

2011

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Recommended Citation

Bernard E. Harcourt, "Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s" (University of Chicago Public Law & Legal Theory Working Paper No. 335, 2011).

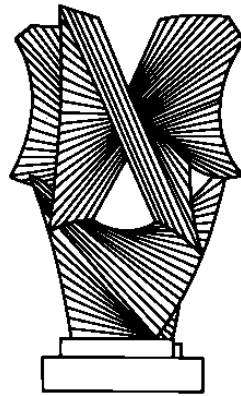
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CHICAGO

JOHN M. OLIN LAW & ECONOMICS WORKING PAPER NO. 542

(2D SERIES)

PUBLIC LAW AND LEGAL THEORY WORKING PAPER NO. 335



REDUCING MASS INCARCERATION:
LESSONS FROM THE DEINSTITUTIONALIZATION OF MENTAL
HOSPITALS IN THE 1960S

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THE UNIVERSITY OF CHICAGO

January 2011

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REDUCING MASS INCARCERATION:
LESSONS FROM THE DEINSTITUTIONALIZATION OF MENTAL HOSPITALS IN THE 1960S.

Bernard E. Harcourt¹

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.²

President Kennedy's aspiration of a 50 percent 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 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 percent.³ The mean decrease per year over that

¹ Professor and Chair, Department of Political Science, and Julius Kreeger Professor of Law, University of Chicago. I am deeply grateful to Carol Steiker for organizing and hosting this remarkable symposium, to Charles Ogletree for commenting on a draft of this essay at the symposium, to Philip Heymann, Mark Kleinman, Adriaan Lanni, Louis Michael Seidman, Jeannie Suk, and Andrew Taslitz for extremely helpful comments and discussion on the draft, and to Chris Berk and Alyssa Kate Ogawa for extraordinary research assistance.

² Quoted in William Gronfein, "Incentives and Intentions in Mental Health Policy: A Comparison of Medicaid and Community Mental Health Programs," 26 *J Health & Social Behavior* 3, 192-206 (1985), at p. 196; *see also* Henry Foley and Steven Sharfstein, *Madness and Government*, Wash D.C.: American Psychiatric Association (1983), at page 166.

³ Gronfein, "Incentives and Intentions," 1985 at p. 196 (Table 1).

period would reach almost 9 percent.⁴ During the next five years, from 1975 to 1980, the drop in inpatient populations would continue, down another 28.9 percent.⁵ All in all, from 1955 to 1980, the number of persons institutionalized in mental health facilities declined by 75 percent.⁶

Truth be told, deinstitutionalization had begun earlier, in about 1955, with an early onset drop of about 15 percent 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, care and treatment, the aftershock of World War II, changing state policies, fiscal crises, and ambitious federal interventions.⁷ 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 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

⁴ 8.59 percent to be exact. *Id.*

⁵ *Id.*

⁶ *Id.* at 192.

⁷ Gerald Grob explores these and more factors in remarkable detail in his lengthy and masterful work, *From Asylum to Community: Mental Health Policy in Modern America*, Princeton University Press 1991. Other important contributions include, among others, William Gronfein, "Incentives and Intentions," 1985 (exploring the role of Medicaid and Medicare, and larger government interventions); William Gronfein, "Psychotropic Drugs and the Origins of Deinstitutionalization," 32 *Social Problems* 5, 439 (1985) (exploring the role of medication); Joseph Morrissey, "Deinstitutionalizing the Mentally Ill: Processes, Outcomes, and New Directions," 147-76, in Walter Gove, ed., *Deviance and Mental Illness*, Beverly Hills: Sage Publications 1982 (exploring professional reorganization and rivalries); Paul Lerman, *Deinstitutionalization and the Welfare State*, New Brunswick: Rutgers University Press 1982 (exploring the shifts in the welfare states); Andrew Scull, *Decarceration: Community Treatment and the Deviant--A Radical View*, Englewood Cliffs, NJ: Prentice-Hall 1977 (exploring the fiscal crisis effects).

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,⁸ 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. 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, 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 two-fold approach. After tracing some of the historical background in Part I, the essay will explore first, 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.

⁸ Some examples of this include Andrew Scull, *Decarceration: Community Treatment and the Deviant--A Radical View* (1977) (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* (1979) (comparing different potential advocacies in response to the demise of the rehabilitative ideal, and specifically contrasting prison abolition to deinstitutionalization on page 80).

⁹ Bernard E. Harcourt, "From the Asylum to the Prison: Rethinking the Incarceration Revolution," 84 *Texas Law Review* 1751 - 1786 (2006), and Bernard E. Harcourt, "An Institutionalization Effect: The Impact of Mental Hospitalization and Imprisonment on Homicide in the United States, 1934 - 2001," forthcoming in *Journal of Legal Studies* (January 2011). See also Steven Raphael, "The Deinstitutionalization of the Mentally Ill and Growth in the U.S. Prison Populations: 1971 to 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* 139(3): 62-73 (2010). At pages 67-69 of her essay, 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.

¹¹ Liat Ben-Moshe, a sociology graduate student at Syracuse University, has a conference paper from 2010 with a very promising title, "Genealogies of Resistance to Incarceration: Abolition politics in anti-prison and deinstitutionalization activism in the U.S., 1950-present." It appears that Ben-Moshe is indeed using the idea of deinstitutionalization activism as a model for prison abolition.

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 the potential increased use of prescribed medications for aggressive behavior, on a voluntary basis, to address problems of conduct disorders as an alternative to incarceration. Diversionary programs modeled on outpatient mental health clinics and involving the administration of prescribed medications already exist, especially for youth, and could 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 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*, should form part of a larger strategy to shift the public perception of those persons incarcerated. 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 is 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*.

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 Ships of Fools navigating down rivers of Renaissance Europe, to the establishment in the seventeenth century of the Hôpital Général in Paris.¹² 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.

I. Historical Background

This is not the first time that the United States faces 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, 40s and 50s.¹³ For those who have not seen the graph before, it can be somewhat striking:

¹² See generally Bernard E. Harcourt, “From the Asylum to the Prison: Rethinking the Incarceration Revolution,” 84 *Texas Law Review* 1751 - 1786 (2006); the specific reference here, of course, is to Michel Foucault, *Madness and Civilization* (Richard Howard trans., Vintage Books 1988) (1961).

¹³ Harcourt, “From the Asylum to the Prison,” 2006; Bernard E. Harcourt, “An Institutionalization Effect: The Impact of Mental Hospitalization and Imprisonment on Homicide in the United States, 1934 – 2001,” forthcoming in *Journal of Legal Studies* (January 2011); Bernard E. Harcourt, *The Illusion of Free Markets: Punishment and the Myth of Natural Order*, Cambridge: Harvard University Press 2011, p. 221-231.

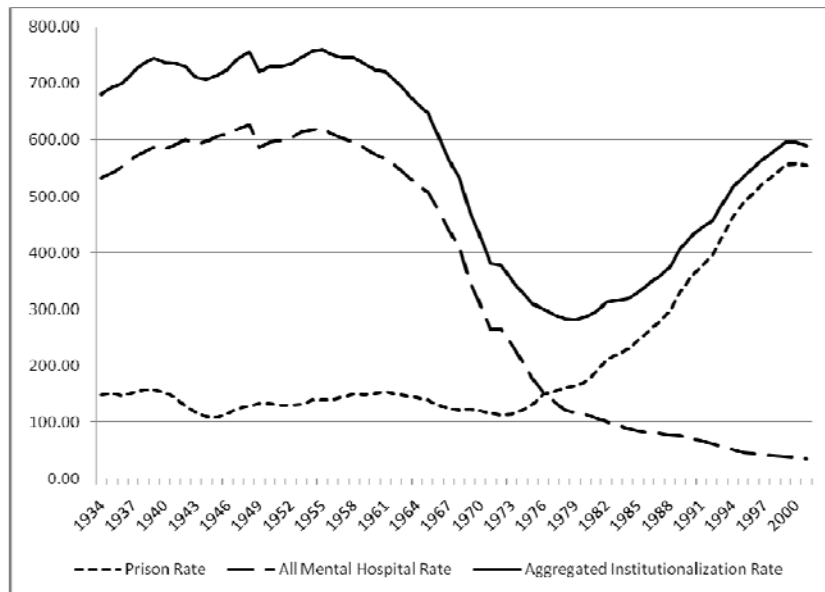


Figure 1: Rates of Institutionalization in Mental Institutions and State and Federal Prisons (per 100,000 adults)

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

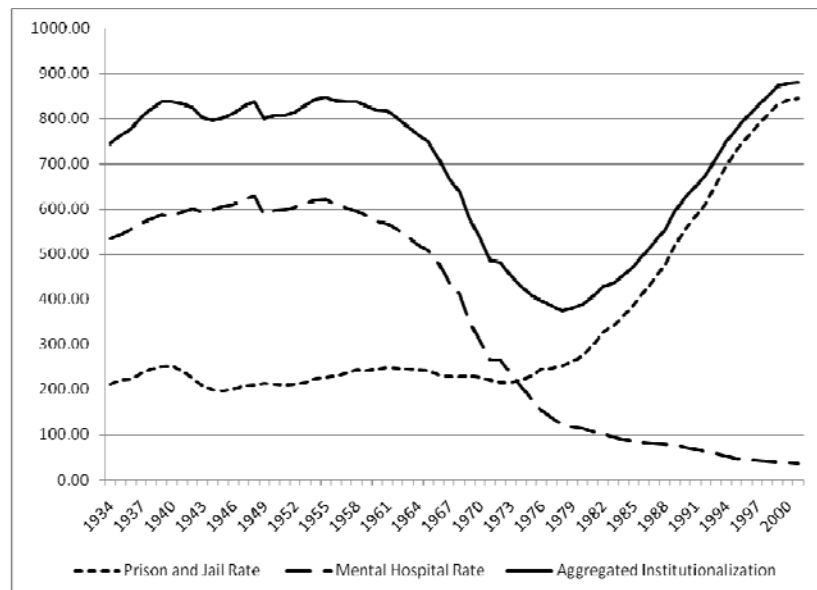


Figure 2: Rates of Institutionalization in the United States (including jail populations)

As this figure demonstrates, the earlier period of mass institutionalization was followed by a dramatic reduction in mental hospital populations in the 1960s and 70s, what we usually refer to as

“deinstitutionalization.”¹⁴ 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.

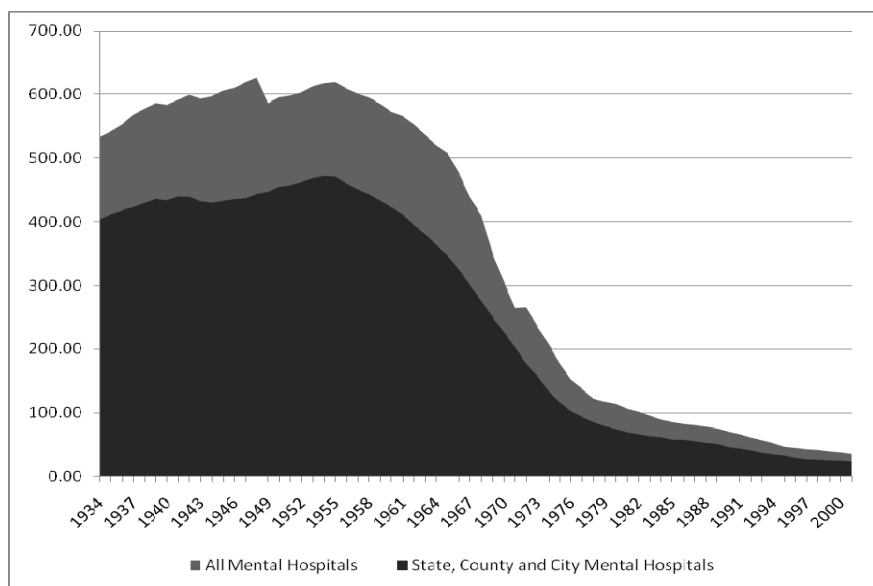


Figure 3: Different Rates of Institutionalization in Mental Institutions in the United States (per 100,000 adults)

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, specifically 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.”¹⁵ There were, to be sure, antecedents.¹⁶ On the Continent, there were penal institutions as far back as the early 1600s

¹⁴ 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 had such reductions as their aims.” William Gronfein, “Psychotropic Drugs and the Origins of Deinstitutionalization,” 32 *Social Problems* 5, 439 (1985). 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”).

¹⁵ David Rothman, *The Discovery of the Asylum*, 1971 at xiii. Rebecca McLennan, in her 2008 book, similarly refers to Rothman’s account as the “master narrative,” see McLennan, *The Crisis of Imprisonment: Protest, Politics, and the Making of the American Penal State, 1776-1941*. Cambridge: Cambridge University Press 2008, at p. 7.

¹⁶ See Pieter Spierenburg, *The Prison Experience: Disciplinary Institutions and Their Inmates in Early Modern Europe*. New Brunswick: Rutgers University Press, 1991, at p. 3-4 and Spierenburg, “Punishment, Power, and

(the Amsterdam *rasphuys*, the *zuchthaus* in Hamburg, and spinhouses for women, for instance),¹⁷ as well as the famous Hôpital Général in Paris established in 1656 by Louis XIV;¹⁸ and 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.¹⁹

In colonial America, care for dependent persons, such as the severely mentally ill, had fallen predominantly on family members or the local parish.²⁰ With time, local governments began to assume responsibility for the care of the mentally ill under a system of "poor laws."²¹ The mentally ill were housed in almshouses, poorhouses, or jails, alongside other persons under supervision or dependency.²² These facilities served largely an incapacitative function, and little effort was made to treat or provide medical care to those confined.²³ The Eastern Lunatic Asylum, the first psychiatric hospital in America, opened in 1773, and by 1816, two psychiatric hospitals were operating in United States.²⁴ Due in part to 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 forty-eight public psychiatric hospitals²⁵; by 1880, seventy-five public psychiatric hospitals housed 41,000 patients.²⁶ These hospitals were small in comparison to the mega-institutions they would become; the largest hospital, Willard Psychiatric Hospital for the Insane, housed only 1,513 patients in residence.²⁷ 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

History" *Social Science History*, Vol. 28, No. 4 (winter 2004), p. 607-636, at p. 616; Michel Foucault, *Madness and Civilization*. Richard Howard, trans. New York: Vintage Books, 1988 at p. 5 (originally published in French in 1961) (on lazar houses for lepers on the outskirts of Medieval cities and the seventeenth century Hôpital Général in Paris); Michael Ignatieff, *A Just Measure of Pain: The Penitentiary in the Industrial Revolution, 1750-1850*. New York: Pantheon Books, 1978, at p. 11-14 (houses of correction and the Amsterdam Rasphouse); Adam Jay Hirsch, *The Rise of the Penitentiary: Prisons and Punishment in Early America*. New Haven: Yale University Press, 1992, at p. 6-8 (discussing eighteenth century Massachusetts penal institutions).

¹⁷ Norval Morris and David Rothman, *The Oxford History of the Prison: The Practice of Punishment in Western Society*. New York: Oxford University Press, 1995, at p. 68 (Spierenburg); see generally Spierenburg, *The Prison Experience*, 1991, at 24.

¹⁸ Foucault, *Madness and Civilization*, 1988, p.37.

¹⁹ Rothman, *Discovery of the Asylum*, 1971, p. xiii.

²⁰ Donna R. Kemp, *Mental Health in America* 2 (2007).

²¹ Gerald N. Grob, *Mental Institutions in America* 33 (1973).

²² Gerald N. Grob & Howard H. Goldman, *The Dilemma of Mental Health Care Policy* 3 (2006).

²³ Gerald N. Grob, *Mental Institutions in America* 34 (1973).

²⁴ 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.

²⁵ Id. at 27.

²⁶ Id. at 82. The total population of the United States at the time was 50 million people.

²⁷ E. Fuller Torrey, *Out of the Shadows* 27 (1997)

Reverend Louis Dwight, called for the placement of the mentally ill in public psychiatric facilities, “rightly organized Hospitals, adapted to the special care of the peculiar malady of the Insane.”²⁸

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. 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, and the foundation for our current prison system. Sing-Sing opened in 1825, Connecticut started building Wethersfield in 1827, Massachusetts reorganized its prison at Charlestown in 1829, followed by Indiana, Wisconsin, and Minnesota in the 1840s.²⁹ “Between 1825 and 1850, state prisons of the Auburn type were built in Maine, Maryland, New Hampshire, Vermont, Massachusetts, Connecticut, New York, the District of Columbia, Virginia, Tennessee, Louisiana, Missouri, Illinois, and Ohio.”³⁰ In addition, Rhode Island, New Jersey, Georgia and Kentucky built prisons on the solitary labor model, and Pennsylvania, which had invented the system of day-time solitary labor, also constructed the Eastern State Penitentiary in the hopes of rejuvenating its model for others to use.³¹

“In all, one can properly label the Jacksonian years ‘the age of the asylum,’” Rothman observes.³² On this point, the historians of the penitentiary agree. Adam Hirsch, in *The Rise of the Penitentiary* (1992), similarly states that “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.”³³ Rebecca McLennan, in her 2008 book on the *Making of the American Penal State*, also traces the penitentiary system to “the age of Jackson.”³⁴ 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.”³⁵ Penal institutions became, in Rothman’s words, places of “first resort, the preferred solution to the problems of poverty, crime, delinquency, and insanity.”³⁶ In *The Illusion of Free Markets: Punishment and the Myth of 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.³⁷

²⁸ Gerald N. Grob & Howard H. Goldman, *The Dilemma of Mental Health Care Policy* 3 (2006).

²⁹ Rothman, *Discovery of the Asylum*, 1971, p. 81.

³⁰ McLennan 2008:63; see generally Lawrence M. Friedman, *Crime and Punishment in American History*. New York: Basic Books, 1993, p. 77-82.

³¹ *Id.*

³² Rothman 1971:xiv.

³³ Hirsch 1992:112.

³⁴ McLennan 2008:54. See also James Q. Whitman, *Harsh Justice*. New York: Oxford University Press, 2008, p. 173-76.

³⁵ Spierenburg 1991:3.

³⁶ Rothman 1971:xiii.

³⁷ Harcourt, *Illusion of Free Markets*, 2011, p. 208-220.

The subsequent growth curves of the two institutions, however, differed markedly. On the penitentiary side, the population remained relatively constant after the initial discovery. Official national prison data only exist for the period beginning in 1850;³⁸ 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 during the first half of the nineteenth century, state prison populations and rates grew enormously, leading to the high national counts beginning in 1850 and reaching a high point in 1870. 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.

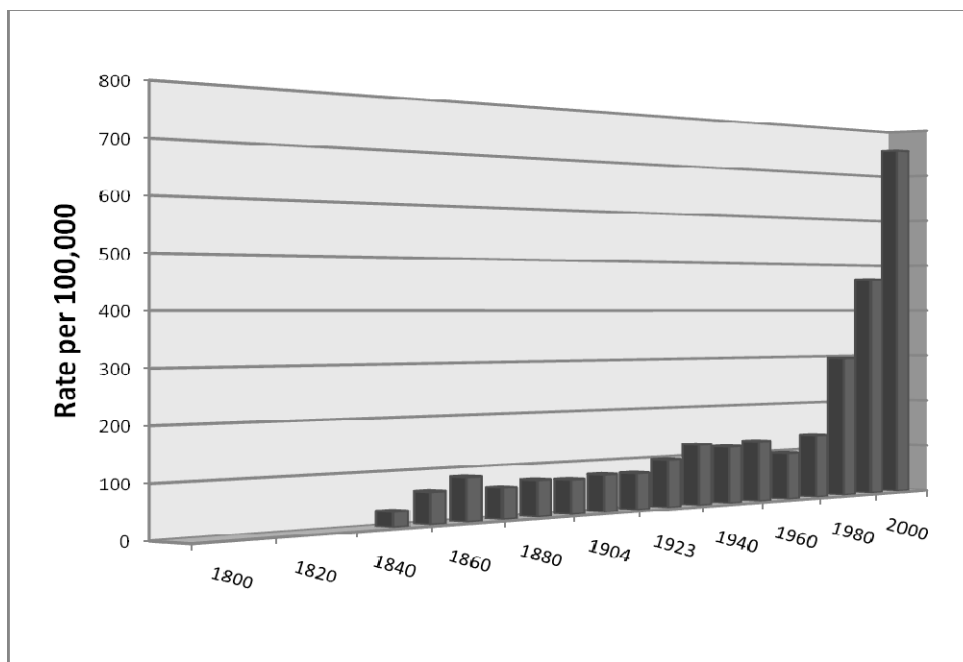


Figure 4: Prison Rate in State and Federal Prisons from 1850 to 2008 (per 100,000 persons).

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. This represented a thirteen-fold increase in the inpatient population, while the total population of the United States grew a little more than threefold.³⁹ The size of the facilities themselves also grew dramatically. For example, New York's Rockland State Hospital housed over

³⁸ Margaret Werner Cahalan, *Historical Corrections Statistics in the United States, 1850-1984*. Rockville, MD: Westat, Inc, 1986, p. 1-28.

³⁹ E. Fuller Torrey, *Out of the Shadows* 82 (1997); see also Gronfein, "Incentives and Intentions," 1985, 194.

9,000 patients, and over 14,000 patients lived in Pilgrim State Hospital.⁴⁰ Commentators have proposed several explanations for this rise in institutional population. One study listed seven factors contributing to the population growth in institutions: “(1) general population growth; (2) the aging of the general population; (3) the constant pressures of overcrowding and need exceeding capacity; (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.”⁴¹ 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.”⁴² Others, such as Thomas Szasz and Thomas Scheff, view the rise in institutionalized population more skeptically, viewing the rise in the population of the “mentally ill” as “a form of social labeling [designed to] suppress nonconformist behavior.”⁴³

As figure 3 shows, after peaking in 1955, inpatient populations in mental hospital 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 55,000.⁴⁴ The average size of the state hospital had fallen from over 2,000 residents to less than 500.⁴⁵

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, 60s and 70s: technological

⁴⁰ Torrey, *Out of the Shadows*, 1997, at 82.

⁴¹ George W. Dowdall, “Mental Hospitals and Deinstitutionalization,” in *Handbook of the Sociology of Mental Health* 520, 520-521 (Carol S. Aneshenel & 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.

⁴² William Gronfein, “Incentives and Intentions”, 1985, p. 194.

⁴³ Gerald N. Grob & Howard H. Goldman, *The Dilemma of Mental Health Care Policy* 52-53 (2006); Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (1961); Thomas J. Scheff, *Being Mentally Ill: A Sociological Theory* (1966).

⁴⁴ Id. at 15.

⁴⁵ Dowdall, “Mental Hospitals and Deinstitutionalization,” in *Handbook of the Sociology of Mental Health* 520, 526 (Carol S. Aneshenel & Jo C. Phelan eds., 1999).

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.

a. 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.⁴⁶ 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.⁴⁷ Though originally developed to sedate patients undergoing surgery, chlorpromazine had tranquilizing effects that led to its administration for mental illness. By 1956, over two million patients had been prescribed chlorpromazine⁴⁸ and at least 37 states were using chlorpromazine or a similar antipsychotic medication in their state mental hospitals.⁴⁹

The early adoption of chlorpromazine was due, in part, to extensive marketing and lobbying efforts by Smith, Kline and French Labs (the manufacturer of Thorazine) for the use of the drug in psychiatric facilities.⁵⁰ For the institutions, the new drug therapy was extremely attractive because it “appeared to offer a solution to one of the problems that had perennially plagued the state hospital: the maintenance of order.”⁵¹ 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.⁵² Drug therapy also offered a treatment for mental illness that could be provided on an out-patient basis.

Although several scholars have noted that the introduction and use of the drugs did not itself cause a significant reduction in patient population,⁵³ the availability of the psychiatric medication had a significant impact on public perception and public policy as well. Tangible medicalization, in

⁴⁶ William Gronfein, “Psychotropic Drugs and the Origins of Deinstitutionalization,” 1985, p. 444.

⁴⁷ E. Fuller Torrey, “Out of the Shadows,” 1997, p. 99.

⁴⁸ *Id.*

⁴⁹ Gronfein, “Psychotropic Drugs and the Origins of Deinstitutionalization,” 1985, p. 441.

⁵⁰ *Id.* at 441-42.

⁵¹ *Id.* at 442.

⁵² David A. Rochecroft, *From Poorhouses to Homelessness: Policy Analysis and Mental Health Care* 215 (1983). Previous treatments, like electroconvulsive therapy, could only be provided on an inpatient basis.

⁵³ Gronfein, “Psychotropic Drugs and the Origins of Deinstitutionalization,” 1985, p. 448; Torrey, *Out of the Shadows*, 1997, p. 99-100.

the form of a pill, promoted the mentally ill “to the status of patients in the eyes of many members of the public.”⁵⁴ 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.”⁵⁵ “[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.”⁵⁶

Policy makers 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 out-patient 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.”⁵⁷

b. Financial Incentives: Federal programs and cost-shifting incentives

A second major contributing factor to deinstitutionalization was federal initiative and interventions 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.⁵⁸ 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.”⁵⁹ The effect of the legislation would be to shift funding from the states to the federal government.

The passage in 1965 of Medicaid⁶⁰ and Medicare⁶¹ 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.⁶² These programs purposefully excluded payments to “institutions for the treatment of mental disease” because the

⁵⁴ Rochecroft, *Poorhouses*, p. 39; Roberts, 1967, p. 25.

⁵⁵ Rochecroft, *From Poorhouses to Homelessness*, 1983, p. 38

⁵⁶ *Id.*

⁵⁷ Gronfein, “Psychotropic Drugs,” 1985, p. 450.

⁵⁸ Bernard L. Bloom, *Community Mental Health 20* (2d ed.1984).

⁵⁹ Gronfein, “Psychotropic Drugs,” 1985, p. 450.

⁶⁰ Medicaid provides selected health care to the indigent, regardless of age, and is funded jointly by contributions from federal and state governments.

⁶¹ Medicare is a federally funded and administered health-insurance program that provides selected health care to “all persons over age 65 who are eligible for Social Security benefits, regardless of income.” Gronfein, “Incentives and Intentions,” 1985, p. 200.

⁶² Gronfein, “Incentives and Intentions,” (citing United States Senate Subcommittee on Long-Term Care)

programs were not designed to supplant state control and financing of psychiatric facilities.⁶³ 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.”⁶⁴

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.⁶⁵ The empirical evidence bears this out. Statistical analyses confirm that “states with greater Medicaid involvement showed larger inpatient declines over the same period.”⁶⁶ Much of this was, naturally, transinstitutionalization, especially into nursing homes, which I discuss later; but it did facilitate deinstitutionalization.

c. 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 percent of those drafted between 1942 and 1945 were found unfit to serve for psychiatric or neurological reasons.⁶⁷ Additionally, 37 percent of soldiers discharged during the war for disability were discharged for mental illness.⁶⁸ 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

⁶³ Torrey, *Out of the Shadows*, 1997, p. 102.

⁶⁴ *Id.*

⁶⁵ 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. Gerald N. Grob, *Mental Institutions in America* 1-35 (1973).

⁶⁶ Gronfein 201

⁶⁷ Rochecroft, *From Poorhouses to Homelessness*, 1983, p. 34.

⁶⁸ *Id.*

treatment of the mentally ill, often acting as whistleblowers and raising public awareness of the conditions in those institutions.⁶⁹ 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.⁷⁰ 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 semi-starvation."⁷¹ *Life Magazine* published "Bedlam 1946," an *exposé* that had graphic and disturbing photos accompanying the description of the poor treatment of mentally ill patients.⁷² "These two articles, appearing in two of the magazines with the widest circulation in the United States, triggered a volcano of exposes and feature articles in other magazines and the daily press which continued for several years."⁷³ 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."⁷⁴ And 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*,⁷⁵ suggested that mental illness was a social construct used to control and limit deviancy in the population.⁷⁶ Other influential works, such as Alfred Stanton and Morris Schwartz's *The Mental Hospital* and Erving Goffman's *Asylums*, suggested that institutionalization itself worsened mental illness. Still other critical works, such as David Rothman's *The Discovery of the Asylum*,⁷⁷ Michel Foucault's *Madness*

⁶⁹ See generally, Alex Sareyan, *The Turning Point* (1994) (discussing how WWII conscientious objectors played a significant role in exposing the poor treatment of institutionalized patients).

⁷⁰ Alex Sareyan, *The Turning Point* 65-71 (1994).

⁷¹ Joseph Halpern et al., *The Myths of Deinstitutionalization: Policies for the Mentally Disabled* 3 (1980).

⁷² Gerald N. Grob & Howard H. Goldman, *The Dilemma of Mental Health Care Policy* 3 (2006).

⁷³ Nina Ridenour, *Mental Health in the United States: A Fifty-year History* 107 (1961).

⁷⁴ Rochecroft, *From Poorhouses to Homelessness*, 1983, p. 52.

⁷⁵ Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (1961) (arguing against modern psychiatry and denying the existence of mental illness).

⁷⁶ See generally Gerald N. Grob, *Mental Illness and American Society 1875-1940* 15 (1983).

⁷⁷ David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (1971).

and Civilization,⁷⁸ and Gerald Grob's *The State and the Mentally Ill*,⁷⁹ 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 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.⁸⁰ 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.⁸¹ 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.⁸² In fact, in 1939, for instance, about 90 percent of all admissions were involuntary commitments.⁸³ 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."⁸⁴ 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.⁸⁵

78. Michel Foucault, *Madness and Civilization* (Richard Howard trans., Vintage Books 1988) (1961).

79. Gerald N. Grob, *The State and the Mentally Ill: A History of Worcester State Hospital in Massachusetts 1830–1920* (1966).

⁸⁰ Bernard L. Bloom, *Community Mental Health* 20 (2d ed.1984).

⁸¹ See, for example, Stephen T. Morse, *A Preference for Liberty: The Case against Involuntary Commitment of the Mentally Disordered*, 70 Cal. L. Rev. 54 (1982); Torrey, *Out of the Shadows*, 1997, p. 142.

⁸² William Gronfein, "Incentives and Intentions," 1985, p. 194.

⁸³ *Id.*

⁸⁴ 422 U.S. 563, 575 (1975).

⁸⁵ Stephen Rachlin, "The Influence of Law on Deinstitutionalization," in *Deinstitutionalization* 41, 46-51 (Leona L. Barasch ed., 1983).

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.⁸⁶ Because the state was unable to meet the judicially-mandated standards of minimally required care, thousands of patients were released.⁸⁷ 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.”⁸⁸ 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 reject new ones.”⁸⁹

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.⁹⁰

B. Drawing Parallels with the Current Situation of Mass Incarceration

⁸⁶ 344 F. Supp. 373 (M. D. Ala 1972).

⁸⁷ Torrey, *Out of the Shadows*, 1997, p. 144.

⁸⁸ *Id.* at 144 n13.

⁸⁹ *Id.* at p. 145.

⁹⁰ Grob, *From Asylum to Community*, 1991, at page 4.

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.

a. 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.⁹¹ Another inmate, schizophrenic, gouged his eyes out after waiting weeks for transfer to a mental hospital in Clearwater, Florida.⁹² 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.⁹³ 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.⁹⁴ We also know that, according to a study released by the Justice Department in September 2006, 56 percent of inmates in state prisons and 64 percent of inmates across the country reported mental health problems within the past year;⁹⁵ 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 substitute for continued detention in many cases, which would naturally help alleviate mass incarceration.

The second thing that is clear is 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.⁹⁶ It is probably fair to say that the United States

⁹¹ Libby Sander, “Inmate's Death in Solitary Cell Prompts Judge to Ban Restraints,” *New York Times*, November 15, 2006.

⁹² Abby Goodnough, “Officials Clash Over Mentally Ill in Florida Jails,” *New York Times*, November 15, 2006.

⁹³ Alisa Ulferts, “Head of DCF is fined \$80,000,” *New York Times*, December 1, 2006.

⁹⁴ Paula M. Ditton, Bureau of Justice Statistics, U.S. Dep't of Justice, 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>.

⁹⁵ Erik Eckholm, “Inmates Report Mental Illness at High Levels,” *New York Times*, September 7, 2006.

⁹⁶ See Health, United States, 2004, Report of the US Department of Health and Human Services, updated at <http://www.cdc.gov/nchs/data/has/has09.pdf#executivesummary>. See also ABC News Report here: <http://abclocal.go.com/kabc/story?section=news/health&id=6143292> ; Bloomberg Report here: <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

is 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 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 50 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, 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 Thorazine to treat violent and anti-social behavior has become commonplace both in and outside of the prison context⁹⁷—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.⁹⁸ 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 taking.

There are a number of other discrete populations that could be, and in fact today are 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

Sunder Rajan's article in the *New Left Review* titled "Biocapital: Indian Clinical Trials and Surplus Health" available here: <http://www.forliberation.org/site/archive/issue0807/article020807.htm>.

⁹⁷ See generally Eric Silver, Richard B. Felson, and Matthew Vaneseltine, "The Relationship between Mental Health Problems and Violence among Criminal Offenders," *Criminal Justice and Behavior* 35, no. 4 (2008): 405-26; Tony Butler, Peter W. Schofield, David Greenberg, Stephen H. Allnutt, Devon Indig, Vaughan Carr, Catherine D'Este, Philip B. Mitchell, Lee Knight, and Andrew Ellis, "Reducing Impulsivity in Repeat Violent Offenders: An Open Label Trial of a Selective Serotonin Reuptake Inhibitor," *Australian and New Zealand Journal of Psychiatry* 44, no. 12 (2010): 1137-43.

⁹⁸ Bernard E. Harcourt, "Making Willing Bodies: Manufacturing Consent Among Prisoners and Soldiers, Creating Human Subjects, Patriots, and Citizens," work-in-progress paper to be presented at the New School Conference on *The Body and the State* on February 11, 2011.

are hormone receptor antagonist compounds that help prevent or inhibit the biologic effects of male sexual hormones.⁹⁹

A second target population is juvenile offenders.¹⁰⁰ 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. A good example is the WrapAround Milwaukee program, winner in 2009 of the Harvard JFK School Innovations in American Government award, an outpatient managed care program that is operated by the Milwaukee County Behavioral Health Division and that is designed to provide individualized care to youths with mental health and emotional needs.¹⁰¹ A third targeted population involves 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.¹⁰²

The model throughout these various developments, essentially, 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.”¹⁰³ 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

⁹⁹ One of the leading researchers here is Martin Kafka. See generally Peer Briken and Martin P. Kafka, “Pharmacological Treatments for Paraphilic Patients and Sexual Offenders,” *Current Opinion in Psychiatry* 20, no. 6 (2007): 609-13.

¹⁰⁰ See generally Christopher A. Mallett, Patricia Stoddard Dare, and Mamadou M. Seck, “Predicting Juvenile Delinquency: The Nexus of Childhood Maltreatment, Depression and Bipolar Disorder,” *Criminal Behaviour and Mental Health* 19, no. 4 (2009): 235-46; Jean Decety, Kalina J. Michalska, Yuko Akitsuki, and Benjamin B. Lahey, “Atypical Empathic Responses in Adolescents with Aggressive Conduct Disorder: A Functional MRI Investigation,” *Biological Psychology* 80, no. 2 (2009): 203-11.

¹⁰¹ See <http://county.milwaukee.gov/WraparoundMilwaukee/WraparoundAward.htm>

¹⁰² See generally Steven S. Martin, Clifford A. Butzin, Christine A. Saum, and James A. Inciardi, “Three-Year Outcomes of Therapeutic Community Treatment for Drug-Involved Offenders in Delaware: From Prison to Work Release to Aftercare,” *The Prison Journal* 79, no. 3 (1999): 294-320; Michelle A. Lang and Belenko Steven, “Predicting Retention in a Residential Drug Treatment Alternative to Prison Program,” *Journal of substance abuse treatment* 19, no. 2 (2000): 145-60; Jason Luty, “What Works in Drug Addiction?” *Adv Psychiatr Treat* 9, no. 4 (2003): 280-88.

¹⁰³ Decety et al., “Atypical Empathic Responses,” 2009, p. 203.

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.”¹⁰⁴ Or, in other words, to identify and treat brain pathways in order to alter behavior.

Thinking more broadly, 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 area 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 acts 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 how schizophrenia, as a diagnosis, became overwhelmingly applied to institutionalized African-American, 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.

b. 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 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.

¹⁰⁴ *Id.*

In contrast to prescription drugs, there have been some writings on the issue of the relationship between the 2008 fiscal crisis and mass incarceration.¹⁰⁵ 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.¹⁰⁶ Gotsch suggests that we are today in a unique political climate (embodied, for instance, by the passage of Second Chance Act under President George W. Bush), a climate substantially different from the era of President Clinton's Omnibus Crime Bill. On 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 crisis¹⁰⁷ and the impact of financial crisis on corrections spending,¹⁰⁸ but the findings are not especially encouraging.

Others contend that the current economic crisis alone will have little effect. In her 2010 *Daedalus* article "Cell Blocks & Red Ink,"¹⁰⁹ 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;"¹¹⁰ 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."¹¹¹ 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.¹¹² Going forward, Gottschalk argues, advocates of decarceration will need to avoid framing the issue primarily as an economic one.¹¹³

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. Berk is

¹⁰⁵ Andrew Dilts is preparing a collection of essays on the topic of *crisis* and contemporary criminal justice to be published in the *Carceral Notebooks*.

¹⁰⁶ Kara Gotsch, "Bipartisan Justice." *The American Prospect* (Dec. 2010): A22-23. Incidentally, that issue of *The American Prospect* is entirely dedicated to mass incarceration and has a number of interesting contributions. See http://www.prospect.org/cs/special_report

¹⁰⁷ Nicole D. Porter, "The State of Sentencing 2009: Developments in Policy and Practice," The Sentencing Project, available here: http://sentencingproject.org/doc/publications/s_ssr2009Update.pdf

¹⁰⁸ Christine S. Scott-Hayward, "The Fiscal Crisis in Corrections: Rethinking Policies and Practices, July 2009 (updated), Vera Institute of Justice, available here: http://www.pewcenteronthestates.org/uploadedFiles/Vera_state_budgets.pdf?n=5515

¹⁰⁹ Marie Gottschalk, "Cell Blocks & Red Ink: Mass Incarceration, The Great Recession & Penal Reform," *Daedalus* 139(3): 62-73 (2010). 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, Marie, *The Prison and the Gallows* (Cambridge: Cambridge University Press 2006): 240-245.

¹¹⁰ Gottschalk, "Cell blocks & red ink," p. 62.

¹¹¹ *Id.* at 63.

¹¹² *Id.* at 64.

¹¹³ *Id.* at 70.

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 penalty.” 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.¹¹⁴ Simon argues, in his *Daedalus* article “Clearing the ‘troubled assets’ of America’s punishment bubble,”¹¹⁵ that the mass incarceration crisis can be mapped onto the housing crisis, suggesting that the analogy to the housing market can 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.”¹¹⁶ Keally McBride has also been writing in this vein on the California crisis.¹¹⁷ 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. 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 speculative prices.

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.¹¹⁸ Some legislators predicted that this change could save the state approximately \$40 million annually,¹¹⁹ whereas others hoped that this could reduce the budget shortfall by \$100 million.¹²⁰ 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 percent of the state’s prisoners are held in privately run facilities.¹²¹ It is, of course, unclear what will

¹¹⁴ Bernard E. Harcourt, *The Illusion of Free Markets: Punishment and the Myth of Natural Order*, at 238-239; Jonathan Simon, “Clearing the ‘troubled assets’ of America’s punishment bubble,” *Daedalus* 139(3): 91-101 (2010).

¹¹⁵ *Daedalus*, Summer 2010, p. 91-101. Simon has also blog posted on this topic here: <http://governingthroughcrime.blogspot.com/search?q=great+recession>.

¹¹⁶ Simon, “Clearing,” 2010, at 97.

¹¹⁷ Need to get this from Keally.

¹¹⁸ *Private Prisons Offer Potential for State Savings* (May 25, 2009), available at <http://www.yumasun.com/opinion/state-50322-potential-balance.html>.

¹¹⁹ *Id.*

¹²⁰ Jennifer Steinhauer, *Arizona May Put State Prisons in Private Hands* (Oct. 23, 2009), available at <http://www.nytimes.com/2009/10/24/us/24prison.html>.

¹²¹ Steinhauer, *Arizona May Put State Prisons in Private Hands*.

ultimately happen with the prison sector, whether it would ever “pop,” whether it will be fully privatized, and whether it will subside.

But it is unlikely that the economic crisis will have much of an effect on prison populations *without* federal 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.”¹²² The real question, then, is whether there could possibly be federal funding mechanisms put in place that could migrate the financial burden of incarceration to the federal government 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. How could this be encouraged today?

Some point to the Justice Reinvestment movement as being 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.”¹²³ 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.

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 projected outcomes. This assistance includes developing implementation

¹²² Gottschalk, “Cell Blocks & Red Ink,” 2010, p. 68.

¹²³ See <http://www.justicereinvestment.org/>

plans with state and local officials and keeping policymakers apprised through frequent progress reports and testimony to relevant legislative committees.

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.

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.”¹²⁴

It might be possible to tap into this current and logic to promote federal 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 economic, 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 ritual.”¹²⁵ 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 leadership will be necessary to make this pact work.

c. The Social Construction of the Convict

The third question is whether we could imagine, at some point, that the public imagination of the “convict” would 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. And 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 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 indicates, possibly, 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.

¹²⁴ See Justice Reinvestment Overview pdf document downloadable at <http://www.justicereinvestment.org/>

¹²⁵ See new paper by Loïc Wacquant on reentry programs.

The California prison overcrowding case, *Schwarzenegger v. Plata* or now *Brown v. Plata*¹²⁶ 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*¹²⁷ and *Coleman v. Schwarzenegger*,¹²⁸ 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.¹²⁹ At issue at 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 will 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 that had been winding its way through the federal courts since the early 1990s. The first case, the *Coleman*¹³⁰ case initiated in 1990, was a class-action lawsuit filed on behalf of 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.”¹³¹ 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. 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.

*Plata v. Schwarzenegger*¹³², 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)¹³³ negotiated a stipulation for injunctive relief in 2002.¹³⁴ 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

¹²⁶ The case has since been recaptioned to *Brown et al. v. Plata et al.*, Supreme Court Docket No. 09-1233.

¹²⁷ *Plata v. Schwarzenegger*, 3:01-cv-01351-TEH (N.D. Cal. 2001).

¹²⁸ *Coleman v. Schwarzenegger*, 2:90-cv-00520-LKK-JFM (E.D. Cal. 1990)

¹²⁹ *Coleman* specifically addresses the lack of mental healthcare facilities; while *Plata* addresses medical facilities generally.

¹³⁰ *Coleman v. Schwarzenegger*, 2:90-cv-00520-LKK-JFM (E.D. Cal. 1990)

¹³¹ 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.

¹³² *Plata v. Schwarzenegger*, 3:01-cv-01351-TEH (N.D. Cal. 2001).

¹³³ Order and Opinion, 2009 WL 24308420, *3 (N.D. Cal., E.D. Cal. 2009).

¹³⁴ *Id.*

management of inmate healthcare into constitutional compliance.¹³⁵ The receiver was granted broad authority to develop and implement a system of medical care delivery that met constitutional standards “as soon as practicable.”¹³⁶

In the mean time, on October 14, 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. 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 penal facilities was the primary cause of the constitutionally inadequate provision of medical and mental health care. 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.”¹³⁷

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.¹³⁸ 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. 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. 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, secure environment.”¹³⁹ 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

¹³⁵ *Id.* at *10. 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.*

¹³⁶ *Id.* at *11.

¹³⁷ Order and Opinion, 2009 WL 24308420, *82 (N.D. Cal., E.D. Cal. 2009).

¹³⁸ 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.

¹³⁹ The Judicial Panel notes, with some frustration, that the State did not propose an alternative population cap that would fix the Constitutional violation. *Id.*

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%.”¹⁴⁰ Given conflicting evidence, the panel ordered a population cap of 137.5% design capacity, “a population reduction halfway between the cap requested by plaintiffs and the wardens’ estimate of the California prison system’s maximum operable capacity absent consideration of the need for medical and mental health care.”¹⁴¹

I realize these are a lot of details, but this litigation at the Supreme Court and the struggle over 130, 137.5 or 145 percent 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?”¹⁴² Justice Stephen Breyer also called attention to the poor conditions—which he later called “a big human rights problem”¹⁴³—stating that “It’s obvious... you 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.”¹⁴⁴

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 (“[I]f I were a citizen of California, I would be concerned about the release of 40,000 prisoners”)¹⁴⁵ and Chief Justice John Roberts, whose questions emphasized the high recidivism rate of parolees¹⁴⁶, 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

¹⁴⁰ Additionally, the Panel found the evidence supporting the adequacy of care at 145% capacity to be “far less persuasive.” *Id.* at *83.

¹⁴¹ *Id.*

¹⁴² Transcript of Oral Argument at 15, *Schwarzenegger v. Plata*, No. 09-1233 (November 30, 2010).

¹⁴³ *Id.* at 27.

¹⁴⁴ *Id.* at 20.

¹⁴⁵ *Id.* at 48.

¹⁴⁶ *Id.* at 67.

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.

Media coverage of the case seems to indicate a growing public sentiment against mass incarceration.¹⁴⁷ 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.¹⁴⁸

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’s 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 is whether there are glaring pitfalls to avoid from the experience 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 Hospital Population

¹⁴⁷ See, e.g., The Crime of Punishment:[Editorial], New York Times. (Late Edition (east Coast)). New York, N.Y.: Dec 6, 2010. p. A.26; David Fathi , Bulging Prisons Put Us At Risk, Contra Costa Times, Walnut Creek, Calif.: Dec 4, 2010. p. A.8; Justices Debate Prison Lawsuit: Justices question if rights of inmates outweigh state’s interest in managing own penal system, Contra Costa Times, Walnut Creek, Calif.: Dec 1, 2010. p. A.11; Adam Liptak, Justices Hear Arguments on California Prison Crowding, New York Times. (Late Edition (east Coast)). New York, N.Y.: Dec 1, 2010. p. A.16; Jimmy Bierman and Jaime Dorenbaum, “Three strikes’ law is a human travesty,” The Sacramento Bee, Sacramento, Calif., Dec 17, 2010, p. A.19; Michael Doyle , Calif. prison ruling expected to be split Supreme Court divided on how to fix crowding, The Fresno Bee. Fresno, Calif.: Dec 1, 2010. p. A.1; Robert Barnes, High court hears California prisons case, The Washington Post. Washington, D.C.: Dec 1, 2010. p. A.2; High Court to look at Calif. prison crowding, The Associated Press, Charleston Daily Mail. Charleston, W.V.: Nov 30, 2010. p. A.10; Warren Richey, California, at Supreme Court, fights judicial order on prison overcrowding, The Christian Science Monitor. Boston, Mass.: Nov 30, 2010; Prison Ruling Stirs Up California, Wall Street Journal (Online), New York, N.Y.: Nov 29, 2010; Joanna Chung and Bobby White, Court to Hear Prison-Crowding Case, Wall Street Journal (Eastern Edition), New York, N.Y.: Nov 29, 2010. p. A.4.

¹⁴⁸David G. Savage, “State prison case falls on dubious ears; High court appears likely to back ruling ordering California to free 40,000 inmates,” Los Angeles Times. Los Angeles, Calif., Dec 1, 2010. p. AA.1; Bob Egelko, “State arguments draw skepticism from high court,” San Francisco Chronicle, San Francisco, Calif., Dec 1, 2010. p. C.1.

Deinstitutionalization in the 1960s and 1970s drew heavily on predictions of dangerousness. The trouble is that the use of risk assessment tools typically has the effect of sorting 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 3,897 male prisoners and 2,376 adult male admittees to state mental hospitals from six different states.¹⁴⁹ What their research revealed is 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, the ... percentage of whites among admitted patients also decreased, from 81.7% in 1968 to 68.3% in 1978.”¹⁵⁰

This is demonstrated in the following graph which charts the shift documented by Steadman, Monahan and their colleagues:

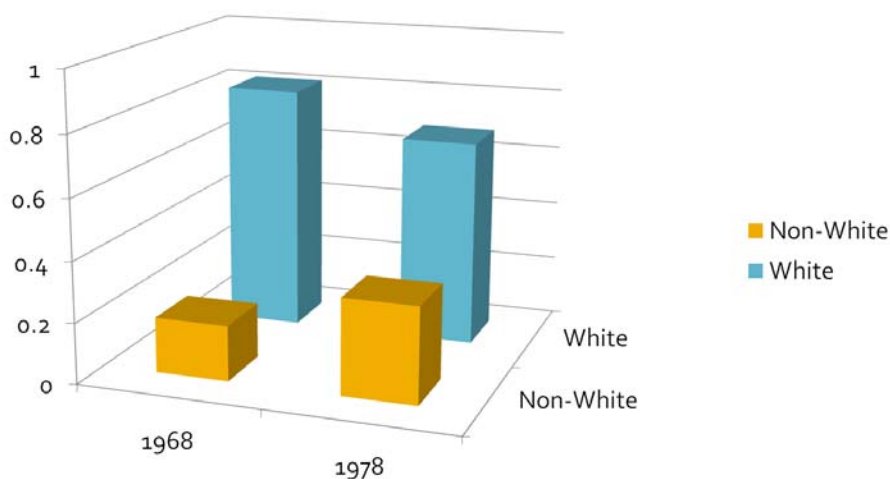


Figure 5: Admissions to mental facilities by Race

¹⁴⁹ 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).

¹⁵⁰ Steadman et al. 1984:479. Note that there was a similar, though less stark shift in prison admissions: “Across the six states, the ... percentage of whites among prison admittees was also relatively stable, decreasing only from 57.6% in 1968 to 52.3% in 1978.” *Id.*

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 about this in an essay, “Risk as a Proxy for Race,” forthcoming in *Criminology and Public Policy*; and Michelle Alexander has forcefully drawn the devastating consequences for 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 emphasizes that the overall institutionalized population did not decrease over the 1960s, in fact rising slightly from 1,035 per 100,000 general population in 1960 to 1,046 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 1970.¹⁵¹ “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%.”¹⁵² 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*,¹⁵³ 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 percent of the total prison population for this year and for roughly 28 to 86 percent of prison inmates suffering from mental illness.”¹⁵⁴ What we also know is that, at the close of the twentieth century, there was a

¹⁵¹ Gronfein, “Incentives and Intentions,” 1985, p. 200.

¹⁵² *Id.*

¹⁵³ Steven Raphael, “The Deinstitutionalization of the Mentally Ill and Growth in the U.S. Prison Populations: 1971 to 1996” (Sept. 2000) (unpublished manuscript), available at <http://ist-socrates.berkeley.edu/~raphael/raphael2000.pdf> (finding that mental hospitalization rates have significant negative effects on prison incarceration rates).

¹⁵⁴ *Id.* at 12.

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.¹⁵⁵

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

IV. Conclusion

Would it ever be possible to hear 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 care 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 care. Merely pouring Federal funds into a continuation of the outmoded type of institutional care which now prevails would make little difference.¹⁵⁶

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 most important lessons from all this, though, is that it may not be possible to make much headway in reducing mass incarceration without the kind of political investment, context, 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 some of the silver linings of 1960s deinstitutionalization while avoiding the glaring pitfalls—or at least, to further study these lessons from deinstitutionalization.

¹⁵⁵ Paula M. Ditton, Bureau of Justice Statistics, U.S. Dep't of Justice, 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>.

¹⁵⁶ President Kennedy's statement to Congress, slightly modified, quoted in Gronfein, "Incentives and Intentions," 1985, at p. 196.

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