system no longer serves (Manor et al., 2025; Siebenförcher et al., 2022).

The interpretation of these prevalence figures requires caution. The association between mental illness and incarceration is not necessarily causal in the direction of crime. As critical scholars have emphasized, people with serious mental illness are more likely to be victims of crime than perpetrators (Karunarathna, 2025; Disability Rights Education & Defense Fund, 2024). The pathways into incarceration for this population typically involve minor, quality-of-life offenses, trespassing, disorderly conduct, petty theft, that are symptomatic of untreated illness, homelessness, or substance use, rather than serious violent crime (Stitt, 2025; Izenberg, 2025). The high prevalence of mental illness in carceral settings is thus best understood as evidence of systemic failure, the failure of community mental health services, housing systems, and social welfare provision, rather than as confirmation that mental illness causes crime (Manor et al., 2025; Solomon & Petros, 2020).

Mechanisms of Criminalization: Policing, Diversion, and Structural Disadvantage

The pathway from mental illness to incarceration is not direct but mediated by specific institutional practices and structural conditions. Understanding these mechanisms is essential for a sociological analysis that moves beyond correlation to explanation (Piatkowska et al., 2024; McNeil et al., 2024). The first point of contact is typically policing, where discretionary decisions shape who enters the criminal justice system and under what circumstances (Rohrer, 2026; Piatkowska et al., 2024).

Contemporary policing practices have increasingly involved responding to calls involving individuals in mental health crisis. However, the training and orientation of police officers are predominantly oriented toward law enforcement rather than mental health intervention (Rohrer, 2026). Research with police officers found that less knowledge about mental illness was correlated with more anxiety during conflictual interactions (Rohrer, 2026). When police encounter individuals exhibiting symptoms of mental illness, disorientation, agitation, apparent noncompliance with commands, they may interpret these behaviors through the lens of criminal threat rather than medical emergency (Rohrer, 2026; Piatkowska et al., 2024). The consequences can be fatal: people experiencing a mental health crisis constitute a disproportionate rate of fatalities during interactions with police (Rohrer, 2026; Karunarathna, 2025). For those who survive the encounter, arrest and booking may follow, initiating a carceral trajectory that could have been diverted at multiple points (Rohrer, 2026; Izenberg, 2025).

Diversion programs, ostensibly designed to redirect individuals with mental illness away from incarceration and into treatment, have become a primary policy response to the criminalization of mental illness. Yet recent research reveals that these programs often operate in ways that expand rather than reduce the reach of the criminal justice system (Schaible & Gant, 2026; Izenberg, 2025). Ethnographic study of Law Enforcement Assisted Diversion (LEAD) programs demonstrates how institutional accountability pressures and bureaucratic oversight contribute to "net widening": individuals who would previously have received no criminal justice intervention at all are now drawn into court-supervised treatment regimens that extend state surveillance and control over their lives (Schaible & Gant, 2026). The concept of the "waiting room effect" similarly describes how diversion strategies may unintentionally reinforce the role of jails by relying on them as places to hold individuals awaiting access to scarce and overburdened community resources (Izenberg, 2025).

The structural disadvantages that bring people with mental illness into contact with the criminal justice system are also the disadvantages that make exit from that system difficult (McNeil et al., 2024; Moore & Tangney, 2017). Housing instability, unemployment, and limited

access to healthcare are both causes and consequences of criminal justice involvement (McNeil et al., 2024; Stitt, 2025). The criminal record that results from even minor offenses creates barriers to employment, housing, and public benefits, producing a form of "invisible punishment" that extends long after formal sentence completion (Moore & Tangney, 2017). For individuals with mental illness, these collateral consequences are compounded by the stigma associated with psychiatric diagnosis, producing a double marginalization that renders reintegration exceptionally difficult (Moore & Tangney, 2017; West et al., 2024).

The racial dimensions of this process are stark. A recent rapid review of ethnic disparities in acute mental health inpatient care found evidence of disparities in involuntary admission, psychiatric diagnoses, forced medication, physical restraint, seclusion, length of stay, and access to appropriate services (Hua & Bhui, 2025). These disparities map onto components identified as underlying institutional racism (Hua & Bhui, 2025; Yakeley, 2026). Black individuals with mental illness are subject to more coercive interventions, including physical restraint and police transport to emergency departments, and are more likely to be arrested rather than diverted to treatment compared to white individuals exhibiting similar symptoms (Yakeley, 2026; Smith et al., 2025). A co-produced review of Black male detention under mental health legislation found that fear is often at the center of the distrust experienced by Black patients, based on experiences of racism and coercive treatment (Heyes et al., 2025). These disparities reflect not only individual bias but the operation of structural racism within both healthcare and criminal justice systems (Hua & Bhui, 2025; Yakeley, 2026).

The Carceral Nexus: Mass Incarceration and Population Mental Health

The analysis thus far has focused on individuals who are directly processed through the criminal justice system. Yet the sociological significance of the carceral nexus extends far beyond those who are arrested, convicted, and imprisoned. Mass incarceration, as a structural feature of contemporary society, exerts profound effects on population mental health through what scholars term "spillover" mechanisms (Holaday et al., 2026; Larrain & Parker, 2026).

A recent study examining the relationship between incarceration and psychiatric emergency department visits among Black Americans from 2006 to 2015 found that one additional individual incarcerated per 100,000 population corresponded with a 1.4% increase in psychiatric ED visits in Black communities (Das et al., 2025). More strikingly, an increase in racial inequity in incarceration, measured as the ratio of Black to white incarcerated populations, coincided with a 2.2% increase in psychiatric emergencies among Black Americans (Das et al., 2025). These findings suggest that the "long arm of incarceration" extends to acute psychiatric emergencies among Black Americans in the broader community, even those who have never been incarcerated themselves (Das et al., 2025). The spillover effects of jail and prison incarceration extend to acute psychiatric emergencies in Black communities, with state-level drug reform policies and policies that reduce labor market and housing discrimination for former inmates potentially having salutary mental health benefits for the broader community (Das et al., 2025; Holaday et al., 2026).

The mechanisms through which mass incarceration produces community-level mental health harms are multiple. Theoretical work posits that mass incarceration can erode social capital by straining social and family networks as well as inducing "carceral churn", the repeated cycling of individuals through jail and prison, and coercive mobility within Black communities (Holaday et al., 2026; Powell & Apel, 2024). High-incarceration neighborhoods experience elevated rates of mental illness, not simply because individuals with mental illness are concentrated in these areas, but because the experience of living in a community marked by police surveillance, repeated removal and return of community members, and the erosion of informal social control mechanisms produces psychological distress (Holaday et al., 2026; Aboagye et al., 2026). Social disorganization theory, which emphasizes the role of weakened community institutions and informal social bonds in producing crime, is relevant here: mass incarceration functions as a mechanism of community disruption that undermines the very social ties that might otherwise protect against both crime and mental distress (Aboagye et al., 2026; Holaday et al., 2026).

The mental health consequences for families of incarcerated individuals are well-documented (Powell & Apel, 2024; Holaday et al., 2026). Partners of incarcerated men experience elevated rates of depression and anxiety, exacerbated by economic strain and the expanded caregiving responsibilities that incarceration imposes (Powell & Apel, 2024). Children of incarcerated parents exhibit elevated emotional distress, behavioral problems, and educational difficulties, with effects that persist into adulthood (Powell & Apel, 2024; Holaday et al., 2026). These spillover effects are not incidental but constitute a form of structural violence: the carceral state systematically distributes psychological harm to

the families and communities of those it imprisons, reproducing disadvantage across generations (Holaday et al., 2026; Powell & Apel, 2024).

The entanglement of therapeutic and penal institutions that characterizes the carceral nexus has profound implications for the sociology of deviance (Stitt, 2025; Schaible & Gant, 2026). When treatment is administered under the threat of punishment, when mental health services are delivered through the criminal justice system, and when the failure to comply with treatment regimens results in incarceration, the distinction between therapy and social control collapses (Stitt, 2025; Cockerham, 2024). The sociology of deviance must reckon with this collapse, recognizing that the institutions that purport to respond to mental illness are increasingly indistinguishable from those that punish it (Stitt, 2025; Weston & Trebilcock, 2025). The concept of governmentality, as developed by Foucault, illuminates this dynamic: risk management, surveillance, and responsibilization operate through ostensibly therapeutic interventions, reproducing punitive and governmental rationalities within reformist programs (Schaible & Gant, 2026).

Findings

The secondary analysis yields six interconnected findings that collectively reframe the relationship between mental illness, crime, and social control as a fundamentally sociological problem rather than a psychiatric one.

At the outset, the overrepresentation of people with mental illness in the criminal justice system is not primarily a function of psychiatric symptomatology causing criminal behavior. The empirical evidence consistently demonstrates that the vast majority of offenses for which this population is arrested are minor, quality-of-life offenses, trespassing, disorderly conduct, petty theft, and public nuisance, driven by co-occurring substance use, homelessness, and poverty rather than serious psychiatric impairment. The overall incidence of serious violence among those with psychiatric diagnoses remains extremely low, a finding that directly contradicts popular assumptions linking mental illness with dangerousness. What compounds this problem is that the mechanisms of criminalization are institutional and structural rather than individual. Policing practices that interpret mental health crises as criminal threats, diversion programs that widen rather than reduce net-widening effects, and the collateral consequences of criminal records operate systematically to channel people with mental illness into carceral pathways. The carceral nexus, understood as the entanglement of therapeutic and penal functions, ensures that treatment and punishment become indistinguishable, with the state's coercive apparatus deployed most readily against those whose social position renders them expendable.

Building on this, another layer of this dynamic involves the health effects of mass incarceration, which extend far beyond those directly imprisoned, producing community-level and familial mental health harms that reproduce disadvantage across generations. Research examining the relationship between incarceration and psychiatric emergency department visits among Black Americans from 2006 to 2015 found that one additional individual incarcerated per 100,000 population corresponded with a 1.4% increase in psychiatric ED visits in Black communities, while an increase in racial inequity in incarceration coincided with a 2.2% increase in psychiatric emergencies among Black Americans. These findings suggest that the "long arm of incarceration" extends to acute psychiatric emergencies among Black Americans in the broader community, even those who have never been incarcerated themselves. The mechanisms through which mass incarceration produces community-level mental health harms are multiple: erosion of social capital, straining of social and family networks, "carceral churn" involving the repeated cycling of individuals through jail and prison, and coercive mobility within Black communities. High-incarceration neighborhoods experience elevated rates of mental illness, not simply because individuals with mental illness are concentrated in these areas, but because the experience of living in a community marked by police surveillance, repeated removal and return of community members, and the erosion of informal social control mechanisms produces psychological distress. Social disorganization theory is relevant here: mass incarceration functions as a mechanism of community disruption that undermines the very social ties that might otherwise protect against both crime and mental distress.

What is more troubling still, the therapeutic and penal institutions have become increasingly entangled, such that treatment administered under carceral authority functions as a modality of social control rather than a genuine alternative to punishment. When treatment is administered under the threat of punishment, when mental health services are delivered through the criminal justice system, and when the failure to comply with treatment regimens results in incarceration, the distinction between therapy and social control collapses. The sociology of deviance must reckon with this collapse, recognizing that the institutions that purport to respond to mental illness are increasingly indistinguishable from those that punish it. The

concept of governmentality illuminates this dynamic: risk management, surveillance, and responsibilization operate through ostensibly therapeutic interventions, reproducing punitive and governmental rationalities within reformist programs. Diversion programs, ostensibly designed to redirect individuals with mental illness away from incarceration and into treatment, often operate in ways that expand rather than reduce the reach of the criminal justice system. Ethnographic study of Law Enforcement Assisted Diversion programs demonstrates how institutional accountability pressures and bureaucratic oversight contribute to "net widening": individuals who would previously have received no criminal justice intervention at all are now drawn into court-supervised treatment regimens that extend state surveillance and control over their lives. The concept of the "waiting room effect" similarly describes how diversion strategies may unintentionally reinforce the role of jails by relying on them as places to hold individuals awaiting access to scarce and overburdened community resources.

Equally consequential, the racial dimensions of this process are constitutive rather than incidental: Black individuals are disproportionately subject to coercive interventions at every stage, and the criminalization of mental illness must be understood as a racialized phenomenon. A recent rapid review of ethnic disparities in acute mental health inpatient care found evidence of disparities in involuntary admission, psychiatric diagnoses, forced medication, physical restraint, seclusion, length of stay, and access to appropriate services. These disparities map onto components identified as underlying institutional racism. Black individuals with mental illness are subject to more coercive interventions, including physical restraint and police transport to emergency departments, and are more likely to be arrested rather than diverted to treatment compared to white individuals exhibiting similar symptoms. A co-produced review of Black male detention under mental health legislation found that fear is often at the center of the distrust experienced by Black patients, based on experiences of racism and coercive treatment. These disparities reflect not only individual bias but the operation of structural racism within both healthcare and criminal justice systems. The intersection of race, class, and gender produces especially severe consequences: Black individuals, particularly Black men, are disproportionately diagnosed with psychotic disorders, subject to coercive interventions, and processed through the criminal justice system.

Cumulatively, the effect of these dynamics is that the prevalence of mental illness in carceral settings is best interpreted as evidence of systemic failure, the inadequacy of community mental health infrastructure, housing, and social welfare provision, rather than as confirmation that mental illness causes crime. Recent systematic reviews examining prevalence of severe mental illness among people in prison across multiple countries have found that depression affects approximately 12.8% of incarcerated individuals, while any psychosis affects 4.1%. Schizophrenia spectrum disorders are present in 3.6% of the prison population, with bipolar disorder at 1.7%. These figures substantially exceed community prevalence rates for comparable diagnostic categories. The treatment gap within carceral institutions is equally significant: the identification of mental illness does not ensure its treatment, and the vast majority of incarcerated individuals with mental illness receive no treatment at all. The prison thus functions less as a therapeutic institution than as a warehouse for populations that the community mental health system has failed to serve. This failure is not accidental but the predictable consequence of deinstitutionalization policies that reduced psychiatric bed capacity without adequate investment in community-based alternatives. Research examining the relationship between psychiatric bed availability and incarceration rates across Latin American countries found an inverse relationship: as psychiatric beds decreased, incarceration rates increased. This pattern suggests that the carceral system has absorbed populations that the mental health system no longer serves. The interpretation of these prevalence figures requires caution: the association between mental illness and incarceration is not necessarily causal in the direction of crime. As critical scholars have emphasized, people with serious mental illness are more likely to be victims of crime than perpetrators.

Finally, and perhaps most significantly for sociological theory, the theoretical implications of these findings for the sociology of deviance are profound. Labeling theory, conflict theory, and governmentality perspectives together illuminate how the criminalization of mental illness is fundamentally a social process rather than a consequence of psychiatric pathology. Labeling theorists, drawing on the symbolic interactionist tradition, argue that deviance is produced through processes of social reaction. An individual engages in a primary deviant act; if this act is discovered and the individual is publicly labeled as deviant, secondary deviance may follow as the labeled person reorganizes their identity and behavior around the deviant status. Applied to mental illness, this framework suggests that diagnostic labels activate stereotypical associations that shape how individuals are perceived, treated, and ultimately how they come to understand themselves. Research on juror

decision-making has found that while diagnostic labels may have limited direct impact on verdicts regarding diminished responsibility, stigma associated with mental illness significantly shapes attributions of blame and dangerousness. This suggests that the consequences of psychiatric labeling operate not primarily through formal legal categories but through the informal stereotypes that such labels activate. Conflict theory offers a complementary perspective, emphasizing how power differentials shape the definition and management of deviance. From this view, the criminalization of mental illness reflects broader patterns of social stratification: those with the least power, the poor, the unhoused, the racially marginalized, are most likely to have their mental distress managed through punitive rather than therapeutic means. The "criminalization of illness" documented in recent scholarship is thus not a neutral response to dangerousness but a manifestation of structural inequality, whereby the state's coercive apparatus is deployed most readily against those whose social position renders them expendable. The social constructionist perspective on mental illness does not deny the reality of psychological suffering or the utility of psychiatric intervention. Rather, it insists that the boundaries of what we call "mental illness" and the institutional responses to it are shaped by social forces that cannot be reduced to medical or biological determinants. The expansive diagnostic categories of contemporary psychiatry, the pharmaceutical industry's role in shaping treatment paradigms, and the cultural narratives that associate mental illness with dangerousness all contribute to the social production of mental illness as a particular kind of identity.

Limitations

Several limitations qualify the conclusions of this analysis and point to future research directions.

To begin with, the evidence base draws predominantly from high-income countries, especially the United States, limiting generalizability to contexts with different criminal justice and mental health systems. The carceral nexus described here reflects a particular configuration of welfare state retrenchment, mass incarceration, and racialized social control that may operate differently elsewhere. Future research should examine whether similar dynamics appear in countries with universal healthcare, lower incarceration rates, or stronger labor protections.

Relatedly, the synthesis relies on published studies subject to publication bias favoring significant findings. Null or negative results may be underrepresented, potentially inflating prevalence estimates and associations. Rapid review methodologies in some cited studies may also introduce unquantifiable selection biases. Furthermore, prevalence figures from prison populations vary substantially across studies due to differences in diagnostic instruments, sampling, and carceral conditions. Pooled estimates, 12.8% for depression, 4.1% for any psychosis, 3.6% for schizophrenia spectrum disorders, and 1.7% for bipolar disorder, may obscure variation across jurisdictions and demographic groups. Distinguishing pre-existing from incarceration-emergent mental illness is also difficult with cross-sectional data. Compounding these concerns, causal mechanisms are difficult to establish with observational data, and some associations may reflect unmeasured confounding, reverse causality, or omitted variable bias. While the analysis interprets findings through a sociological lens emphasizing structural mechanisms, the observational evidence base limits causal claims.

Beyond these methodological constraints, the analysis focuses on institutional dimensions and does not fully explore subjective experiences of individuals navigating these systems, which would require qualitative methods. Phenomenological and narrative approaches would illuminate how people make sense of their trajectories, resist or accommodate labels, and experience the collapse of therapeutic and penal logics. Additionally, the analysis does not fully address heterogeneity within mental illness. "Serious mental illness" encompasses diverse conditions with potentially different relationships to criminal justice involvement, treatment needs, and trajectories. Future research should examine diagnostic specificity.

It must also be noted that reliance on secondary data constrains the analysis to questions and variables measured in original studies. Important factors, quality of community mental health services, housing availability, social networks, nature of police encounters, may not be consistently measured. Moreover, findings may not apply to low- and middle-income countries, where mental health services are scarce, incarceration rates differ, and the mental illness–criminal justice relationship may follow different patterns. Comparative research is needed. In a related vein, the analysis does not systematically examine gender. Women with mental illness may face different patterns of criminalization, coercion, and barriers to reintegration. Future research should examine these differences.

A concluding limitation is that the analysis focuses on the contemporary period and does not fully historicize the carceral nexus. Historical research would contextualize the current moment and identify contingencies shaping present configurations of mental health and criminal justice institutions.

Conclusion

The sociology of crime and deviance offers indispensable tools for understanding the relationship between mental health, crime, and social control. Moving beyond individual-pathology explanations, this analysis demonstrates that the criminalization of mental illness is a fundamentally social process rooted in labeling, structural disadvantage, and the expansion of carceral governance. The prevalence of mental illness in carceral settings reflects systemic failure rather than the dangerousness of the mentally ill. The mechanisms of criminalization operate through institutional practices that channel structurally vulnerable populations into carceral pathways. The consequences extend far beyond those imprisoned, producing community-level harms that reproduce disadvantage across generations. Addressing the carceral nexus requires not merely reform of criminal justice institutions but transformation of the social conditions, housing, healthcare, employment, and racial inequality, that make mental illness a pathway to punishment rather than a condition deserving of care.

The analysis has synthesized recent empirical research to examine the sociological dimensions of the intersection between mental health, crime, and deviance. It has established theoretical foundations for understanding deviance and mental illness as socially defined phenomena, examined empirical evidence on mental illness prevalence in carceral settings, analyzed mechanisms of criminalization including policing practices, diversion programs, and structural disadvantage, and examined the spillover effects of mass incarceration for population mental health. The findings suggest that the carceral nexus is not an incidental feature of contemporary society but a central mechanism through which social inequality is reproduced and through which the state manages marginalized populations.

The theoretical implications of this analysis extend beyond the specific case of mental illness and criminal justice involvement. The collapse of the distinction between therapeutic and penal institutions raises fundamental questions about the nature of social control in contemporary society. When treatment is administered under the threat of punishment, when mental health services are delivered through the criminal justice system, and when the failure to comply with treatment regimens results in incarceration, the liberal distinction between care and coercion becomes untenable. The carceral nexus thus represents not only a policy failure but a theoretical challenge to conventional understandings of deviance, social control, and the welfare state.

The policy implications of this analysis are equally profound. The findings suggest that incremental criminal justice reform, police training programs, diversion initiatives, mental health courts, is unlikely to address the fundamental dynamics that produce the carceral nexus. These reforms may even exacerbate the problem by expanding the reach of the criminal justice system into domains previously managed by therapeutic institutions. What is required instead is structural transformation of the systems that produce mental distress and channel it into carceral pathways: investment in community mental health services, affordable housing, employment opportunities, and social welfare provision; reduction of racial inequality in both healthcare and criminal justice systems; and a fundamental rethinking of the relationship between the state's coercive apparatus and its therapeutic functions.

The analysis also suggests directions for future research. Comparative research is needed to examine how the carceral nexus varies across national contexts and what factors shape its configuration. Longitudinal research is needed to understand the causal mechanisms linking mental illness to criminal justice involvement and to identify points of intervention. Qualitative research is needed to understand the subjective experiences of individuals navigating the carceral nexus and to capture dimensions of lived experience that quantitative and institutional data cannot fully capture. And theoretical research is needed to develop more adequate conceptual frameworks for understanding the entanglement of therapeutic and penal institutions in contemporary society.

In conclusion, the criminalization of mental illness is not an inevitable consequence of psychiatric disorder but a product of specific institutional arrangements and structural forces. The carceral nexus, the entanglement of therapeutic and penal functions such that treatment and punishment become indistinguishable, represents a fundamental challenge to the sociology of deviance and to the broader project of understanding social control in contemporary society. Addressing this challenge requires not only empirical research but theoretical innovation and political commitment to structural transformation. The stakes are high: the well-being of millions of individuals with mental illness, the health of their families and communities, and the integrity of the principles of justice and care that purport to guide our institutions.

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