Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s

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In a message to Congress in 1963, President John F. Kennedy outlined a federal program designed to reduce by half the number of persons in custody. The institutions at issue were state hospitals and asylums for the mentally ill, and the number of such persons in custody was staggeringly large, in fact comparable to contemporary levels of mass incarceration in prisons and jails. President Kennedy's message to Congress—the first and perhaps only presidential message to Congress that dealt exclusively with the issue of institutionalization in this country—proposed replacing state mental hospitals with community mental health centers, a program ultimately enacted by Congress in 1963 under the Community Mental Health Centers Act. President Kennedy's message to Congress was straightforward:

> If we launch a broad new mental health program now, it will be possible within a decade or two to reduce the number of patients now under custodial care by 50 percent or more. Many more mentally ill can be helped to remain in their homes without hardship to themselves or their families. Those who are hospitalized can be helped to return to their own communities . . . . Central to a new mental health program is comprehensive community care. Merely pouring Federal funds into a continuation of the outmoded type of institutional care which now prevails would make little difference.[1]

President Kennedy's aspiration of a 50% drop, it turns out, underestimated the extent of deinstitutionalization that would take place. The passage of the Community Mental Health Centers Act in 1963 would be followed by the largest

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[1] William Gronfein, *Incentives and Intentions in Mental Health Policy: A Comparison of Medicaid and Community Mental Health Programs*, 26 J. HEALTH & SOC. BEHAV. 192, 196 (1985) [hereinafter *Incentives*] (quoting HENRY FOLEY & STEVEN SHARFSTEIN, MADNESS AND GOVERNMENT 166 (1983)).

institutional migration that has ever occurred in this country. During the period 1965 to 1975, the inpatient population in state and county mental hospitals would plummet a stunning 59.3%.[2] The mean decrease per year over that period would reach almost 9%.[3] During the next five years, from 1975 to 1980, the drop in inpatient populations would continue, down another 28.9%.[4] All in all, from 1955 to 1980, the number of persons institutionalized in mental health facilities declined by 75%.[5]

Truth be told, deinstitutionalization had begun earlier, with an early onset drop of about 15% over the period 1955 to 1965. Moreover, the most reliable research attributes the sharp declines over the period 1955 to 1980 to several larger factors, not merely the passage in 1963 of the Community Mental Health Centers Act, nor the rapid accomplishment of fully funded community mental health centers by 1965. A far larger set of societal changes were at play, including the reorganization of the psychiatric profession, shifting views on mental illness, changes in care and treatment, the aftershock of World War II, changing state policies, fiscal crises, and ambitious federal interventions.[6] If one were to narrow these factors down, based on the leading social scientific evidence, three would stand out: first, the development and use of psychiatric medicines as treatment for even severe mental illness; second, the development of federal social welfare programs (such as Medicaid and Medicare) that created financial incentives to channel care for the mentally ill to alternative settings; and, third, changing societal perceptions of mental illness, coupled with public awareness of the problems and abuses endemic to the system of institutionalized care that resulted in political and legal challenges regarding the care and status of the mentally ill.

But even though the historical record is complex, one simple fact remains: *this country has deinstitutionalized before*. As we think about mass incarceration today and how to reduce our prison populations, it is useful to recall some lessons from that history. What, if anything, can we learn from deinstitutionalization in the 1960s? More precisely, might any of the forces that helped set off and shape

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[2] *Id.* at 196.

[3] 8.59% to be exact. *Id.*

[4] *Id.*

[5] *Id.* at 192.

[6] Gerald Grob explores these factors and more in remarkable detail in his lengthy and masterful work, FROM ASYLUM TO COMMUNITY: MENTAL HEALTH POLICY IN MODERN AMERICA (1991) [hereinafter ASYLUM]. Other important contributions include, among others, PAUL LERMAN, DEINSTITUTIONALIZATION AND THE WELFARE STATE (1982) (exploring the shifts in the welfare state); ANDREW SCULL, DECARCERATION: COMMUNITY TREATMENT AND THE DEVIANT—A RADICAL VIEW (1977) (exploring the fiscal crisis effects); *Incentives*, *supra* note 1 (exploring the role of Medicaid and Medicare and larger government interventions); William Gronfein, *Psychotropic Drugs and the Origins of Deinstitutionalization*, 32 SOC. PROBS. 437, 439 (1985) (exploring the role of medication); Joseph Morrissey, *Deinstitutionalizing the Mentally Ill: Processes, Outcomes, and New Directions*, *in* 6 DEVIANCE AND MENTAL ILLNESS (Walter R. Gove ed., 1982) (exploring professional reorganization and rivalries).

deinstitutionalization in the 1950s contribute to a reduction of our prison population today? Alternatively, are there aspects to be avoided from our earlier experience with deinstitutionalization or ways to decarcerate in a more successful manner today? These are the questions that motivate this essay.

Oddly, relatively little has been written on the parallel between mental hospital deinstitutionalization and the contemporary problem of mass incarceration. Early on, there were some writings in the late 1970s on decarceration tied to the prison abolition movement that explored the problem through the lens of mental health deinstitutionalization,[7] but for the most part, those interventions were not lasting. A number of scholars at the time predicted that prison decarceration would follow in the footsteps of the deinstitutionalization of mental hospitals (David Rothman was probably the best example of this), but they were proven wrong.[8] More recently, there has been empirical and theoretical work drawing parallels between the levels of mental health institutionalization in the mid-twentieth century and prison incarceration today,[9] though that research has not drawn parallels regarding *de*institutionalization. Some researchers, such as Marie Gottschalk, have begun to mention deinstitutionalization in the context of the current economic crisis and its impact on mass incarceration,[10] and several younger scholars, especially Anne Parsons, a history graduate student at the University of Illinois at Chicago, and Liat Ben-Moshe, a sociology graduate student at Syracuse University, have ongoing doctoral research on the relationship between mental health and criminality, or hospitals and prisons in the late twentieth century. Ben-Moshe, for instance, is using the idea of deinstitutionalization activism as a model for prison abolition.[11] But all in all,

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[7] Some examples of this include SCULL, *supra* note 6 (viewing both the prison and the asylum as tools to manage capitalism's "junk populations," and exploring both deinstitutionalization and decarceration as responses to capitalist crisis, from a Marxist surplus labor analysis perspective); Benjamin Frank, *The American Prison: The End of an Era*, FED. PROBATION, Sept. 1979, at 3 (comparing different potential advocacies in response to the demise of the rehabilitative ideal, and specifically contrasting prison abolition to deinstitutionalization).

[8] DAVID J. ROTHMAN, THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC 295 (1971); ROBERT SOMMER, THE END OF IMPRISONMENT v–viii (1976).

[9] Bernard E. Harcourt, *An Institutionalization Effect: The Impact of Mental Hospitalization and Imprisonment on Homicide in the United States, 1934–2001*, 40 J. LEGAL STUD. 39 (2011) [hereinafter *Institutionalization Effect*]; Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution*, 84 TEX. L. REV. 1751 (2006) [hereinafter *Rethinking*]; s*ee also* Steve Raphael, *The Deinstitutionalization of the Mentally Ill and Growth in the U.S. Prison Populations: 1971–1996* (Sept. 2000) (unpublished manuscript), *available at* http://ist-socrates.berkeley.edu/~raphael/raphael2000.pdf.

[10] Marie Gottschalk, *Cell Blocks & Red Ink: Mass Incarceration, The Great Recession & Penal Reform*, DAEDALUS, Summer 2010, at 62. Gottschalk discusses deinstitutionalization and argues that it involved a complex set of factors including political leadership, psychiatric profession changes, media and litigation, which represented a larger context that cannot be reduced to economic crisis. *Id*. at 67–69.

[11] Liat Ben-Moshe, a sociology graduate student at Syracuse University, has an unpublished dissertation from 2010 with a very promising title, Genealogies of Resistance to Incarceration:

there is still relatively little in terms of sustained discussion of the parallels to be drawn or lessons to be learned from deinstitutionalization, making this a ripe topic for preliminary analysis and for further research. This essay should be understood as the former: some preliminary thoughts on the lessons and pitfalls to be learned from deinstitutionalization in the 1960s.

The essay will take a twofold approach. After tracing some of the historical background in Part I, the essay will explore; in Part II, the three leading factors that were instrumental in bringing about deinstitutionalization in the 1960s, in an effort to discern whether there might be any useful parallels in the contemporary effort to reduce prison populations. Along this first line of inquiry, I will suggest several possible avenues worth further consideration—all the while recognizing that there are clear dangers associated with each.

First, with regard to the use of prescribed medications and other biological interventions, there is certainly room for greater and improved psychiatric care and treatment of prison inmates. The proportion of prisoners with mental health difficulties far exceeds the professional and institutional capacities of departments of correction in most states. Naturally, this would involve transinstitutionalization, rather than decarceration, but it is unquestionably necessary today. Moreover, it might also be worth considering, very cautiously, the increased use of medications for aggressive behavior, on a voluntary basis, as an alternative to incarceration. Diversionary programs modeled on outpatient mental health clinics and involving the administration of prescribed medications already exist and could possibly be developed further and expanded. In a similar vein, the increased use of GPS monitoring and other biometric devices could serve as a substitute to incarceration. Finally, on the topic of controlled substances, a move toward the legalization of marijuana and other lesser drugs would also have a direct impact on reducing our prison populations.

Second, federal and state leadership could be encouraged to create federal funding incentives for diversionary programs, reentry programs, and other ways of reintegrating offenders (or avoiding incarceration from the outset) that would give states a financial motive to move prisoners out of the penitentiary and into outpatient programs. The key variable here is to give states an economic and fiscal incentive to move convicts out of state prisons and into non-custodial programs (or to circumvent the correctional facilities from the outset) on the model of Medicaid reimbursement for outpatient community mental health treatment.

Third, high-profile litigation of prison conditions, of the paucity of mental health treatment, and of prison overcrowding, as well as documentaries of prison life along the lines of Frederick Wiseman's 1967 film *Titicut Follies*[12] should form part of a larger strategy to shift the public perception of those persons incarcerated.

Abolition Politics within Deinstitutionalization and Anti-Prison Activism in the U.S., 1950–present (on file with author). It appears that Ben-Moshe is indeed using the idea of deinstitutionalization activism as a model for prison abolition.

[12] TITICUT FOLLIES (Zipporah Films 1992).

Increased public awareness of the reality of prison life could contribute to greater willingness to support federal policies aimed at helping reduce our prison populations.

All of these ideas may well involve Faustian bargains, and the dangers associated with each are apparent; but, given our previous experience with deinstitutionalization, there is no reason to believe that it will be possible to reduce prison populations without getting our hands dirty.

In Part III, the essay then addresses, even more directly, the darker sides of deinstitutionalization, in an effort to identify mistakes from the past and pitfalls to avoid. Here, the two major areas of concern are the increased racialization of the mental hospital population that accompanied deinstitutionalization in the 1960s, as well as the problem of transinstitutionalization that has been already identified. It would be absolutely crucial, in any effort to reduce mass incarceration, to avoid both the further racialization of the prison population and the transinstitutionalization of prisoners into other equally problematic institutions, such as homeless shelters or the kind of large mental institutions depicted precisely in documentaries like *Titicut Follies*.[13]

Two caveats before I begin. First, in this essay, I set aside the questions *whether* to decarcerate and by *how much*. I recognize well that those are important preliminary questions that would need to be addressed fully and frankly. However, they would call for a far lengthier treatment than I could possibly give them in this article. Accordingly, I address here only the question of *how* to decarcerate—or, more precisely, what lessons to learn and pitfalls to avoid from our previous experience with deinstitutionalization. Second, I also set aside larger social theoretic questions about the possibility of genuine deinstitutionalization. The classic texts of social theory from the mid-to-late twentieth century told a relatively consistent story of the rise and fall of discrete institutions, *and* of the remarkable continuity of confinement and social exclusion—from the lazar houses for lepers on the outskirts of Medieval cities, to the establishment in the seventeenth century of the Hôpital Général in Paris.[14] There may be, in fact, no true escape from our levels of institutionalization, and the apparent transfer from mental hospitals to prisons may be another indicator of that ominous fact. But in this essay, I will set aside that darker interpretation and, again, focus on how we might *try* to decarcerate.

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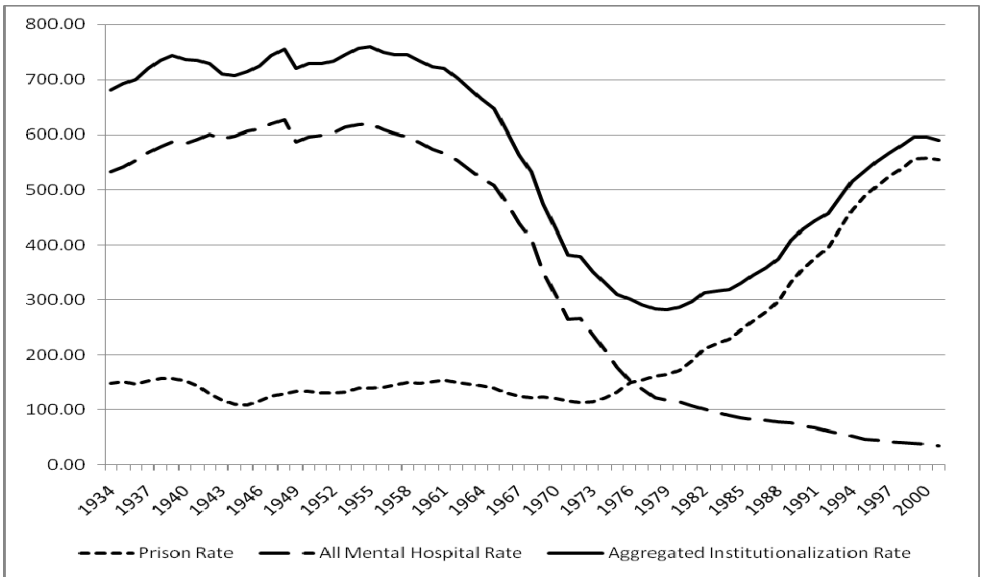
[13] *Id.*

[14] *See generally Rethinking*, *supra* note 9; the specific reference here, of course, is to MICHAEL FOUCAULT, MADNESS AND CIVILIZATION: A HISTORY OF INSANITY IN THE AGE OF REASON (Richard Howard trans., Vintage Books 1988) (1961).

I. HISTORICAL BACKGROUND

This is not the first time that the United States has faced mass institutionalization. As I have demonstrated elsewhere, the level of incarceration in the United States today matches the level of total institutionalization (in mental hospitals and prisons) in the 1930s, 1940s, and 1950s.[15] For those who have not seen the graph before, it can be somewhat striking:

Figure 1: Rates of Institutionalization in Mental Institutions and State and Federal Prisons (per 100,000 adults)[16]

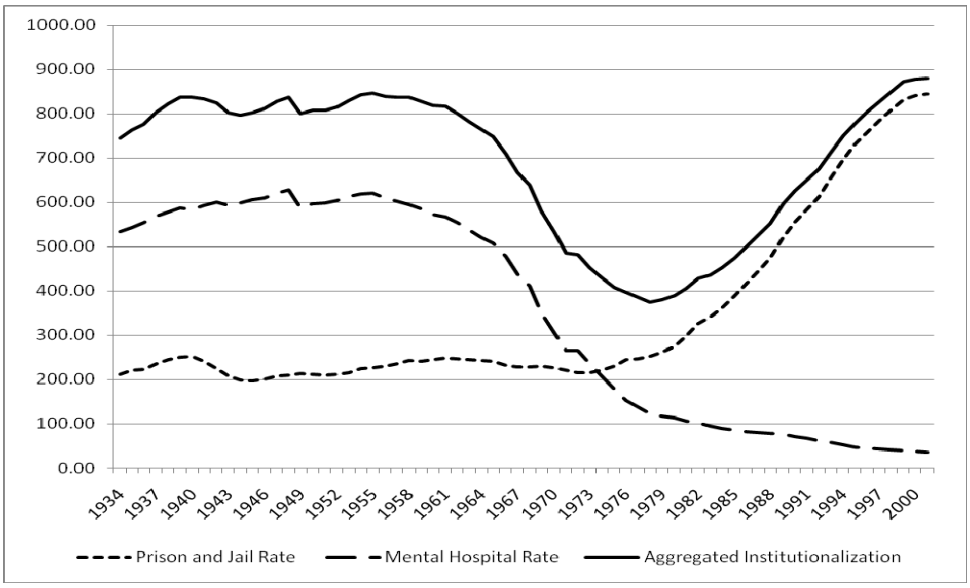


[15] BERNARD E. HARCOURT, THE ILLUSION OF FREE MARKETS: PUNISHMENT AND THE MYTH OF NATURAL ORDER 221–31 (2011) [hereinafter ILLUSION]; *Institutionalization Effect*, *supra* note 9, at 41; *Rethinking*, *supra* note 9, at 1776.

[16] Data collected from *Institutionalization Effect*, *supra* note 9, at 42.

In fact, even if we include the jail population, the contrast remains remarkable. Here is the same graph, including the rate of jail incarceration:

Figure 2: Rates of Institutionalization in the United States (including jail populations)[17]



As these figures demonstrate, the earlier period of mass institutionalization was followed by a dramatic reduction in mental hospital populations in the 1960s and 1970s, what we usually refer to as "deinstitutionalization."[18] The amount of deinstitutionalization was remarkable, whether one focuses on state and county mental hospitals alone or on the larger set of institutions for persons with mental health problems (including institutions for persons with mental retardation, VA mental health units, and private mental hospitals), as demonstrated in Figure 3.

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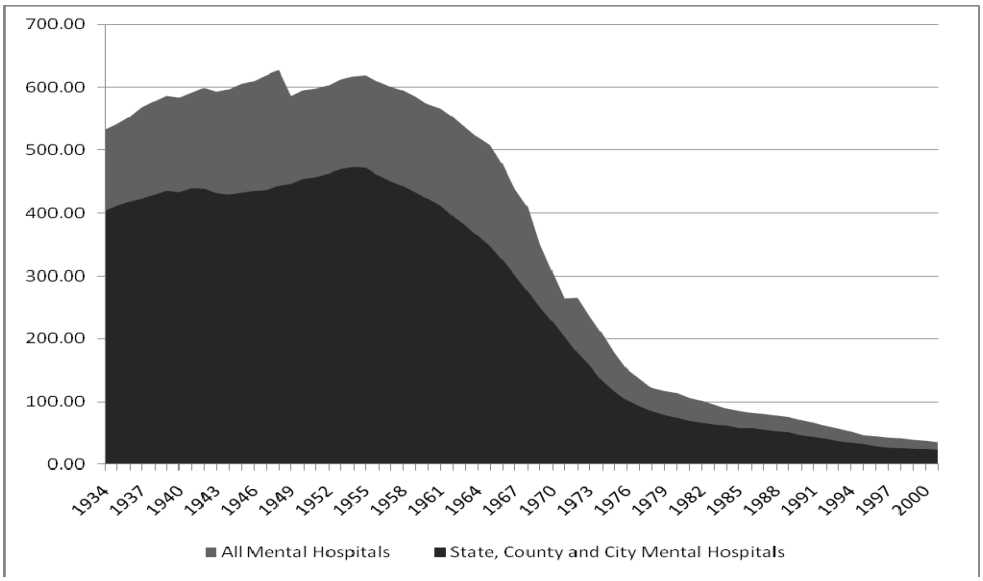
[17] Data collected from *Institutionalization Effect*, *supra* note 9, at 43.

[18] The term "deinstitutionalization" is used in the research literature to refer to both the declining inpatient population in mental institutions and the social and political policies that led to the declines in populations. William Gronfein separates the two concepts into "operational deinstitutionalization," the actual reductions in inpatient populations, and "policy deinstitutionalization," what he refers to as "the programs, policies, laws, and judicial decisions which have such reductions as their aim." Gronfein, *supra* note 6, at 439. For the purposes of this article, the term "deinstitutionalization" is used primarily to refer to the decline in patient populations and the use of large-scale, state-run psychiatric facilities for treatment of the mentally ill (what Gronfein refers to as "operational deinstitutionalization").

Figure 3: Different Rates of Institutionalization in Mental Institutions in the United States (per 100,000 adults)[19]



Although the asylum and the penitentiary were both born in the early nineteenth century in the United States, their growth trajectories differed significantly over the twentieth century—resulting in these divergent growth curves. In *The Discovery of the Asylum*, David Rothman penned what is still considered the master narrative of the birth of these institutions, not only the emergence of "penitentiaries for the criminal" and "asylums for the insane," but also "almshouses for the poor, orphan asylums for homeless children, and reformatories for delinquents."[20] There were, to be sure, antecedents.[21] On the Continent, there were penal institutions as far back as the early 1600s: the Amsterdam *rasphuis*, the *zuchthaus* in Hamburg, and spinhouses for women, for

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[19] Data collected from *Institutionalization Effect*, *supra* note 9, at 53.

[20] ROTHMAN, *supra* note 8, at xiii. *See* REBECCA M. MCLENNAN, THE CRISIS OF IMPRISONMENT 7 (2008).

[21] *See* FOUCAULT, *supra* note 14, at 5 (on lazar houses for lepers on the outskirts of Medieval cities and the seventeenth century Hôpital Général in Paris); ADAM JAY HIRSCH, THE RISE OF THE PENITENTIARY: PRISONS AND PUNISHMENT IN EARLY AMERICA 6–8 (1992) (discussing eighteenth-century Massachusetts penal institutions); MICHAEL IGNATIEFF, A JUST MEASURE OF PAIN: THE PENITENTIARY IN THE INDUSTRIAL REVOLUTION, 1750–1850, at 11–14 (1978) (describing houses of correction and the Amsterdam Rasphouse); PIETER SPIERENBURG, THE PRISON EXPERIENCE: DISCIPLINARY INSTITUTIONS AND THEIR INMATES IN EARLY MODERN EUROPE 12–38 (1991) [hereinafter THE PRISON EXPERIENCE]; Pieter Spierenburg, *Punishment, Power, and History*, 28 SOC. SCI. HIST. 607 (2004).

instance,[22] as well as the famous Hôpital Général in Paris established in 1656 by Louis XIV.[23] In the immediate post-Revolutionary period, several states experimented with houses of repentance and a penitential system of punishment. But there was, nevertheless, in Rothman's words, a "revolution in social practice" in the early 1800s that produced both the asylum and the penitentiary, among other institutions.[24]

In colonial America, care for dependent persons, such as the severely mentally ill, had fallen predominantly on family members or the local parish.[25] With time, local governments began to assume responsibility for the care of the mentally ill under a system of "poor laws."[26] The mentally ill were housed in almshouses, poorhouses, or jails, alongside other persons under supervision or dependency.[27] These facilities served largely an incapacitative function, and little effort was made to treat or provide medical care to those confined.[28] The Eastern Lunatic Asylum, the first psychiatric hospital in America, opened in 1773, and by 1816 two psychiatric hospitals were operating in the United States.[29] Due in part to the efforts of reformers, the number of hospitals devoted to the treatment of mental illness began to grow at about that time. By 1861, there were four dozen public psychiatric hospitals;[30] by 1880, seventy-five public psychiatric hospitals housed 41,000 patients.[31] These hospitals were small in comparison to the mega-institutions they would become; the largest hospital, Willard Psychiatric Hospital for the Insane, housed only 1513 patients in residence.[32] It was, however, during this period that a more medicalized notion of mental illness began to prevail, in tandem with a wave of social reform in the United States. Reformers, such as Dorothy Dix and Reverend Louis Dwight, called for the placement of the mentally ill in public psychiatric facilities as "rightly organized Hospitals, adapted to the special care of the peculiar malady of the Insane."[33]

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[22] THE OXFORD HISTORY OF THE PRISON 68 (Norval Morris & David Rothman eds., 1995); *see also* THE PRISON EXPERIENCE, *supra* note 21, at 24.

[23] FOUCAULT, *supra* note 14, at 37.

[24] ROTHMAN, *supra* note 8, at xiii.

[25] DONNA R. KEMP, MENTAL HEALTH IN AMERICA 2 (2007).

[26] GERALD N. GROB, MENTAL INSTITUTIONS IN AMERICA: SOCIAL POLICY TO 1875, at 33 (1973).

[27] GERALD N. GROB & HOWARD H. GOLDMAN, THE DILEMMA OF FEDERAL MENTAL HEALTH POLICY: RADICAL REFORM OR INCREMENTAL CHANGE? 2–3 (2006).

[28] GROB, MENTAL INSTITUTIONS, *supra* note 26, at 33–34.

[29] E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 81 (1997). Eastern Lunatic Asylum only had 20 beds and was not operating at full capacity until 1800.

[30] *See generally* ROTHMAN, *supra* note 8, at 130–54.

[31] TORREY, *supra* note 29, at 27. The total population of the United States at the time was fifty million people.

[32] *See generally* ROTHMAN, *supra* note 8, at 130–54.

[33] GROB & GOLDMAN, *supra* note 27.

On the penitentiary side, a few key dates signal the contemporary emergence of the penitentiary. Construction on Auburn's famous cell-house began in 1819 and was completed in 1821.[34] The Auburn model—the penitentiary system of daytime labor in collectivity, but in silence, followed by isolation in single-man cells—proved popular, and led to a massive spree of prison construction during the 1820s and 1830s, which served as the foundation for our current prison system. Sing-Sing opened in 1825, Connecticut started building Wethersfield in 1827, and Massachusetts reorganized its prison at Charlestown in 1829, followed by Indiana, Wisconsin, and Minnesota in the 1840s.[35] Between 1825 and 1850, Auburn-type state prisons were built in Maine, Maryland, New Hampshire, Vermont, Massachusetts, Connecticut, New York, the District of Columbia, Virginia, Tennessee, Louisiana, Missouri, Illinois, and Ohio.[36] In addition, Rhode Island, New Jersey, Georgia, and Kentucky built prisons on the solitary labor model, and Pennsylvania, which had invented the system of daytime solitary labor, also constructed the Eastern State Penitentiary in the hopes of rejuvenating its model for others to use.[37]

"In all, one can properly label the Jacksonian years 'the age of the asylum,'" Rothman observes.[38] On this point, the historians of the penitentiary agree. Adam Hirsch, in *The Rise of the Penitentiary*, similarly states "The penitentiary had its heyday in the United States in the 1830s. Facilities proliferated, the literature thrived, and visitors traveled great distances to view American prisons in action."[39] Rebecca McLennan, in her 2008 book, *Making of the American Penal State*, also traces the penitentiary system to "the age of Jackson."[40] Even Pieter Spierenburg, a historian of the early modern period who prefers to rewind the historical clock to the 1600s, admits that in the United States a "relatively condensed transition" to the penitentiary model occurred in the 1820s "due to the particular circumstances of its development."[41] Penal institutions became, in Rothman's words, places of "first resort, the preferred solution to the problems of poverty, crime, delinquency, and insanity."[42] In *The Illusion of Free Markets: Punishment and the Myth of*

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[34] *See generally* ROTHMAN, *supra* note 8, at 79.

[35] *Id*. at 81.

[36] MCLENNAN, *supra* note 20, at 63; *see generally* LAWRENCE M. FRIEDMAN, CRIME AND PUNISHMENT IN AMERICAN HISTORY 77–82 (1993).

[37] *See* MCLENNAN, *supra* note 20, at 63; ROTHMAN, *supra* note 8, at 79–81; *see generally* FRIEDMAN, *supra* note 36, at 78–82 (1993).

[38] ROTHMAN, *supra* note 8, at xiv.

[39] HIRSCH, *supra* note 21, at 112.

[40] MCLENNAN, *supra* note 20, at 54; *see also* JAMES Q. WHITMAN, HARSH JUSTICE: CRIMINAL PUNISHMENT AND THE WIDENING DIVIDE BETWEEN AMERICA AND EUROPE 173–76 (2008).

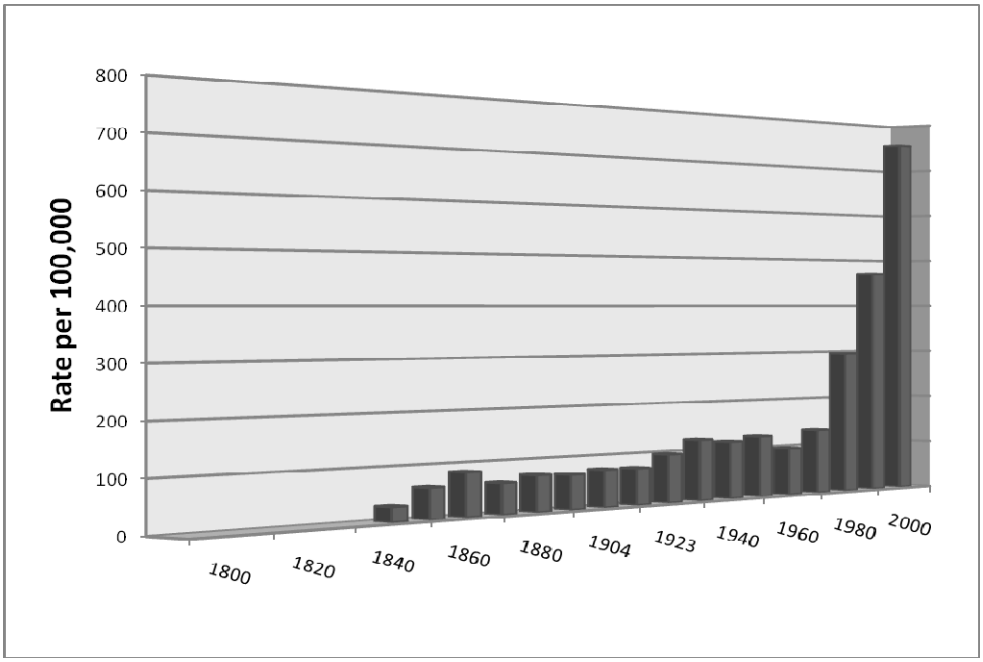
[41] THE PRISON EXPERIENCE, *supra* note 21, at 3.

[42] ROTHMAN, *supra* note 8, at xiii.

Natural Order, I offer some insights into why the age of the asylum was born during the Market Revolution, but will move along faster here.[43]

The subsequent growth curves of the two institutions, however, differed markedly. On the penitentiary side, the population remained relatively constant after the initial burst. Official national prison data only exist for the period beginning in 1850.[44] Prior to that, we have local data, predominantly the product of the Prison Discipline Society of Boston and the Prison Association of New York, both privately organized associations intended to monitor the growth of prisons. These sources reveal that, at the birth of the penitentiary, state prison populations and rates grew enormously, leading to high national counts beginning in 1850 and reaching a high point in 1870.[45] From the high point in 1870, however, prison rates in the United States would essentially remain relatively stable, with some fluctuations, until the prison explosion in the 1970s. Figure 4 charts the growth of the prison population over this period.

Figure 4: Prison Rate in State and Federal Prisons from 1850 to 2008 (per 100,000 persons).[46]



[43] ILLUSION, *supra* note 15, at 208–20.

[44] MARGARET WERNER CAHALAN, HISTORICAL CORRECTIONS STATISTICS IN THE UNITED STATES, 1850–1984, at 1–27 (1986).

[45] ILLUSION, *supra* note 15, at 218.

[46] Data derived from *id*. at 200, 218.

In contrast, the population in psychiatric institutions experienced a period of rapid growth toward the end of the nineteenth century and into the first half of the twentieth. From 1880 to 1955, the number of patients residing in psychiatric facilities rose from about 41,000 to over half a million.[47] This represented a thirteen-fold increase in the inpatient population, while the total population of the United States grew a little more than threefold.[48] The size of the facilities themselves also grew dramatically. For example, New York's Rockland State Hospital housed over 9000 patients, and over 14,000 patients lived in Pilgrim State Hospital.[49] Commentators have proposed several explanations for this rise in institutional population. One study lists seven factors contributing to the population growth in institutions, including importantly, "(4) public and professional confidence in, and willingness to utilize, mental hospitals; (5) a broader conception of mental illness; (6) an increasingly long duration of stay [for mental illness recovery]; and (7) decreased tolerance for deviant behavior and perhaps higher rates of mental illness."[50]

Others have pointed to institutionalization as a response to "the lack of effective and lasting treatments for serious mental illness, and the pressure brought to bear by families and communities who wanted a safe shelter for seriously disturbed members."[51] Others, such as Thomas Szasz and Thomas Scheff, view the rise in institutionalized population more skeptically, specifically as "a form of social labeling [designed to] suppress nonconformist behavior."[52]

As Figure 3 shows, after peaking in 1955, inpatient populations in mental hospitals began to show a striking and steady downward trend. In 1955, more than 558,000 patients resided in public mental hospitals; by 2000, this population had fallen to 55,000.[53] The average size of the state hospital had fallen from over 2000 residents to less than 500.[54]

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[47] TORREY, *supra* note 29, at 82

[48] *Id*. *See also Incentives*, *supra* note 1, at 194.

[49] TORREY, *supra* note 29, at 82.

[50] George W. Dowdall, *Mental Hospitals and Deinstitutionalization*, *in* HANDBOOK OF THE SOCIOLOGY OF MENTAL HEALTH 519, 521 (Carol S. Aneshensel & Jo C. Phelan eds., 1999). It is worth noting that this study took place after World War II, as the war itself greatly impacted subsequent mental health policy.

[51] *Incentives*, *supra* note 1, at 194.

[52] GROB & GOLDMAN, *supra* note 27, at 53; *see generally* THOMAS J. SCHEFF, BEING MENTALLY ILL: A SOCIOLOGICAL THEORY (1966); THOMAS SZASZ, THE MYTH OF MENTAL ILLNESS (1961).

[53] GROB & GOLDMAN, *supra* note 27, at 15.

[54] Dowdall, *supra* note 50, at 525.

II. EXPLORING THE MAJOR FORCES THAT CONTRIBUTED TO DEINSTITUTIONALIZATION

What explains that remarkable drop in the number and rate of mental patients, and could there be any parallel forces at play today in the prison context? The first task of this essay is to address this question—to analyze the stunning decrease in mental hospital populations and the forces that brought it about, in order to explore whether the factors that influenced deinstitutionalization in the 1960s could possibly relate to our current situation of mass incarceration. I will proceed in two steps, focusing first on the 1960s and then analyzing possible implications for our contemporary situation.

A. *The Major Factors Influencing Deinstitutionalization in the 1960s*

The most reliable social scientific research converges on three major social and political forces that contributed to deinstitutionalization during the 1950s, 1960s, and 1970s: technological advancements in drug therapy for treatment of mental illness, economic incentives to shift care for the mentally ill to community-based outpatient facilities, and changing societal attitudes regarding mental illness. I will address each of these in turn, in order to then explore whether they point to useful directions today.

1. Drugs and the Development of Psychiatric Medication

Prior to the development of psychiatric drug therapy, the most widely used treatments for mental illness included electroconvulsive therapy, insulin coma therapy, and lobotomy.[55] These treatments had significant side effects, including brain damage, and were provided on an inpatient basis. Treatment for the mentally ill underwent rapid change in the 1950s, however, with the introduction of psychiatric medication. In 1954, chlorpromazine, marketed under the trade name Thorazine, became the first widely available antipsychotic medication.[56] Though originally developed to sedate patients undergoing surgery, chlorpromazine had tranquilizing effects that led to its use in treating mental illness. By 1956, over two million patients had been prescribed chlorpromazine[57] and at least thirty-seven states were using chlorpromazine or a similar antipsychotic medication in their state mental hospitals.[58]

The early adoption of chlorpromazine was due, in part, to extensive marketing and lobbying efforts by Smith, Kline and French Labs (the manufacturer of

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[55] Gronfein, *supra* note 6, at 444.

[56] *See* TORREY, *supra* note 29, at 99.

[57] *Id.*

[58] Gronfein, *supra* note 6, at 441.

Thorazine) for the use of the drug in psychiatric facilities.[59] For the institutions, the new drug therapy was extremely attractive because it "appeared to offer a solution to one of the problems which perennially plagued the state hospitals: the maintenance of order."[60] The rise in patient populations in state hospitals had left the facilities with chronic scarcity in human and physical resources, and the use of medication allowed the hospitals to manage more patients with less staff—and even to allow some patients to manage their own severe psychotic symptoms.[61] Drug therapy also offered a treatment for mental illness that could be provided on an outpatient basis.

Although several scholars have noted that the introduction and use of the drugs did not itself cause a significant reduction in patient population,[62] the availability of the psychiatric medication had a significant impact on public perception and public policy as well. Tangible medicalization, in the form of a pill, promoted the mentally ill "to the status of patients in the eyes of many members of the public."[63] As some researchers have noted, "tranquilizing drugs affected the climate of opinion in mental health care in a way that carried beyond their value as medical applications."[64] "[M]ental health professionals began to advocate community care, in part, because the introduction of psychotropic medications contributed significantly to [the] systematic management of many severely psychotic patients and made discharging them back to the community possible."[65]

Policymakers also looked to psychiatric medicine to move institutionalized patients, no longer considered incurable or untreatable, back into the community. Thus, the move away from institutionalized mental healthcare was heavily influenced by the development of psychiatric medication, not only because it allowed outpatient care for mental illness, but also because it changed public and political sentiment regarding the mentally ill. As Gronfein writes, "testimony from a number of sources does indicate that the advent of psychotropic medications was linked to the emergence of a new philosophy regarding what was possible and desirable in the provision of mental health care for the seriously mentally ill."[66]

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[59] *Id.* at 441–42.

[60] *Id*. at 442.

[61] *See* DAVID A. ROCHEFORT, FROM POORHOUSES TO HOMELESSNESS: POLICY ANALYSIS AND MENTAL HEALTH CARE 51 (1st ed. 1993). Previous treatments, like electroconvulsive therapy, could only be provided on an inpatient basis.

[62] Gronfein, *supra* note 6, at 448; TORREY, *supra* note 29, at 99–100.

[63] ROCHEFORT, *supra* note 61, at 39.

[64] *Id*. at 38.

[65] *Id*.

[66] Gronfein, *supra* note 6, at 450.

2. Financial Incentives: Federal Programs and Cost-Shifting Incentives

A second major contributing factor to deinstitutionalization was federal initiatives beginning in the early 1960s. In 1963, President Kennedy proposed the Community Mental Health Centers Act with the idea of creating community-based mental health centers to provide comprehensive mental health care.[67] Interestingly, President Kennedy attributed the plan to "the new drugs acquired and developed in recent years which make it possible for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society."[68] The effect of the legislation would be to shift funding from the states to the federal government.

The passage in 1965 of Medicaid[69] and Medicare[70] reinforced this trend. In order to take advantage of federal Medicaid funding, states had incentives to move patients out of state mental hospitals and into other institutions that were subsidized with federal money.[71] These programs purposefully excluded payments to "institutions for the treatment of mental diseases" because the programs were not designed to supplant state control and financing of psychiatric facilities.[72] As a result, states began moving patients out of state mental hospitals and into nursing homes or psychiatric wards of general hospitals that were heavily subsidized with federal money. Other federal programs, such as Supplemental Security Income (SSI), provided direct benefits to the mentally ill in the community. As some scholars have noted, "state incentives for cost-shifting to the federal government reside almost exclusively in the discharge of patients from state hospitals, who then become eligible for SSI, Medicaid, food stamps, and other federal benefits."[73]

In short, the expansion of federal social welfare programs contributed to deinstitutionalization by creating financial incentives for states to change the locus of care of the mentally ill away from state institutions.[74] The empirical evidence bears this out. Statistical analyses confirm that "states with greater Medicaid

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[67] BERNARD L. BLOOM, COMMUNITY MENTAL HEALTH: A GENERAL INTRODUCTION 20 (2d ed. 1984).

[68] Gronfein, *supra* note 6, at 450.

[69] Medicaid provides selected health care to the indigent, regardless of age, and is funded jointly by contributions from federal and state governments. *See Incentives*, *supra* note 1, at 200.

[70] Medicare is a federally funded and administered health-insurance program that provides selected health care to "all persons over 65 who are eligible for Social Security benefits, regardless of income." *Id*.

[71] *Id*. (citing United States Senate Subcommittee on Long-Term Care).

[72] TORREY, *supra* note 29, at 102.

[73] *Id*.

[74] As a historical side note, some have theorized that institutionalization of the mentally ill in state psychiatric facilities was also driven by cost-shifting incentives. State-run institutions emerged as a replacement to locally funded workhouses and almshouses, thus shifting the cost of care for the mentally ill from local to state governments. GROB, *supra* note 26, at 1–35 (1972).

involvement [showed] larger inpatient declines over the same period."[75] Much of this was, naturally, transinstitutionalization, especially into nursing homes, which I discuss later; but it did facilitate deinstitutionalization.

3. Changing Social Attitudes towards Mental Illness

Together, these trends helped reshape social and cultural perceptions of mental illness. Psychiatric medication and growing knowledge about the biochemical causes of mental illness contributed to raising understanding and sympathy for the mentally ill, and offered proof that not all mental illness was incurable. These changing perceptions were in part catalyzed by World War II—in several ways. First, approximately 12% of those drafted between 1942 and 1945 were found unfit to serve for psychiatric or neurological reasons.[76] Additionally, 37% of soldiers discharged during the war for disability were discharged for mental illness.[77] The pervasiveness of mental illness among enlisted men, a sympathetic group in the eyes of the general public, helped reduce stigma against the mentally ill, while also raising awareness of the prevalence of mental illness in the general population.

World War II also had the indirect effect of raising public awareness about the treatment of the mentally ill in state institutions. During the war, conscientious objectors, in lieu of military service, worked as attendants in mental hospitals that had been left understaffed by the war efforts. Exposed to the neglect, abuse, and deficiencies in care for the mentally ill, many tried to reform the treatment of the mentally ill, often acting as whistleblowers and raising public awareness of the conditions in those institutions.[78] In the fall of 1943, for example, the *Cleveland Press* published a series of articles about inhumane conditions within Cleveland State Hospital, based on the account of the conscientious objectors serving in the hospital.[79] The exposé ultimately led to a grand jury investigation and the firing of the hospital's superintendent.

Other critical accounts of the conditions in institutions also received significant public attention. A series of articles published in *Reader's Digest* described "hundreds of naked mental patients herded into huge, barn-like, filth-infested wards, in all degrees of deterioration, untended and untreated, stripped of every vestige of human decency, many in stages of semistarvation."[80] *Life*

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[75] *Incentives*, *supra* note 1, at 201.

[76] ROCHEFORT, *supra* note 61, at 34; *see* ASYLUM, *supra* note 6, at 5–23.

[77] *Id*.

[78] *See generally* ALEX SAREYAN, THE TURNING POINT: HOW MEN OF CONSCIENCE BROUGHT ABOUT MAJOR CHANGE IN THE CARE OF AMERICA'S MENTALLY ILL (1994) (discussing how WWII conscientious objectors played a significant role in exposing the poor treatment of institutionalized patients).

[79] *Id.* at 65–71.

[80] JOSEPH HALPERN ET AL., THE MYTHS OF DEINSTITUTIONALIZATION: POLICIES FOR THE MENTALLY DISABLED 3 (1980).

Magazine published *Bedlam 1946*, an exposé that had graphic and disturbing photos accompanying the description of the poor treatment of mentally ill patients.[81] As Nina Ridenour observed, "These two articles, appearing in two of the magazines with the widest circulation in the United States, triggered a volcano of exposés and feature articles in other magazines and the daily press which continued for several years."[82] Personal accounts of institutionalized life from former patients and attendants, such as Mary Jane Ward's *The Snake Pit*, Sylvia Plath's *The Bell Jar*, and Ken Kesey's *One Flew Over the Cuckoo's Nest*, as well as documentary films such as Frederick Wiseman's 1967 *Titicut Follies*, gave devastating insight into institutional life. Attention from the popular media seems to have had an effect; survey data from the period confirms a positive shift in public opinion "in terms of better public understanding of mental illness and greater tolerance or acceptance of the mentally ill."[83] The increased acceptance and understanding of the mentally ill, coupled with vivid depictions of abuse in institutions, sparked public outcry against institutional psychiatric care.

Reviled in the popular press, mental institutions also received criticism in intellectual circles. Some, such as Thomas Szasz in his influential book *The Myth of Mental Illness*,[84] suggested that mental illness was a social construct used to control and limit deviancy in the population.[85] Other influential works, such as Alfred Stanton and Morris Schwartz's *The Mental Hospital*[86] and Erving Goffman's *Asylums*,[87] suggested that institutionalization itself worsened mental illness. Still other critical works, such as David Rothman's *The Discovery of the Asylum*,[88] Michel Foucault's *Madness and Civilization*,[89] and Gerald Grob's *The State and the Mentally Ill*,[90] raised questions about the continuity of confinement across different realms, especially the asylum and the prison. Rising sentiment against the use of institutions for psychiatric treatment, buttressed by knowledge of the poor conditions within institutions, engendered a reform movement for

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[81] NINA RIDENOUR, MENTAL HEALTH IN THE UNITED STATES: A FIFTY-YEAR HISTORY 106 (1961).

[82] *Id*. at 107.

[83] ROCHEFORT, *supra* note 61, at 52 (quoting a 1960s U.S. Department of Health, Education, and Welfare publication).

[84] SZASZ, *supra* note 52 (arguing against modern psychiatry and denying the existence of mental illness).

[85] *See generally* GERALD N. GROB, MENTAL ILLNESS AND AMERICAN SOCIETY, 1875–1940, at 15 (1983).

[86] ALFRED STANTON & MORRIS SCHWARTZ, THE MENTAL HOSPITAL: A STUDY OF INSTITUTIONAL PARTICIPATION IN PSYCHIATRIC ILLNESS AND TREATMENT (1954).

[87] ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATIONS OF MENTAL PATIENTS AND OTHER INMATES (1961).

[88] ROTHMAN, *supra* note 8.

[89] FOUCAULT, *supra* note 14.

[90] GERALD N. GROB, THE STATE AND THE MENTALLY ILL: A HISTORY OF WORCESTER STATE HOSPITAL IN MASSACHUSETTS, 1830–1920 (1966).

community mental health, an alternative approach that favored a more decentralized, short-term, treatment-oriented system of mental health care services over long-term custodial care in institutions.[91] These cultural shifts, both in public understanding of mental illness and in perception of institutionalized treatment of the mentally ill, contributed to the depopulation trend in institutions.

In concert with changing social perceptions of the mentally ill and mental health care, developments within the law regarding confinement and treatment of the mentally ill accelerated the trend of deinstitutionalization. With the political backdrop of the civil liberties movement, advocates for the mentally ill viewed institutionalized care not as an asylum to protect the mentally ill, but as an intrusion on the liberty and autonomy of the mentally ill, and they sought legal reforms restricting involuntary psychiatric treatment.[92] Similar to the NAACP's strategy to end school segregation, advocates for the mentally ill used litigation to chip away at the legal foundations of institutional psychiatric care by challenging the procedures governing commitment and treatment.

Advocates first pushed for heightened procedural due process protections with regard to involuntary commitment. A heightened standard for commitment would have had direct and dramatic effects on the institutionalized population, because the most common path to admission to mental hospitals was involuntary commitment throughout the early part of the twentieth century and well into the 1960s.[93] In fact, in 1939, for instance, about 90% of all admissions were involuntary commitments.[94] In *O'Connor v. Donaldson*, the Supreme Court held that the state could not "constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[95] Other cases that followed, such as *Addington v. Texas* (requiring "clear and convincing" evidence if a proceeding may result in indefinite confinement), imposed further due process requirements on involuntary commitment procedures.[96]

Advocates then sought to exert pressure on institutions to release patients through the establishment of minimally adequate standards of care, or "right to treatment." In 1972, the Fifth Circuit in *Wyatt v. Stickney*, finding the treatment of patients in Alabama unconstitutional, held that the Constitution guarantees a right to treatment and habilitation for civilly committed persons in state institutions.[97]

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[91] *See* BLOOM, *supra* note 67, at 22.

[92] *See, e.g.*, TORREY, *supra* note 29, at 142; Stephen T. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54, 54–55 (1982).

[93] *Incentives*, *supra* note 1, at 194.

[94] *Id*.

[95] O'Connor v. Donaldson, 422 U.S. 563, 575 (1975).

[96] Stephen Rachlin, *The Influence of Law on Deinstitutionalization*, *in* DEINSTITUTIONALIZATION 41, 46–51 (Leona L. Bachrach ed., 1983).

[97] Wyatt v. Stickney, 344 F. Supp. 373, 374 (M. D. Ala. 1972).

Because the state was unable to meet the judicially-mandated standards of minimally required care, thousands of patients were released.[98] The remedy—depopulation—was an intentional outcome; a right to treatment that set an unattainable standard of care was seen, by advocates, as the best way to deinstitutionalize thousands of people.[99] These decisions, which heightened the procedures required for commitment and the standards of care for the committed, "exerted continuing pressure on state hospital physicians and administrators to discharge existing patients and to reject new ones."[100]

There were, in sum, a number of interwoven factors that converged in the period following World War II that would, together, shift public policy away from mental institutionalization and help contribute to the massive deinstitutionalization that took place during the period 1955 to 1980. Though I have focused on the three leading factors identified in the research literature, other forces were also at play. Gerald Grob, the leading scholar on the topic, summarizes the wider landscape as follows:

> First, the experience of World War II appeared to demonstrate the efficacy of community and outpatient treatment of disturbed persons. Second, a shift in psychiatric thinking fostered receptivity toward a psychodynamic and psychoanalytic model that emphasized life experiences and the role of socioenvironmental factors. Third, the belief that early intervention in the community would be effective in preventing subsequent hospitalization became popular, a belief fostered by psychiatrists and other mental health professionals identified with a public health orientation. Fourth, a pervasive faith developed that psychiatry was able to identify (and presumably ameliorate) those social and environmental conditions that played an important role in the etiology of mental illnesses. Fifth, the introduction of psychological and biological therapies (including, but not limited to, psychotropic drugs) held out the promise of a more normal existence for individuals outside mental hospitals. Finally, an enhanced social welfare role for the federal government not only began to diminish the authority of state governments but also hastened the transition from an institutionally based to a community-oriented policy.[101]

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[98] TORREY, *supra* note 29, at 144.

[99] *See id*.

[100] *Id*. at 145.

[101] ASYLUM, *supra* note 6, at 4.

B. *Drawing Parallels with the Current Situation of Mass Incarceration*

I will turn, now, to our current situation, in order to explore whether these factors resonate in today's context and whether they might conceivably point us in useful directions to help alleviate the problem of mass incarceration.

1. Prescribed Drugs and Other Biological Interventions

On the question of prescription drugs and mental health treatment, two things are quite clear. First, the condition of mentally ill prisoners in state correctional systems and county jails is of increasing concern nationwide. The stories of individual inmates are horrifying. A prison inmate in Jackson, Michigan—who authorities described as "floridly psychotic"—died in his segregation cell, naked, shackled to a concrete slab, lying in his own urine, scheduled for a mental health transfer that never happened.[102] Another inmate, schizophrenic, gouged his eyes out after waiting weeks for transfer to a mental hospital in Clearwater, Florida.[103] Meanwhile, the head of Florida's social services was forced to resign abruptly in 2006 after being fined $80,000 and facing criminal contempt charges for failing to transfer severely mentally ill jail inmates to state hospitals.[104] Given the paucity of mental health care for prisoners, it is difficult to get a good sense of how many inmates have serious mental health conditions. What we know is that, at the turn of the twentieth century, there was a high level of diagnosed mentally ill offenders in prisons and jails in the United States—283,800 in 1998, representing 16% of jail and state prison inmates.[105] We also know that, according to a study released by the Justice Department in September 2006, 56% of inmates in state prisons and 64% of inmates across the country reported mental health problems within the past year;[106] much of this is associated with depression, and that depression may be caused by the institutionalization itself. Ultimately, it is extremely hard to quantify correctly the number of detained inmates who need, but are not receiving, mental health care and medication. But there is no question that the number is very high and that treatment and medication could be substitutes for continued detention in many cases, which would naturally help alleviate mass incarceration.

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[102] Libby Sander, *Inmate's Death in Solitary Cell Prompts Judge to Ban Restraints*, N.Y. TIMES, Nov. 15, 2006, http://www.nytimes.com /2006/11/11/us/15prison.html?_r=2&pagewanted=print.

[103] Abby Goodnough, *Officials Clash Over Mentally Ill In Florida Jails*, N.Y. TIMES (Nov. 15, 2006), http://query.nytimes.com/gst/fullpage.html?res=9E04E5DA173EF936A25752C1A9609C8B63&pagewanted=all.

[104] Alisa Ulferts, *Head of DCF is Fined $80,000*, ST. PETERSBURG TIMES (Dec. 1, 2006), http://www.sptimes.com/2006/12/01/news_pf/Tampabay/Head_of_DCF_is_fined_.shtml.

[105] PAULA M. DITTON, BUREAU OF JUSTICE STATISTICS, SPECIAL REPORT: MENTAL HEALTH AND THE TREATMENT OF INMATES AND PROBATIONERS 3 (1999), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf.

[106] Erik Eckholm, *Inmates Report Mental Illness at High Levels*, N.Y. TIMES (Sept. 7, 2006), http://www.nytimes.com/2006/09/07/us/07prisons.html.

Second, it is clear that the use of prescribed medication in the United States has increased markedly since the 1950s. Today, according to data from the Department of Health and Human Services, about half of all Americans take at least one prescription drug, with about one in six Americans taking three or more medications.[107] The United States may well be one of the most medicated nations in the world today. Now, to be sure, the overall rise in the use of prescription medications coincided with the sharp increase in the prison population over the past forty years. So, more drugs are certainly not, or at least, not necessarily a panacea. However, there is no way of knowing, without further research, whether the populations at risk of incarceration are among those who have experienced increased use of prescription drugs, nor whether the increased use of prescription medication actually dampened prison growth. If indeed the correlation between medication and prison population operates through criminogenic behavior—in other words, if we assume a direct crime and punishment nexus, which is a relatively simplistic assumption—we still do not know whether the increased use of medication over the last fifty years actually dampened prison growth or had no effect, given the simultaneity problem: it is entirely possible that the prison population could have risen even more if there had been less generalized use of prescribed medication.

One question to pose, then, very cautiously, is whether the enhanced use of medications might contribute to deinstitutionalization of our prisons. There are reasons to think that it might. The use of psychotropic drugs to treat violent and antisocial behavior has become commonplace both in and outside of the prison context[108]—and it is not immediately apparent that increased, voluntary medicalization would be morally, ethically, or politically *worse* than forcible detention in prison. This raises complex questions about prisoners and consent—questions that I explore elsewhere.[109] But the alternatives are not without their own problems—moral, ethical, and political. Perhaps it is, in the end, a Faustian bargain, but one worth considering.

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[107] *See* NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH & HUMAN SERV., HEALTH, UNITED STATES, 2009, *available at* http://www.cdc.gov/nchs/data/hus/hus09.pdf#executivesummary; *see also* Denise Danor, *Study: Americans on Chronic Medicines*, ABC7.COM (May 14, 2008), http://abclocal.go.com/kabc/story?section=news/health&id=6143292; David Olmos, *Prescription Drug Use Rose to Include Half of American in 2008*, BLOOMBERG (Sept. 2, 2010), http://www.bloomberg.com/news/2010-09-02/prescription-drug-use-rose-to-include-half-of-americans-in-2008-u-s-says.html. For a fascinating discussion of the implications and outsourcing of pharmaceutical trials, see Kaushik Sunder Rajan, *Biocapital: Indian Clinical Trials and Surplus Health*, NEW LEFT REVIEW, http://www.forliberation.org/site/archive/issue0807/article020807.htm (last visited Apr. 19, 2011).

[108] *See generally* Tony Butler, *Reducing Impulsivity in Repeat Violent Offenders: An Open Label Trial of a Selective Serotonin Reuptake Inhibitor*, 44 AUSTL. & N.Z. J. PSYCHIATRY 1137 (2010); Eric Silver et al., *The Relationship Between Mental Health Problems and Violence Among Criminal Offenders*, 35 CRIM. JUST. & BEHAV. 405 (2008).

[109] Bernard E. Harcourt, *Making Willing Bodies: The University of Chicago Human Experiments at Stateville Penitentiary*, SOC. RES.: AN INT'L Q., Summer 2011, at 443.

The concerns here are legion, though. There are a number of populations that are today being targeted for increased pharmaceutical interventions. The first involves sexual offenders. There has been a lot of research investigating the possibility and effectiveness of biological interventions, including testosterone-lowering hormonal treatments, with an eye to reducing sexual offender recidivism. Pharmacologically-based treatment options have been developed in an effort to chemically alter sexual drives and offending behavior. Some of the pharmacological developments in this area include the development of selective serotonin re-uptake inhibitors (SSRIs), which are also used as anti-depressants for the treatment of anxiety and other personality disorders; psychostimulants; hormonal treatment experiments; and antiandrogen treatment (GnRHs), which are hormone receptor antagonist compounds that help prevent or inhibit the biologic effects of male sexual hormones.[110]

A second targeted population is juvenile offenders.[111] In this context, there has been a lot of research focused on "conduct disorder" and the development of antimanic medications for certain forms of hyperactivity disorders, as well as the use of psychological assessments like the MSYSI-2 and MAYSI-2 to identify potential juvenile offenders and then find diversionary programs for them. These diversionary programs often involve outpatient programs that incorporate the use of medication. An example is the 2009 winner of the Harvard Kennedy School Innovations in American Government Award: the Wraparound Milwaukee program. The program, an outpatient managed care program that is operated by the Milwaukee County Behavioral Health Division, is designed to provide individualized care to youths with mental health and emotional needs.[112]

A third targeted population is associated with the outpatient treatment of drug addiction. For non-violent drug offenders, there are now well-established outpatient treatments using methadone, buprenorphine, lofexidine, and naltrexone; as well as diversionary programs and various outpatient care programs.[113]

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[110] One of the leading researchers here is Martin Kafka. *See generally* Peter Briken & Martin P. Kafka, *Pharmacological Treatments for Paraphilic Patients and Sexual Offenders*, 20 CURRENT OPINION IN PSYCHIATRY 609 (2007).

[111] *See generally* Jean Decety et al., *Atypical Empathic Responses in Adolescents with Aggressive Conduct Disorder: A Functional MRI Investigation*, 80 BIOLOGICAL PSYCHOL. 203 (2008); Christopher A. Mallett et al., *Predicting Juvenile Delinquency: The Nexus of Childhood Maltreatment, Depression and Bipolar Disorder*, 19 CRIM. BEHAV. & MENTAL HEALTH 235 (2009).

[112] Milwaukee County Behavioral Health Division, *Wraparound Milwaukee 2009 Innovations in American Government Award Winner*, COUNTY OF MILWAUKEE, http://county.milwaukee.gov/WraparoundMilwaukee/WraparoundAward.htm (last visited Oct. 8, 2011).

[113] *See generally* Michelle A. Lang & Belenko Steven, *Predicting Retention in a Residential Drug Treatment Alternative to Prison Program*, 19 J. SUBSTANCE ABUSE TREATMENT 145 (2000); Jason Lutz, *What works in drug addiction?*, 9 ADVANCES IN PSYCHIATRIC TREATMENT 280, 280–88 (2003); Steven S. Martin et al., *Three-Year Outcomes of Therapeutic Community Treatment for Drug-Involved Offenders in Delaware: From Prison to Work Release to Aftercare*, 79 PRISON J. 294 (1999).

The model throughout these specific interventions, it seems, is to identify physiological or biological causes of violent behavior and to use medication to modify those causal agents. This approach can be seen at work, for example, in the research of Jean Decety, a psychologist at the University of Chicago. His research focuses on adolescents with "conduct disorder" or "CD," a mental disorder defined by "a longstanding pattern of violations of rules and laws" and characterized by symptoms such as "physical aggression, manipulative lying, theft, forced sex, bullying, running away from home overnight, and destruction of property."[114] Decety and his colleagues explore the neural responses of adolescents to empathy-eliciting and sympathy-eliciting stimuli, such as the sight of someone in pain (the image of someone having their fingers stuck in a car door, for instance). The idea is to see whether painful situations trigger different activity in the brain. Using neuro-imaging, their studies try to differentiate between brain activity in juveniles with conduct disorder versus those without conduct disorder. The goal, ultimately, is to identify different neural pathways, in order to then explore possible treatment addressed to those brain activities. As Decety writes, "Biological studies of CD should lead to new approaches to its treatment, both by understanding the mechanisms underpinning CD and by matching treatments to specific deficits in different individuals with this heterogeneous disorder."[115] Or, in other words, to identify and treat brain pathways in order to alter behavior.

I have deep reservations about many of these specific interventions on both political and ethical grounds. The more general idea of encouraging voluntary and consensual use of antipsychotic drugs is somewhat less troubling than these biological "solutions" to criminal offending—and may help to decarcerate. Thinking more broadly, though, two other related possibilities come to mind. First, the gradual legalization or medicalization of marijuana is likely to have, or eventually may have, dramatic effects on reported crime levels both through decriminalization and also by eliminating the drug trade and its attendant violence. This is especially true on the border with Mexico where the marijuana drug trade is wreaking havoc. If marijuana and other lesser controlled substances are eventually legalized, this would surely have a significant effect on reducing the incarcerated population. Second, functional substitutes to incarceration, such as GPS monitoring and other forms of home surveillance and detention, can be thought of as an alternative form of medicalization—as something like prescription drugs that act as an alternative to incarceration. These developments as well should be considered as substitutes to the prison.

A great danger in this approach is the potential racialization of psychological diagnoses of deviance—a danger made vivid by our past experience with schizophrenia, as demonstrated brilliantly by Jonathan Metzl in his book, *The Protest Psychosis: How Schizophrenia Became a Black Disease* (2010). In his research at Ionia State Hospital in Michigan, Metzl recounts the shocking story of

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[114] Decety et al., *supra* note 111, at 203.

[115] *Id*.

how schizophrenia as a diagnosis became overwhelmingly applied to institutionalized African-Americans, and how the experience there mirrored the national conversation that increasingly linked blackness to madness. Like the prison itself—as I discuss later—mental illness, especially related to violence, became increasingly racialized during the second half of the twentieth century, and this would be something important to guard against.

2. The Great Recession of 2008

The second factor to consider involves ways of restructuring federal reimbursement programs to make it more attractive to states to decarcerate, especially during these times of economic crises. Would it be possible to imagine, in our hard economic times, a federal initiative aimed at diverting fiscal resources toward programs that promote alternatives to incarceration? Is there anyone in a position of leadership at the federal or state level who would be willing to take on this issue, as President Kennedy did in 1963? President Barack Obama certainly embraced health care as a major policy reform during his first two years in office, despite the Great Recession of 2008; and he had to deal with a massive Republican backlash to his health care reforms during the next two years. Is it even conceivable that mass incarceration could be placed on President Obama's agenda or on that of any future President? It may be difficult to imagine, I confess, but a positive answer to these questions seems almost essential to making any headway in reducing mass incarceration.

In contrast to prescription drugs, there have been some writings on the issue of the relationship between the 2008 fiscal crisis and mass incarceration.[116] Some researchers, such as Kara Gotsch of the Sentencing Project, argue that the financial crisis has already triggered a new climate of bipartisanship on punishment.[117] Gotsch suggests that we are today in a unique political climate (embodied, for instance, by the passage of the Second Chance Act under President George W. Bush)—a climate substantially different from the era of President Clinton's Omnibus Crime Bill. In her view, the fiscal crisis is already leading to bipartisanship around sentencing policy and prison reform. (Recent policy research has looked at the changes at the state level in response to the fiscal crisis[118] and the impact of financial crisis on corrections spending,[119] but the findings are not especially encouraging.)

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[116] *See generally* 6 THE CARCERAL NOTEBOOKS (2010), *available at* www.thecarceral.org/journal-vol6.html.

[117] Incidentally, this issue of THE AMERICAN PROSPECT is entirely dedicated to mass incarceration and has a number of interesting contributions. Kara Gotsch, *Bipartisan Justice*, AM. PROSPECT A22-A23 (Dec. 6, 2010), *available at* http://prospect.org/cs/articles?article=bipartisan_justice#.

[118] NICOLE D. PORTER, SENTENCING PROJECT, THE STATE OF SENTENCING 2009: DEVELOPMENTS IN POLICY AND PRACTICE, (2010), *available at* http://www.sentencingproject.org/doc/publications/s_ssr2009Update.pdf.

Others contend that the current economic crisis alone will have little effect. In her 2010 *Daedalus* article *Cell Blocks & Red Ink*,[120] Gottschalk argues that economic troubles are not necessarily a catalyst for decarceration: "Mounting fiscal pressures on their own will not spur communities, states, and the federal government to empty jails and prisons."[121] In fact, she argues, it may be the inverse. "If history is any guide, rising public anxiety in the face of persistent economic distress and growing economic inequalities may, in fact, ignite support for more punitive penal policies."[122] Economic hard times (for a variety of reasons) are more likely to stoke the fire of public punitiveness—as we saw at the time of the Great Depression and the New Deal.[123] Going forward, Gottschalk argues, advocates of decarceration will need to avoid framing the issue primarily as an economic one.[124]

Chris Berk at the University of Chicago has a working-paper titled *Investment Talk: Comments on the Use of the Language of Finance in Prison Reform Advocacy*, which focuses on what he calls "an emerging discourse in prison reform circles," or "investment talk," that uses the language and concepts of investment and finance to argue for large-scale prison reform.[125] Berk is skeptical of this new discourse and suggests that it may undermine prison reform advocacy because, first, it takes the interpretation of social cost to be given, rather than politically contested, and second, it empowers a particular set of experts and knowledge, consolidating the logic of neoliberal penality.[126] Consequently, Berk argues, investment talk does not necessarily imply, as some advocates suggest, more limited, community-controlled punishment practices.

Still others, such as Jonathan Simon and myself, have drawn parallels between the prison boom and the housing bubble.[127] Simon argues, in his *Daedalus*

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[119] CHRISTINE S. SCOTT-HAYWARD, VERA INST. JUSTICE THE FISCAL CRISIS IN CORRECTIONS: RETHINKING POLICIES AND PRACTICES (July 29, 2009), *available at* http://www.vera.org/files/The-fiscal-crisis-in-corrections_July-2009.pdf.

[120] Gottschalk, *supra* note 10, at 62–73. The original formulation of Gottschalk's argument traces to her earlier book, where she argued that financial crisis does not necessarily mean that Left and Right will end up reaching across the aisle or that the results will be a reduction in punishment. *See* MARIE GOTTSCHALK, THE PRISON AND THE GALLOWS 240–45 (2006).

[121] Gottschalk, *supra* note 10, at 62.

[122] *Id*. at 63.

[123] *Id*. at 64.

[124] *Id*. at 70.

[125] Chris Berk, *Investment Talk: Comments on the Use of the Language of Finance in Prison Reform Advocacy*, 6 THE CARCERAL NOTEBOOKS 115 (2010), *available at* http://www.thecarceral.org/cn6_Berk.pdf.

[126] *Id*.

[127] ILLUSION, *supra* note 15, at 238–39; Jonathan Simon, *Clearing the 'Troubled Assets' of America's Punishment Bubble*, DAEDALUS, Summer 2010, at 91–101.

article *Clearing the 'Troubled Assets' of America's Punishment Bubble*,[128] that the mass incarceration crisis can be mapped onto the housing crisis, suggesting that the analogy may reveal potential remedies to the current crisis. "For the prisons themselves," Simon suggests, "we need a conversion program similar to the plan developed to handle former military installations closed down as a result of Congress's base-closing commission in the 1990s."[129] Keally McBride has also been writing in this vein on the California crisis.[130] In *The Illusion of Free Markets*, I suggest that the growth of prisons has, in fact, resembled the "bubble economies" that we witnessed over the past few decades—the "dot-com bubble" of the late 1990s and the "real estate bubble" of the late 2000s.[131] Prison building (a form of real estate, sadly) exploded in the 1990s, generating a remarkable outburst of expenditures, jobs, *and debt*. It is possible to think of the growth of the prison sector as resembling, in many ways, the growth of the real estate sector: fueled by irresponsible lending or borrowing, growing beyond future capacity, resting on speculation, and producing huge indebtedness.

The Great Recession of 2008 has certainly put severe pressure on the "prison bubble"—if that is a fair term—as many states find themselves unable to service the debt associated with prison building or carry the expenses associated with massive prison populations. This has been nowhere more clear than in Arizona where, in early 2009, the state legislators began discussing the idea of converting the entire state-run prison system into a privately run corporation to counteract the $3.3 billion revenue shortfall expected that year.[132] Some legislators predicted that this change could save the state approximately $40 million annually,[133] whereas others hoped that this could reduce the budget shortfall by $100 million.[134] The plan to privatize the whole sector has gone forward, though it would only add to Arizona's already-significant reliance on private prisons: to date, nearly 30% of the state's prisoners are held in privately run facilities.[135] It is, of course, unclear what will ultimately happen with the prison sector, whether it would ever "pop," whether it will be fully privatized, and whether it will continue to grow.

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[128] *Id*. at 91–101. Simon has also posted a blog on this topic: Jonathan Simon, *Punishment, States, and the Governance of Crime: Looking for the Future of Mass Incarceration in the Sunbelt*, GOVERNING THROUGH CRIME (Nov. 19, 2010), http://governingthroughcrime.blogspot.com/.

[129] Simon, *supra* note 127, at 97.

[130] Keally McBride, *California Penalty: The End/Price of the Neoliberal Exception*, 6 THE CARCERAL NOTEBOOKS 131 (2010), *available at* http://www.thecarceral.org/cn6_McBride.pdf.

[131] ILLUSION, *supra* note 15, at 238.

[132] *Private prisons offer potential for state savings*, YUMA SUN (May 25, 2009), http://www.yumasun.com/opinion/state-50322-potential-balance.html.

[133] *Id*.

[134] Jennifer Steinhauser, *Arizona May Put State Prisons in Private Hands*, N.Y. TIMES, Oct. 24, 2009, at A1, *available at* http://www.nytimes.com/2009/10/24/us/24prison.html.

[135] *Id*.

But it is unlikely that the economic crisis will have much of an effect on prison populations *without* federal or state leadership. This is, I believe, a lesson from deinstitutionalization, and in this regard I agree with Marie Gottschalk, who writes (correctly I believe) that "[t]he deinstitutionalization case demonstrates the enormous importance of the political context for the development and implementation of successful federal and state policies to drastically shrink state institutions . . . . [L]eadership at the federal level was critical to enacting change."[136] The real question, then, is whether there could possibly be funding mechanisms put in place that could migrate the financial burden of incarceration in such a way as to promote, ultimately, alternatives to incarceration. This was the model of 1960s deinstitutionalization: shifting the funding burden to the federal government as a way to incentivize the states to move patients into other facilities closer to the community and closer to home. Could this be encouraged today?

Some point to the Justice Reinvestment movement as a way to address this question. "Justice Reinvestment," a project of the Council of State Governments Justice Center, is, in its own words, "a data-driven approach to reduce corrections spending and reinvest savings in strategies that can decrease crime and strengthen neighborhoods."[137] The project is intended to be evidence-driven and to discover cost-effective ways of keeping society safe. The mantra is evidence, cost-effective policies, and measured performance—as evidenced by its three-prong approach:

1. Analyze data and develop policy options. Justice Center experts analyze crime, arrest, conviction, jail, prison, and probation and parole supervision data provided by state and local agencies; map specific neighborhoods where large numbers of people under criminal justice supervision live and cross-reference this information with reports of criminal activity and the need for various services (including substance abuse and mental health treatment programs) and resources (such as unemployment or food stamp benefits); and assess available services critical to reducing recidivism. Using that state-specific information, the Justice Center develops practical, data-driven, and consensus-based policies that reduce spending on corrections to reinvest in strategies that can improve public safety.[138]
2. Adopt new policies and put reinvestment strategies into place. Once government officials enact the policy options, they must take steps to verify that the policies are adopted effectively. The Justice Center assists jurisdictions with translating the new policies into practice, and ensuring related programs and system investments achieve

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[136] Gottschalk, *supra* note 10, at 68.

[137] *Background*, THE COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER, http://www.justicecenter.csg.org/about_us/background (last visited Oct. 8, 2011).

[138] *Strategy*, JUSTICE REINVESTMENT, http://justicereinvestment.org/strategy (last visited Oct. 8, 2011).

> projected outcomes. This assistance includes developing implementation plans with state and local officials and keeping policymakers apprised through frequent progress reports and testimony to relevant legislative committees.[139]
>
> 3. Measure performance. Finally, the Justice Center ensures that elected officials receive brief, user-friendly, and up-to-date information that explains the impact of enacted policies on jail and prison populations, and on rates of reincarceration and criminal activity. Typically, this includes a "dashboard" of multiple indicators that make it easy for policymakers to track—in real time—the changes in various components of the criminal justice system.[140]

According to the Justice Reinvestment project, this is precisely the approach that led, for instance, to the investment of $241 million by the Texas legislature in 2007 "to expand the capacity of substance abuse and mental health treatment and diversion programs, and to ensure that the release of low-risk individuals is not delayed due to lack of in-prison and community-based treatment programs" and to the investment of $7.9 million in Kansas "to expand treatment programs and strengthen probation and parole."[141]

It might be possible to tap into this logic to promote federal or state leadership as a cost-effective way around mass incarceration. On the other hand, of course, this entire approach could simply be a lot of technocratic nonsense—a lot of politics masquerading as economistic, cost-efficiency language. And the entire cottage industry of reentry and diversionary programs may well be a grand illusion, or, in Loïc Wacquant's terms, a lot of "myth and ceremony."[142] The question, ultimately, may be whether the public economy of reentry is more or less favorable than that of mass incarceration. Once again, these avenues may involve a devil's pact. What is clear, though, is that federal or state leadership will be necessary to make this pact work—should we go down that path.

3. The Social Construction of the Convict

The third question is whether we could imagine, at some point, that the public imagination of the "convict" could ever be reshaped. This is not simply a matter of changing social meaning. It involves complicated processes of identification. Although exceedingly complex, here too there may be something fruitful. The place to look may be the recent litigation of California prison overcrowding at the United States Supreme Court—a high-profile media and cultural event that may

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[139] *Id*.

[140] *Id*.

[141] *See* COUNCIL OF STATE GOVERNMENTS, *supra* note 137.

[142] *See* Loïc Wacquant, *Prisoner Re-entry as Myth and Ceremony*, 34 DIALECT. ANTHROPOL. 605 (2010).

signal wider appreciation for the prison conditions facing convicted inmates. An analysis of the rhetoric and surrounding media coverage of the oral argument before the Supreme Court possibly indicates a growing awareness of overcrowding in prisons and the resulting poor conditions. The case may serve as an illustration of how to mobilize greater attention on the problems associated with mass incarceration.[143]

The California prison overcrowding case, *Schwarzenegger v. Plata* or now *Brown v. Plata*,[144] was argued at the U.S. Supreme Court on November 30, 2010, on the question of the authority of the federal courts to issue and fashion remedies to rectify unconstitutionally poor conditions within prisons, pursuant to the Prison Litigation Reform Act, 18 U.S.C. § 3626 ("PLRA"). The Supreme Court litigation arose out of two separate class action lawsuits, *Plata v. Schwarzenegger*[145] and *Coleman v. Schwarzenegger*,[146] filed on behalf of prisoners incarcerated in California State prisons. In both cases, the prisoners successfully claimed that poor medical and mental health care provided by the California Department of Corrections and Rehabilitation ("CDCR") violated their constitutional rights.[147] At issue before the Supreme Court was the remedy fashioned by the courts to correct the constitutional violation. More specifically, a three-judge panel in the consolidated cases had ordered that California create and file a population reduction plan that would, in no more than two years reduce the population of the CDCR's adult institutions to 137.5% of their combined design capacity. The appeal to the Supreme Court concerned the scope of this remedial order.

The cases have a complicated procedural history and have been winding their way through the federal courts since the early 1990s. The first case, the *Coleman*[148] case initiated in 1990, was a class-action lawsuit filed on behalf of

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[143] This article was written several months before the Supreme Court issued its opinion in Brown v. Plata, 131 S. Ct. 1910, on May 23, 2011, and was past final edits before the release of the opinion. It is interesting to note, though, that Justice Kennedy's opinion for the majority included two photographs of gymnasium-style prison conditions with concentrated inmates, as well as an image of the "telephone-booth-sized cages without toilets" that are used for suicidal inmates. In addition, the *New York Times*, the following day had front-page coverage of the decision including another large, color photograph of the prison overcrowding. *See* Adam Liptak, *Justices, 5-4, Tell California to Cut Prison Crowding*, N.Y. TIMES, May 24, 2011, at A1, *available at* http://www.nytimes.com/2011/05/24/us/24scotus.html?pagewanted=all. This is further evidence that the imagery of prison overcrowding and mass incarceration may be increasingly permeating the public imagination.

[144] The case has since been re-captioned to *Brown et al. v. Plata*, No. 09-1233 (May 23, 2011).

[145] Plata v. Schwarzenegger, No. 3:01-CV-01351-TEH (N.D. Cal. Apr. 5, 2001).

[146] Originally filed as Coleman v. Wilson, No. CV-00520-TEH (E.D. Cal. Apr. 23, 1990).

[147] *Coleman* specifically addresses the lack of mental healthcare facilities while *Plata* addresses medical facilities generally. *See* Three-Judge Court Opinion and Order, Coleman v. Schwarzenegger, No. 2:90-CV-0520 LKK JFM; Plata v. Schwarzenegger, No. 3:01-CV-01351- THE (Aug. 4, 2009), *available at* http://www.caed.uscourts.gov/caed/Documents/90cv520o10804.pdf [hereinafter Opinion and Order].

[148] Coleman v. Wilson, 912 F. Supp. 1282 (E.D. Cal. 1995).

California inmates with serious mental disorders. The *Coleman* plaintiffs raised claims based on inadequate mental health care provided to California prisoners. In 1995, following a full trial in front of a Magistrate Judge, the District Court found that the mental health care provided to California's inmates was constitutionally inadequate, and that the State did not provide "basic, essentially common sense, components of a minimally adequate prison mental health care delivery system."[149] Based on these findings, the *Coleman* court entered an order requiring defendants to develop plans to remedy the constitutional violations under the supervision of a special master.[150] The Special Master supervised over a decade of remedial efforts. By 2006, when the District Court judge granted the *Coleman* plaintiffs' motion for a hearing before a three-judge panel, the court had issued over 70 orders in the *Coleman* case.[151]

Plata v. Schwarzenegger, filed in 2001, was a class action lawsuit claiming that the delivery of medical care in the California State penal system was constitutionally inadequate. The parties in *Plata* (who had been informally negotiating since 1999) negotiated a stipulation for injunctive relief in 2002.[152] After three years of reports of the State's noncompliance with the agreement (October 2005), the *Plata* court appointed a receiver to oversee the CDCR and bring its management of inmate healthcare into constitutional compliance.[153] The receiver was granted broad authority to develop and implement a system of medical care delivery that met constitutional standards "as soon as practicable."[154]

In the meantime, on October 4, 2006, then-Governor Schwarzenegger declared a state of emergency, stating that the overcrowding in prisons posed a substantial risk to the health and safety of workers and inmates in California prisons, and that immediate action was required to prevent death and harm caused by severe overcrowding.[155] Following the Governor's declaration of the state of emergency, both the plaintiffs in the *Plata* and *Coleman* cases filed motions to convene a three-judge panel under PLRA to consider whether a Prison Release Order should be considered, and the motions were granted. The cases were consolidated, and heard before a three-judge panel to assess whether a Prison Release Order was an appropriate remedy under the PLRA. Following an extensive evidentiary hearing, the panel determined that overcrowding in state

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[149] Specific deficiencies cited by the court included delays in treatment, which worsened and exacerbated illness, improper screening, improper medication management, poor record keeping and chronic understaffing. Opinion and Order, supra note 143, at 25.

[150] *Coleman*, 912 F. Supp. at 1298.

[151] Opinion and Order, *supra* note 147, at 27.

[152] *Id*. at 10.

[153] *See id*. at 20. The Plata court considered the appointment of a Receiver "a drastic measure" but blamed "the State's abdication of responsibility," and stating that the court had "no choice but to step in to fill the void." *Id*.

[154] *Id*.

[155] *See id*. at 43.

penal facilities was the primary cause of the constitutionally inadequate provision of medical and mental health care.[156] The panel ordered California to create and file a population reduction plan that will in no more than two years reduce the population of the CDCR's adult institutions to 137.5% of their combined design capacity.[157]

In the appeal before the Supreme Court, the State of California challenged the three-judge order mandating that the State reduce the population of the prisons to 137.5% of their designed capacity within two years.[158] The three-judge panel chose this cap based on expert testimony and evidence presented during the hearing. The plaintiffs had requested a 130% design capacity cap, and supported the request with expert testimony, which included reports from the Gubernatorial Strike Team tasked with addressing the Prison Overcrowding State of Emergency and the Bureau of Prisons.[159] Both reports set population management goals to cap inmate populations at 130% design capacity. The State argued that these population goals were "desirable," but not constitutionally required.[160] Other expert testimony, including a 2004 Corrections Independent Review Panel (prepared by a group of experienced California prison wardens) suggested that "a system operating at 145% design capacity could 'support full inmate programming in a safe and secure environment.'"[161] However, testimony regarding this report showed that adequate medical and mental health facilities were not accounted for in preparing the report; the court therefore reasoned that capping the population at 145% capacity would not be enough to provide adequate care. Thus the judicial panel credited the evidence supporting the 145% estimate "to the extent that it suggests that the limit on California's prison population should be somewhat higher than 130% but lower than 145%."[162] Given conflicting evidence, the panel ordered a population cap of 137.5% design capacity, which was "a population reduction halfway between the cap requested by plaintiffs and the wardens' estimate of the California prison

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[156] *Id*. at 52.

[157] *Id*. at 183.

[158] The challenge rests in part on the language of the PLRA, which states that a court cannot issue a prisoner release order unless "(i) a court has previously entered an order for less intrusive relief that has failed to remedy the deprivation . . . . ; and (ii) the defendant has had a reasonable amount of time to comply with the previous court orders." 18. U.S.C. 3226 (a) (3) (A). California argues in part that it has not had a reasonable amount of time to remedy the violations. Brief of Plata Appellees at i, Schwarzenegger v. Plata, 130 S. Ct. 3413 (2010) (No. 09-1233), 2010 WL 4641625 at *25.

[159] Opinion and Order, *supra* note 147, at 124.

[160] *Id*. at 130.

[161] The Judicial Panel notes, with some frustration, that the State did not propose an alternative population cap that would fix the Constitutional violation. *Id*. at 128.

[162] Additionally, the Panel found the evidence supporting the adequacy of care at 145% capacity to be "far less persuasive." *Id*. at 130.

system's maximum operable capacity absent consideration of the need for medical and mental health care."[163]

I realize these are a lot of details, but this litigation at the Supreme Court and the struggle over 130%, 137.5%, or 145% overpopulations are very significant because together, they signal a greater awareness of the plight of prisoners and of their conditions of incarceration. The rhetoric at the oral argument and the media coverage of the Supreme Court case seem to indicate a growing and wider awareness of overcrowding in prisons and the resulting poor conditions, as well as a growing concern for the best way to allocate public resources to address these problems. Concern for the welfare of prisoners was evident in several questions asked by the Justices. Justice Sonia Sotomayor openly asked the State to address the human costs of overcrowding: "When are you going to avoid the needless deaths that were reported in this record? When are you going to avoid or get around people sitting in their feces for days in a dazed state? When are you going to get to a point where you're going to deliver care that is going to be adequate?"[164] Justice Stephen Breyer also called attention to the poor conditions—which he later called "a big human rights problem"[165]—stating that "it's obvious . . . . [y]ou cannot have mental health facilities that will stop people from killing themselves and you cannot have medical facilities that will stop staph and tubercular infection in conditions like this."[166]

Other questions indicated a fear of the consequences of the population cap, reflecting the debates over the proper treatment of the mentally ill (isolated in asylums or integrated into communities). But unlike the mental health debates, in the prison context confinement itself is a part of punishment, and supposedly an immediate deterrent to further crime. This consequentialist argument was reflected in questions by Justice Samuel Alito[167] and Chief Justice John Roberts, whose questions emphasized the high recidivism rate of parolees,[168] when addressing whether the three-judge panel's order gave appropriate consideration to community safety, in adherence with PLRA.

The oral arguments also indicated a growing frustration and exhaustion with the public consequences of a large prison population. Justice Alito questioned the appropriateness of a mandated prison cap, but Justices Breyer, Ginsburg and Kennedy each emphasized the failure of previous attempts to improve conditions. Throughout the argument, references were made to the failure to secure funding to improve prison conditions to a constitutionally adequate state.

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[163] *Id*.

[164] Transcript of Oral Argument at 15, Schwarzenegger v. Plata, 131 S. Ct. 631 (No. 09-1233), *available at* http://www.supremecourt.gov/oral_arguments/argument_transcripts/09-1233.pdf.

[165] *Id*. at 27.

[166] *Id*. at 20.

[167] *Id*. at 47 ("[I]f I were a citizen of California, I would be concerned about the release of 40,000 prisoners").

[168] *Id*. at 66–67.

Media coverage of the case seems to indicate a growing public sentiment against mass incarceration.[169] Many editorials, with titles such as *The Crime of Punishment* and *Overcrowding in Prisons Put Us All at Risk*, supported upholding the three-judge panel's decision capping the prison population. Even articles that focused more on the oral argument (and less on advocacy) seemed to note the skepticism members of the Court showed for the State's arguments.[170]

This kind of high-profile litigation may well help to shift popular views about prisons and prison conditions. Along with documentary films in the vein of *Titicut Follies*, it is possible to imagine these legal and cultural interventions having an effect on public perception that could ultimately reduce prison populations. It is true that, while public sentiment may be more sympathetic to the more egregious examples of horrific conditions in prisons, it seems unlikely that prisoners will ever be able to evoke the same amount of sympathy as the mentally ill. In contrast to mental patients, prisoners tend to be viewed as deserving of their punishment. The question, though, is whether they will continue to be viewed as deserving of the excessive forms of punishment associated with these overcrowded and unsanitary prisons and jails.

III. THE PITFALLS OF DEINSTITUTIONALIZATION: WHAT TO AVOID?

A second large area to consider involves the pitfalls associated with deinstitutionalization in the 1960s. The dangers here are even more straightforward. Two leap to mind: the increased racialization of the institutions as they were deinstitutionalized, and second, the transinstitutionalization that occurred in the wake of deinstitutionalization.

A. *Racialization of the Institutionalized Population*

Deinstitutionalization in the 1960s and 1970s drew heavily on predictions of future dangerousness. The difficulty here is that the use of risk assessment tools

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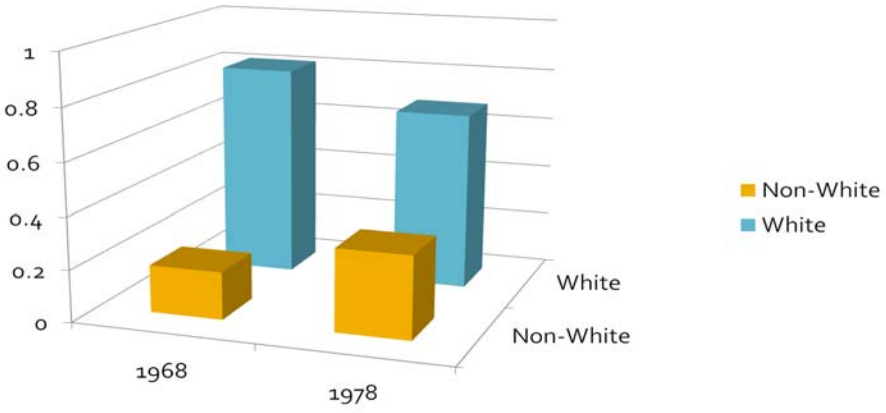
[169] *See, e.g.*, Robert Barnes, *High Court Hears California Prison Case*, WASH. POST, Dec. 1, 2010, at A2; Jimmy Bierman & Jamie Dorenbaum, Editorial, *Viewpoints: 'Three Strikes Law' is a Human Travesty*, SACRAMENTO BEE, Dec. 17, 2010, at A19; *The Crime of Punishment*, N.Y. TIMES, Dec. 6, 2010, at A26; Michael Doyle, *California Prison Ruling Expected to Be Split: Supreme Court Divided on How to Fix Crowding*, THE FRESNO BEE., Dec. 1, 2010, at A1; David Fathi, *Bulging Prisons Put Us At Risk*, CONTRA COSTA TIMES, Dec. 4, 2010, at A8; *High Court to Look at Calif. Prison Crowding*, THE ASSOCIATED PRESS, Nov. 30, 2010, *available at* 2010 WLNR 23811684; Adam Liptak, *Justices Hear Arguments on California Prison Crowding*, N.Y. TIMES, Dec. 1, 2010, at A16; Warren Richey, *California, at Supreme Court, Fights Judicial Order on Prison Overcrowding*, CHRISTIAN SCI. MONITOR (Nov. 30, 2010), http://www.csmonitor.com/USA/Justice/2010/1130/California-at-Supreme-Court-fights-judicial-order-on-prison-overcrowding; *Prison Ruling Stirs Up California*, WALL ST. J. (Nov. 29, 2010), http://online.wsj.com/article/SB10001424052748703785704575642940131431372.html.

[170] Bob Egelko, *State Arguments Draw Skepticism from High Court*, S.F. CHRON., Dec. 1, 2010 at C1; David G. Savage, *State Prison Case Falls on Dubious Ears; High Court Appears Likely to Back Ruling Ordering California to Free 40,000 Inmates*, L.A. TIMES, Dec. 1, 2010, at AA1.

typically has the effect of sorting based on race and increasing the racial disproportion within our "dangerous" populations. This was certainly the case with regard to mental hospitals. It is also likely to happen with prisons if we rely too heavily on risk assessment.

The turn to dangerousness had a distinctly disproportionate effect on African-American populations: the proportion of minorities in mental hospitals increased significantly during the process of deinstitutionalization. From 1968 to 1978, for instance, there was a significant demographic shift among mental hospital admittees. 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 using a randomly selected sample of 3897 male prisoners and 2376 adult male admittees to state mental hospitals from six different states.[171] Their research revealed that the proportion of non-whites admitted to mental facilities increased from 18.3% in 1968 to 31.7% in 1978: "Across the six states studied . . . [t]he percentage of whites among admitted patients also decreased, from 81.7% in 1968 to 68.3% in 1978."[172] This is demonstrated in the following graph, which charts the shift documented by Steadman, Monahan, and their colleagues:

Figure 5: Admissions to mental facilities by Race



The track record is damning: mental hospitals were deinstitutionalized by focusing on dangerousness and the result was a sharp increase in the black representation in asylums and mental institutions. I have written at greater length

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[171] Henry J. Steadman et al., *The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations, 1968–1978*, 75 J. CRIM. L. & CRIMINOLOGY 474, 478 (1984).

[172] *Id.* at 479. Note that there was a similar, though less stark shift in prison admissions: "Across the six states . . . . [t]he percentage of whites among prison admittees was also relatively stable, decreasing only from 57.6% in 1968 to 52.3% in 1978." *Id.*

about this in an essay, *Risk as a Proxy for Race*, and Michelle Alexander has forcefully drawn the devastating consequences for African-American communities and American politics in her book *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* (2010) and in her contribution to this symposium. It is absolutely crucial that, in any effort to reduce mass incarceration, this pitfall be avoided.

B. *Transinstitutionalization*

The other danger to avoid is transinstitutionalization. This unquestionably happened with the mentally ill, as they were not only transferred to nursing homes, but eventually became a much larger segment of the prison population. William Gronfein has documented the transinstitutionalization of older mental patients from hospitals to nursing homes in the 1970s. Gronfein emphasized that the overall institutionalized population did not decrease over the 1960s, but in fact rose slightly from 1035 per 100,000 general population in 1960 to 1046 per 100,000 in 1970. Yet, during this period, the proportion of the institutionalized population in nursing and old age homes increased from 19% in 1950 to 25% in 1960, and reached 44% by 1970.[173] As Gronfein explained, "The total number of nursing care and related homes rose from 16,701 in 1963 to 22,558 in 1971, an increase of 35.1%, while the number of beds available in such homes rose from 568,560 to 1,235,405, an increase of 117.3%."[174] In Gronfein's view, this was the product of Medicare and Medicaid, which encouraged the substitution of one institution (nursing care) for another (mental hospitals).

In addition, we have all witnessed the transinstitutionalization of mental health patients into prisons and jails. In his paper, *The Deinstitutionalization of the Mentally Ill and Growth in the U.S. Prison Populations: 1971 to 1996*,[175] Steven Raphael explores the relationship between mental hospitalization and prison populations using state-level data for the period 1971 to 1996, and finds that deinstitutionalization from 1971 to 1996 probably resulted in between 48,000 and 148,000 additional state prisoners in 1996, which, according to Raphael, "accounts for 4.5 to 14% of the total prison population for this year and for roughly 28 to 86% of prison inmates suffering from mental illness."[176] 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.[177]

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[173] *Incentives*, *supra* note 1, at 200.

[174] *Id*.

[175] Steven Raphael, The Deinstitutionalization of the Mentally Ill and Growth in the U.S. Prison Populations: 1971 to 1996 (September 2000) (unpublished manuscript, on file with the Goldman School of Public Policy at University of California, Berkeley).

[176] *Id*. at 12.

[177] DITTON, *supra* note 105.

There is a significant risk that any decarceration will simply produce new populations for other institutions, whether homeless shelters, inpatient treatment facilities, or other locked-down facilities. This is certainly what happened last time. The question is, can it be avoided this time?

IV. CONCLUSION

Would it ever be possible to listen to a President of the United States declare to Congress:

> If we launch a broad new program now, it will be possible within a decade or two to reduce the number of prisoners now under custodial detention by 50 percent or more. Many more inmates can be helped to remain in their homes without hardship to themselves or their families. Those who are incarcerated can be helped to return to their own communities . . . . Central to a new program is comprehensive community services. Merely pouring Federal funds into a continuation of the outmoded type of institutional detention which now prevails would make little difference.[178]

I do not know the answer to this question, and my task has not been to predict or to speculate, but rather to sketch, preliminarily, some lessons from our past experience of deinstitutionalization. Whether I, personally, am optimistic or pessimistic should be of no concern to you. One of the important lessons that should be of concern, though, is that it may not be possible to make much headway in reducing mass incarceration without the kind of political investment and will that President John F. Kennedy expressed in 1963. If we are indeed to work toward decreased prison populations, the task ahead will be to maximize the silver linings of 1960s deinstitutionalization while avoiding the glaring pitfalls—or, at the very least, to further study the lessons from deinstitutionalization.

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[178] President Kennedy's statement to Congress, slightly modified. *Incentives*, *supra* note 1, at 196.