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The Road to Hell is Paved with Good Intentions: Deinstitutionalization and Mass Incarceration Nation

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THE ROAD TO HELL IS PAVED WITH GOOD INTENTIONS:
DEINSTITUTIONALIZATION AND MASS INCARCERATION
NATION

CORINNA BARRETT LAIN*

ABSTRACT

They say that the road to hell is paved with good intentions, and our failed implementation of deinstitutionalization in the 1970s is a prime example of the point. In this symposium contribution—a response to Jeffrey Bellin’s book Mass Incarceration Nation—I offer a historical account of deinstitutionalization of state mental hospitals, tracing how severely mentally ill patients were discharged from state hospitals and eventually made their way back to secure beds, but in our nation’s jails and prisons instead. Mental health and mass incarceration are not separate crises, I argue, but rather interconnected problems with an interconnected past that require an interconnected solution. The lessons of deinstitutionalization’s failures can inform how our decarceration story plays out, offering an opportunity to avoid the mistakes of our past and move toward a more just, humane, and equitable future—a future that takes the “mass” out of mass incarceration.

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INTRODUCTION

Jeffrey Bellin’s *Mass Incarceration Nation* makes an important contribution to the current conversation about mass incarceration and the harms of the carceral state. Bellin offers a fresh, nuanced take on the issue, drawing from his experience as a former prosecutor and engaging readers with witty prose that drives his points home. “*Lock them up*’ is not just an applause line at political campaign rallies,” he writes in one of my favorite passages, “[i]t has become our country’s unofficial motto.”¹

The core of Bellin’s contribution is a recognition that mass incarceration is the result of two distinct forces—one vertical, one horizontal.² The vertical force is the increase in sentencing severity; over time, those who violated the criminal law faced increasingly steep sentences for the same criminal conduct.³ But equally, if not more impactful is what Bellin calls the “horizontal expansion of the criminal law’s footprint.”⁴ Bellin shows (quite persuasively, I might add) that starting in the 1970s, the crimes for which people were incarcerated expanded beyond the most serious offenses—murder, rape, robbery, and the like—to include prohibitions that served other, more policy-based goals.⁵ “Criminal laws had become, at best, a policy tool that politicians used to discourage behaviors, like drug use or drunk driving or possessing weapons,” Bellin writes.⁶ “At worst,” he adds, “these laws were toxic vectors for bias and discrimination.”⁷ *If only we could get back to where we once were.*

Bellin tells the story of an incarceration rate in the early 1970s that was low and unremarkable, followed by a temporary spike in crime.⁸ This spike, Bellin explains, created a punitivism that far

1. JEFFREY BELLIN, *MASS INCARCERATION NATION: HOW THE UNITED STATES BECAME ADDICTED TO PRISONS AND JAILS AND HOW IT CAN RECOVER* 194 (2023) (emphasis added).

2. *See id.* at 29 (“The key insight here is that there are two important and distinct things changing simultaneously.”); *id.* at 48 (“This approach required two components: new laws and increased enforcement.”).

3. *See id.* at 29 (noting “a vertical increase in sentence severity”).

4. *See id.*

5. *Id.* at 6.

6. *Id.* at 3.

7. *Id.*

8. *See id.* at 6 (“In the early 1970s, the US incarceration rate was low and unremarkable.

outsized the crime problem itself and made the criminal law the lever that politicians pulled to solve society's most vexing problems.⁹ And all this is true.

But separate and apart from these events was another set of events in the 1970s—a series of developments *outside* the criminal law that fed people *into* the criminal legal system—and it complicates the story that *Mass Incarceration Nation* tells. Bellin is right that politicians turned to the criminal law in the 1970s to solve society's most vexing problems. But the developments I have in mind foisted onto the criminal legal system a vexing problem that politicians never intended our jails and prisons to solve: what to do with people suffering from severe mental illness.

By “severe mental illness,” I mean a clinically recognized severe mental illness according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5).¹⁰ The DSM-5 is the gold standard for defining mental disorders, and it defines severe mental illness as a “clinically significant disturbance ... in the psychological, biological, or developmental processes underlying mental functioning” that results in a “comparatively severe impairment” that is persistent over time.¹¹ The list of disorders recognized as severe mental illnesses in the DSM-5 includes schizophrenia, psychotic disorders, bipolar disorder, and major depression.¹² By definition, these are people whose mental illness severely impairs their ability to be functioning members of society.

Then, spurred by a temporary spike in crime, everyone discovered something that they wanted to punish more severely.... Americans wanted tougher laws, tougher cops, tougher prosecutors, and tougher judges.”)

9. See *id.* at 37 (“The crime surge's primary contribution was that it fostered an environment where politicians and the public became attracted to harsh criminal laws.”); *id.* at 48 (“Politicians ... turned to the criminal justice architecture to solve society's most vexing problems, like drug addiction, gun violence, child pornography, drunk driving and intrafamily abuse.”).

10. See AM. PSYCH. ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS 20 (5th ed. 2013).

11. *Id.*; AM. PSYCH. ASS'N, PROFICIENCY IN PSYCHOLOGY: ASSESSMENT AND TREATMENT OF SERIOUS MENTAL ILLNESS 5 (2009) (“[Serious mental illness] refers to mental disorders that carry certain diagnoses, such as schizophrenia, bipolar disorder, and major depression; that are relatively persistent (e.g., lasting at least a year); and that result in comparatively severe impairment in major areas of functioning.”).

12. See *supra* note 10 and accompanying text; see also GERALD N. GROB, THE MAD AMONG US: A HISTORY OF THE CARE OF AMERICA'S MENTALLY ILL 2-3 (1994) (naming a number of severe mental illnesses and explaining how they inhibit basic functioning in society).

In 2021, this cohort was estimated to be 5.5 percent of the adult population in the United States—just over 14 million people.¹³

This symposium contribution offers an addendum—a “yes, and” with a “yes, but”—to the tale that *Mass Incarceration Nation* tells. I agree that incarceration in this country ballooned in the 1970s because we added to the vertical and horizontal footprint of the law. But I argue that incarceration in this country also swelled because we deinstitutionalized people with severe mental illness and then did not fund the community services that were supposed to serve this fragile population, resulting in their *re*-institutionalization through the criminal justice system.

To be clear, my claim is not that deinstitutionalization itself was bad, or that the plight of those who suffer from severe mental illness is the only reason (or even the main reason) for the soaring incarceration rates of the 1970s. My claim is that our failure to care for this underserved population played its own role in our mass incarceration crisis, feeding not only our jails and prisons but also fears about crime and the punitivism that came with it. In short, the story of mass incarceration is not just a story about what we did with the criminal law in the 1970s. It is also a story about what we did *not* do elsewhere and what happened as a result.

All this is to say that I largely agree with Bellin’s account, and applaud it. We have been talking about mass incarceration for over a decade, and no one has made the contribution he has; no one has looked at the problem through such a nuanced lens. I would simply offer that we can, and should, nuance the discussion even further by recognizing that our failure to serve the needs of those who suffer from severe mental illness has itself contributed to mass incarceration in important and underappreciated ways.

To make my point, Part I begins with a brief history of deinstitutionalization, explaining what was driving it, when it happened, and how it worked. Part II details what happened next: large segments

13. *Mental Illness*, NAT’L INST. MENTAL HEALTH (Mar. 2023), <https://www.nimh.nih.gov/health/statistics/mental-illness> [<https://perma.cc/CSR5-4THM>]. The NIMH uses the term “serious mental illness” rather than “severe mental illness,” and apparently, the two terms are used interchangeably. See generally Kenneth T. Kinter, *What’s in a Name: “Serious”, “Severe”, and “Severe and Persistent,”* 21 INT’L J. PSYCHOSOCIAL REHABILITATION 52-54 (2017). In my mind, all mental illness is serious, while only a subset is severe, so I use the term “severe mental illness” here.

of the severely mentally ill population ended up on the streets, and from there, in our nation's jails and prisons, which today stand as the largest in-patient facilities for severely mentally ill people in virtually every state. Part III comes back into conversation with *Mass Incarceration Nation*, explaining how the account I offer adds to some of the points that Bellin makes while complicating others. In the end, mass incarceration and our mental health crisis are interconnected problems with an interconnected past. Only by recognizing them as such can we move to a more just, humane, and equitable future.

I. DEINSTITUTIONALIZATION

To understand the role that deinstitutionalization (or more precisely, the policies implementing it) played in our nation's mass incarceration crisis, it is first necessary to understand what deinstitutionalization was. Here I provide that understanding, explaining what was driving deinstitutionalization, when it happened, and how it worked.

I start with a fun fact (of sorts). The first psychiatric hospital in what would become the United States was the Publick Hospital for Persons of Insane and Disordered Minds, established in 1773 in none other than Williamsburg, Virginia.¹⁴ Exactly 250 years later, in 2023, Williamsburg would be the site of a symposium on *Mass Incarceration Nation*, and the esteemed *Law Review* of its college would be publishing this paper. It is hard to imagine a more apropos place to make my point.

In the early years of the Republic, psychiatric hospitals were few and far between.¹⁵ But history took a turn in 1841 when a former schoolteacher visited a Massachusetts jail to teach a Bible class and was horrified to find it full of prisoners suffering from mental

14. ALISA ROTH, *INSANE: AMERICA'S CRIMINAL TREATMENT OF MENTAL ILLNESS* 78 (2018). The hospital was financially strained during the revolutionary war and closed shortly after the war ended, but reopened in 1786. *See id.* at 79. Presumably, it reopened as "Eastern Lunatic Asylum" as other sources refer to it by that name. *See, e.g.*, E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS* 81 (1997).

15. *See* Alisa Roth, *The Truth About Deinstitutionalization*, *THE ATLANTIC* (May 25, 2021), <https://www.theatlantic.com/health/archive/2021/05/truth-about-deinstitutionalization/618986/> [https://perma.cc/DF37-6CWM].

illness.¹⁶ As the story goes, she was so moved by the plight of these prisoners and the deplorable conditions in which they were being held that she made it her mission to travel around the country, visiting jails and advocating for the creation of state psychiatric hospitals.¹⁷ Over time, the idea took hold. By 1880, there were over a hundred state psychiatric hospitals, and the percentage of mentally ill people languishing in jail was under 1 percent.¹⁸

In theory, psychiatric hospitals were places of care and respite, sanctuaries for the mentally ill.¹⁹ But in practice, they were none of those things. By the 1940s, state psychiatric hospitals had become overcrowded with patients and understaffed as a result of funding cuts from the Great Depression and the diversion of human resources during World War II.²⁰ Years of neglect had turned them from sanctuaries to human warehouses, austere places where people suffering from severe mental illness were left to languish in notoriously wretched conditions.²¹ Patients were beaten and shackled, starved and neglected, and locked in their cells for shamefully long periods of time.²² As one psychiatrist put the point, state psychiatric

16. *Id.* (discussing work of Dorothea Dix); GROB, *supra* note 12, at 46-48.

17. Roth, *supra* note 15.

18. See TORREY, *supra* note 14, at 27-28; Deanna Pan, *Timeline: Deinstitutionalization and Its Consequences*, MOTHER JONES (Apr. 29, 2013), <https://www.motherjones.com/politics/2013/04/timeline-mental-health-america/> [<https://perma.cc/F4AJ-94N9>]. For a deep dive into the emergence of state mental institutions and their larger historical context, see generally DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC* (1971).

19. See ROTH, *supra* note 14, at 85; Gary Chaimowitz, *The Criminalization of People With Mental Illness*, 57 CAN. J. PSYCH. 1 (2012).

20. RAELE JEAN ISAAC & VIRGINIA C. ARMAT, *MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL* 68 (1990); TORREY, *supra* note 14, at 82; GROB, *supra* note 12, at 165-169; see also *id.* at 104 (“From the very advent of mental institutions, the total insane population far exceeded the number of available beds.”).

21. See ANNE E. PARSONS, *FROM ASYLUM TO PRISON: DEINSTITUTIONALIZATION AND THE RISE OF MASS INCARCERATION AFTER 1945* 25-31 (2018); TORREY, *supra* note 14, at 82 (“Hospitals that had originally been built as humane asylums had become on the best of days merely human warehouses. On the difficult days, they became much worse than that.”).

22. See TORREY, *supra* note 14, at 82-84; PARSONS, *supra* note 21, at 25-31; *id.* at 56 (quoting Pennsylvania’s Department of Welfare Secretary as referring to the mentally ill in psychiatric hospitals as “forgotten and neglected, subjected to cruelties and punishment; mechanically restrained; locked in cells and solitarily confined for horribly long periods of time”).

hospitals did “a good job of keeping patients physically alive and mentally sick.”²³

As it so happened, conscientious objectors were assigned to work in these hospitals as an alternative to military service during World War II, and they became whistleblowers, telling the press about the shockingly inhumane treatment they were seeing.²⁴ In Ohio, this led to a high-profile grand jury investigation of the state’s psychiatric hospital,²⁵ and an excerpt of the grand jury’s 1944 report is worth quoting here. The report stated:

The Grand Jury is shocked beyond words that a so-called civilized society would allow fellow human beings to be mistreated as they are at Cleveland State Hospital.... Cleveland State Hospital is not a hospital; it is a custodial institution in which we have incarcerated the sick.... The atmosphere reeks with the false notion that the mentally ill are criminals and sub-humans.²⁶

State psychiatric hospitals at the time were fundamentally *carceral* spaces, prison-like places where the state controlled patients’ every move and ruled with an iron hand.²⁷ “We were wardens instead of therapists,” the superintendent of one state psychiatric hospital later recalled.²⁸

What happened in Ohio sparked interest in mental hospitals more generally. Media in other states started looking at the conditions of their state hospitals, and within two years, the issue exploded onto the national scene. In 1946, *Life Magazine* published a twelve-page exposé on the bleak conditions of state psychiatric hospitals, documenting its claims with haunting photos of neglect and despair.²⁹ “We jam-pack men, women, and sometimes even

23. Matt Ford, *America’s Largest Mental Hospital is a Jail*, THE ATLANTIC (June 8, 2015), <https://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/> [<https://perma.cc/9N4G-NUE5>].

24. See TORREY, *supra* note 14, at 83; ISAAC & ARMAT, *supra* note 20, at 68. For an excellent discussion, see generally ALEX SAREYAN, *THE TURNING POINT: HOW MEN OF CONSCIENCE BROUGHT ABOUT MAJOR CHANGE IN THE CARE OF AMERICA’S MENTALLY ILL* (1994).

25. See TORREY, *supra* note 14, at 83.

26. *Id.* (quoting grand jury report).

27. See PARSONS, *supra* note 21, at 9.

28. *Id.* at 82.

29. Albert Q. Maisel, *Bedlam 1946: Most U.S. Mental Hospitals Are a Shame and a*

children into hundred-year old firetraps,” it stated, where shorter stays were “only because death comes faster to the abused, the beaten, the drugged, the starved, and the neglected.”³⁰ The same year, *Reader’s Digest* published a series on state psychiatric hospitals, describing “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 states of semistarvation.”³¹ As others have noted, these two articles, appearing in magazines that at the time had the largest circulation in the country, brought enormous public attention to the issue.³²

All this coincided with the publication of the book *The Snake Pit*, also in 1946.³³ *The Snake Pit* was the semi-autobiographical account of Mary Jane Ward, a novelist who was involuntarily committed to a state psychiatric hospital after suffering a breakdown in 1941.³⁴ Ward’s devastating account of institutionalization, which included vivid details of indignities and abuse, fanned the flames of public outrage, again portraying state hospitals as quasi-prisons, but without the procedural protections of the criminal law.³⁵

Disgrace, LIFE MAGAZINE, May 1946. For photos, see *Bedlam 1946* (photograph), in *Jerry Cooke Archives, Inc.*, <https://www.jerrycookearchives.com/photo-essays/bedlam-1946/> [<https://perma.cc/5MPY>]. See PARSONS, *supra* note 21, at 28-29 (discussing the *Life Magazine* article and reproducing one of its pictures).

30. Maisel, *supra* note 29.

31. Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 68 (2011) (internal quotation omitted); see NINA RIDENOUR, MENTAL HEALTH IN THE UNITED STATES: A FIFTY-YEAR HISTORY 106-07 (1961) (discussing *Reader’s Digest* series); ISAAC & ARMAT, *supra* note 20, at 68. See generally Albert Q. Maisel, *The Shame of Our Mental Hospitals*, READER’S DIGEST, May-July 1946.

32. See RIDENOUR, *supra* note 31, at 106-07; Harcourt, *supra* note 31, at 69; GROB, *supra* note 12, at 205. Also in 1946, Mike Gorman wrote a series of articles exposing the terrible state of Oklahoma’s mental hospitals, which likewise received national attention. See Mike Gorman, *Misery Rules in State Shadowland* (series), DAILY OKLAHOMAN (1946). The series is maintained in The Mike Gorman Papers on the National Library of Medicine website. Mike Gorman, *Misery Rules in the Shadowland*, NAT’L LIBR. MED. (1996), <https://profiles.nlm.nih.gov/spotlight/tg/catalog.nlm.nlmuid-101743403X100-doc> [<https://perma.cc/9F76-NLHD>]; see also GROB, *supra* note 12, at 205-06 (discussing Mike Gorman’s investigative reporting on Oklahoma’s mental hospitals, and noting that it catapulted him to national prominence); Roth, *supra* note 15, at 86 (noting Gorman’s reporting in 1946).

33. See generally MARY JANE WARD, THE SNAKE PIT (1946).

34. See *id.*; see also PARSONS, *supra* note 21, at 32-35.

35. See PARSONS, *supra* note 21, at 14-15, 32-35.

Two years later, journalist Albert Deutsch published his book *The Shame of the States*, once again shocking the public with graphic descriptions of decay, neglect, and abuse in the nation's mental hospitals.³⁶ Like *The Snake Pit*, *The Shame of the States* was critically acclaimed and brought intense public scrutiny to the nation's psychiatric hospitals.³⁷ By the end of the decade, the state of institutionalized care for the mentally ill population had become a nationwide scandal.³⁸

By the mid-1950s, the anti-psychotic drug Thorazine had become widely available, offering the possibility of medicalized outpatient care as an alternative treatment modality for those who were mentally ill.³⁹ By the end of the decade, leaders in the field were arguing that state hospitals could—and *should*—be closed. State mental hospitals were “antiquated, outmoded, and rapidly becoming obsolete,” the president of the American Psychiatric Association (APA) stated in his 1958 presidential address, adding:

We can still build them but we cannot staff them; and therefore we cannot make true hospitals of them.... I do not see how any reasonably objective view of our mental hospitals today can fail to conclude that they are bankrupt beyond remedy. I believe therefore that our large mental hospitals should be liquidated as rapidly as can be done in an orderly and progressive fashion.⁴⁰

The future chair of the National Mental Health Committee took a similar stance, arguing that state mental hospitals were too burdened by the “freightage of despair, defeatism, despondency, filth,

36. ALBERT DEUTSCH, *THE SHAME OF THE STATES* (1948).

37. See GROB, *supra* note 12, at 203-04.

38. See PARSONS, *supra* note 21, at 28; Harcourt, *supra* note 31, at 69 (discussing “public outcry against institutional psychiatric care”).

39. See TORREY, *supra* note 14, at 8; PARSONS, *supra* note 21, at 46.

40. ISAAC & ARMAT, *supra* note 20, at 69. This is not to suggest that leaders in the field were silent about state psychiatric hospitals before this time. To the contrary, they strongly criticized state mental hospitals even in the early 1950s, before Thorazine was available. See *id.* at 68 (“Treatment can scarcely be said to exist for the majority [of state mental hospitals]. It is mostly care and custody. Mass methods, herding and regimentation, are the rule.” (quoting the president of the American Psychiatric Association in his 1953 address)); *id.* (“Conditions in our state mental hospitals are rotten. For want of a more adequate word, and I don’t know that I could find a more adequate word, I can only tell you the state mental hospital system stinks.” (quoting the superintendent of one state mental hospital at the National Governor’s Conference on Mental Health in 1954)).

futility, and failure” to survive, and that the only path forward was “to tear down the whole rotting structure and build afresh.”⁴¹

That takes us to the 1960s, when deinstitutionalization formally began.⁴² The book *One Flew Over the Cuckoo’s Nest* was published in 1962 and became a best seller, once again bringing the state of the nation’s psychiatric hospitals into sharp relief. The book, which was based on author Ken Kesey’s experience working in a state mental hospital, detailed not only cruelty and neglect, but also gross abuses of state power, including forced medical sedation, shock therapy, and surgical lobotomies.⁴³ It was becoming apparent that “treatment” in state hospitals was a problem of its own. As renowned psychologist Gerald Caplan explained:

In the past twenty years, we have come to the realization that most of the symptoms of the chronic deteriorated psychotics who crowd the back wards of our mental hospitals are produced by the pathogenic environment in which we incarcerate them, rather than by the mental disorder which led to their admission.⁴⁴

State mental hospitals were worse than failed solutions. They were carceral spaces that were contributing to—perhaps even *causing*—the very psychosis that they were designed to treat. The irony was thick: state hospitals were making mentally ill people more sick.

All this set the stage for President John F. Kennedy’s announcement of a “bold new approach” to psychiatric care in 1963.⁴⁵ Kennedy’s interest in mental illness was deeply personal; his sister had been institutionalized and subjected to a lobotomy, which had left her even more disabled than before.⁴⁶ Kennedy had seen for himself the harsh realities of institutional life, and ameliorating the

41. *Id.* at 69 (quoting Mike Gorman) (internal citations omitted).

42. Deinstitutionalization informally began in the mid-1950s, when Thorazine became widely available. *See* TORREY, *supra* note 14, at 8.

43. *See* PARSONS, *supra* note 21, at 69 (discussing KEN KESEY, *ONE FLEW OVER THE CUCKOO’S NEST* (1962)).

44. ISAAC & ARMAT, *supra* note 20, at 84; *see also id.* at 111 (quoting civil liberties litigator Bruce Ennis as saying that mental hospitals were “where sick people get sicker and sane people go mad”).

45. TORREY, *supra* note 14, at 178.

46. *See id.*

problem became part of his policy agenda. In January 1963, Kennedy spoke of “abandonment of the mentally ill ... to the grim mercies of custodial institutions” in his State of the Union address, and the next month, he delivered a special message to Congress proposing what he called “comprehensive community care” as an alternative to psychiatric hospitalization.⁴⁷ “[N]ew drugs acquired and developed in recent years ... 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,” Kennedy explained.⁴⁸ Under his plan, “reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability.”⁴⁹ Congress passed the 1963 Community Mental Health Act shortly thereafter, providing federal funding for states to establish community mental health centers that would offer outpatient care, emergency assistance, partial hospitalization, and a number of other support services for those who were mentally ill.⁵⁰ It would be Kennedy’s last major piece of legislation; he was assassinated three weeks later.⁵¹

Yet the 1963 Community Mental Health Act was not the only thing propelling deinstitutionalization in the 1960s; two other developments had a massive impact as well. One was the advent of Medicaid in 1965, which added financial incentives to the 1963 Act.⁵² Medicaid excluded payments to “institutions of mental diseases,”⁵³ but it paid for psychiatric and medical care outside that

47. *Id.* (internal quotations omitted); Harcourt, *supra* note 31, at 53 (internal quotations omitted); *see also* ISAAC & ARMAT, *supra* note 20, at 76-78 (discussing Kennedy’s special message to Congress and proposal).

48. Harcourt, *supra* note 31, at 67; *see also* ISAAC & ARMAT, *supra* note 20, at 77 (“I am convinced that, if we apply our medical knowledge and social insights fully, all but a small portion of the mentally ill can eventually achieve a wholesome and constructive social adjustment. It has been demonstrated that two out of three schizophrenics—our largest category of mentally ill—can be treated and released within 6 months.” (quoting Kennedy)).

49. ISAAC & ARMAT, *supra* note 20, at 78 (quoting Kennedy).

50. *See id.* at 81; PARSONS, *supra* note 21, at 74-75.

51. *See* TORREY, *supra* note 14, at 178.

52. *See* Andrew Scull, “Community Care”—A Historical Perspective on Deinstitutionalization, 64 PERSPECTIVES IN BIOLOGY & MED. 70, 74-75 (2021) (discussing how Medicaid and Medicare allowed states to shift the cost of expenditures on the severely mentally ill population, and the population transfers that occurred as a result).

53. ROTH, *supra* note 14, at 91-92 (internal quotation omitted) (discussing statutory exclusion for an “institution of mental diseases” and statutory definition of the term).

setting,⁵⁴ while other federal welfare benefits were available to those who were disabled due to mental illness (which readily described most discharged mental institution patients).⁵⁵ This created an enormous financial incentive for states to move mentally ill patients out of state hospitals and into outpatient and other institutional settings.⁵⁶ States were paying for residential care in psychiatric hospitals, but if those patients resided in nursing homes, group homes, or halfway houses instead, the federal government would pick up most of the tab for those who needed financial assistance.⁵⁷ As others have noted, the allure of financially subsidized care for this population likely did more to spur deinstitutionalization than the actual provisions of the 1963 Act.⁵⁸

The other development propelling the country towards deinstitutionalization at the time was a bevy of lawsuits. The civil rights movement gave rise to a patients' rights movement aimed at ending involuntary commitment altogether, at least where patients did not pose a clear and present danger to themselves or others.⁵⁹ Partnering with the ACLU, lawyers in the 1960s filed "liberation lawsuits" that challenged involuntary commitment procedures as a violation of the right to self-determination and bodily autonomy.⁶⁰ More often

54. *Id.*

55. See TORREY, *supra* note 14, at 94-99 (discussing Medicaid, Supplemental Security Income, and other federal welfare benefits); GROB, *supra* note 12, at 290-92; Harcourt, *supra* note 31, at 67 (discussing other federal welfare benefits).

56. Harcourt, *supra* note 31, at 67.

57. See TORREY, *supra* note 14, at 102-03; PARSONS, *supra* note 21, at 75; Harcourt, *supra* note 31, at 67; see also David Rothman, *The Rehabilitation of the Asylum*, THE AMERICAN PROSPECT (Oct. 1, 1992), <https://prospect.org/health/rehabilitation-asylum/> [<https://perma.cc/K6CP-JTSG>] ("With the 1965 passage of Medicare and Medicaid, the federal government assumed between half and three-quarters of the cost of nursing home care for the elderly, thereby giving states every incentive to discharge aged inpatients (some 30 percent of the total) to nursing homes.")

58. See TORREY, *supra* note 14, at 100-01; PARSONS, *supra* note 21, at 75.

59. See ISAAC & ARMAT, *supra* note 20, at 109; PARSONS, *supra* note 21, at 71-72; Harcourt, *supra* note 31, at 70.

60. ISAAC & ARMAT, *supra* note 20, at 115, 139; PARSONS, *supra* note 21, at 89-91; Harcourt, *supra* note 31, at 70. Given the deplorable condition of many state mental hospitals, an interesting aside is whether litigation was also aimed at securing better hospital conditions. By and large, the answer appears to be no, for strategic reasons. Suits to improve mental hospital conditions would have forced states to invest money in those hospitals, rather than shutting them down and investing the money in community mental health resources instead. In addition, improved mental hospitals may have weakened the case for deinstitutionalization. As discussed in text, the sense at the time was that state mental

than not, they won.⁶¹ After two decades of bad press, courts had little confidence in state mental hospitals and were receptive to claims that the criteria were too relaxed for involuntarily sending people there, prompting states to revise their involuntary commitment statutes to require a showing of imminent danger as opposed to a mere need for treatment.⁶² Eventually, the Supreme Court weighed in as well, ruling in 1975 that mental illness alone could not justify involuntary commitment where an individual was not dangerous and could live safely in freedom.⁶³ Gone were the days when people suffering from mental illness could be committed on the basis of their disruptive behavior and disordered thinking.⁶⁴ The vast majority of mental hospital commitments were involuntary, and in the 1960s and 1970s, courts made the showing necessary for an involuntary commitment exceedingly hard to meet.⁶⁵

All these historical developments converged to create a tsunami of support for deinstitutionalization. Conservatives saw a way to

hospitals were beyond repair. As such, the preferred solution was not to improve conditions, but rather to free mentally ill people from those conditions altogether. For an insightful discussion of this and other litigation strategies surrounding the deinstitutionalization movement, see generally Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1 (2012).

61. See ISAAC & ARMAT, *supra* note 20, at 139 (discussing broadly the successes of liberation lawsuits); Paul F. Stavis, *Why Prisons Are Brim-Full of the Mentally Ill: Is Their Incarceration a Solution or a Sign of Failure?*, 11 GEO. MASON U. C.R. L.J. 157, 172-74 (2000) (noting that most cases ended by consent decrees, and that for states, “[l]osing these cases was ironically a major win” as they “would lead to closing of old, often decrepit, troublesome and expensive state hospitals”).

62. See ISAAC & ARMAT, *supra* note 20, at 15, 249; PARSONS, *supra* note 21, at 104; Dae-Young Kim, *Psychiatric Deinstitutionalization and Prison Population Growth: A Critical Literature Review and Its Implications*, 27 CRIM. JUST. POL’Y REV. 3, 6 (2016); Steven Raphael & Michael A. Stoll, *Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate*, 42 J. L. STUD. 187, 191 (Jan. 2013).

63. See *O’Connor v. Donaldson*, 422 U.S. 563, 575 (1975) (“A finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the ‘mentally ill’ can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.”); see also *Addington v. Texas*, 441 U.S. 418, 433 (1979) (raising the burden of proof required to commit persons for psychiatric treatment from the usual civil burden of proof of “preponderance of the evidence” to “clear and convincing evidence”).

64. See PARSONS, *supra* note 21, at 100.

65. In 1939, 90 percent of all commitments to mental hospitals were involuntary commitments. See Harcourt, *supra* note 31, at 70.

save money; liberals saw a way to protect a vulnerable class.⁶⁶ The sociopolitical stars were aligned, with legal, financial, political, and cultural forces all pushing states to empty their mental hospitals—and that is exactly what they did. Deinstitutionalization began with a trickle in the 1950s, picked up steam in the 1960s, and became a movement in the 1970s as state hospitals discharged patients, refused admissions, shortened stays, and reduced their number of beds.⁶⁷ It would be the largest institutional migration in this nation's history.⁶⁸

The numbers tell the tale. In 1955, at the height of institutionalization, state psychiatric hospitals housed over a half-million people—558,000 to be precise.⁶⁹ By 1994, that number was under 72,000—a drop of 87 percent in terms of sheer numbers, and that was forty years later, when the country's population had grown by over 50 percent, and the cohort of severely mentally ill people had grown along with it.⁷⁰ President Kennedy had hoped to achieve a 50 percent reduction in the number of people in state mental hospitals.⁷¹ When adjusted for population growth, the actual reduction was 92 percent.⁷² By 2000, the number of people in state mental hospitals had shrunk even further to just 55,000 nationwide.⁷³ For a sense of perspective, in 2010, the United States had about 14 mental hospital beds per 100,000 people; that number is the same as it was in 1850.⁷⁴

66. ISAAC & ARMAT, *supra* note 20, at 15. For an argument that the failures of deinstitutionalization can be traced back to the fact that mental health advocates partnered with fiscal conservatives, who were aligned on the goal of deinstitutionalization but not on the goal of a robust system of community mental health care, see generally Bagenstos, *supra* note 60.

67. See TORREY, *supra* note 14, at 9 (Figure 1.2 showing number of inpatients in state mental hospitals from 1950 through 1995); Henry J. Steadman, John Monahan, Barbara Duffee, Eliot Hartstone & Pamela Clark Robbins, *The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations, 1968-1978*, 75 J. CRIM. L. & CRIMINOLOGY 474, 475 (1984) (discussing various ways that deinstitutionalization took place); *id.* at 479 (discussing the phenomenon of “drastically reduced lengths of hospital stay”).

68. Harcourt, *supra* note 31, at 53-54.

69. To be even more precise, the number was 558,239. TORREY, *supra* note 14, at 8.

70. See *id.* at 8-9.

71. Harcourt, *supra* note 31, at 53.

72. TORREY, *supra* note 14, at 8-9.

73. See Harcourt, *supra* note 31, at 64.

74. See Pan, *supra* note 18.

In theory, deinstitutionalization was a progressive policy—an enlightened, more humane way of treating people who were mentally ill.⁷⁵ But as implemented, it is widely viewed as “the largest failed social experiment in twentieth-century America.”⁷⁶ Why deinstitutionalization was such a failure and what that has to do with mass incarceration are the parts of the story I tell next.

II. *RE*-INSTITUTIONALIZATION THROUGH THE CRIMINAL LAW

“What went wrong?” Bellin asks in *Mass Incarceration Nation*.⁷⁷ His answer is an expansion of the vertical and horizontal footprint of the criminal law, but deinstitutionalization was going horribly wrong at the same time, and that also had a profound impact on mass incarceration.

To understand why, it is first helpful to have a better sense of the cohort of individuals discharged from mental hospitals during deinstitutionalization. Between 50-60 percent of discharged patients had been diagnosed with schizophrenia.⁷⁸ Another 10-15 percent had some sort of organic brain disease or damage, and another 10-15 percent had been diagnosed with severe manic-depressive disorder or major depression.⁷⁹ In short, somewhere between 70-90 percent of the people discharged during deinstitutionalization were suffering from a severe mental illness or condition.⁸⁰ These were people who, by definition, were severely impaired in their ability to be functioning members of society.

That may not have been an issue if the community mental health centers established under the 1963 Community Mental Health Act had done what they were supposed to do—but they did not. Only

75. See *supra* text accompanying note 48; see also TORREY, *supra* note 14, at 10-11 (quoting President Jimmy Carter’s Commission on Mental Health as reporting that the objective of deinstitutionalization through the 1963 Act was “maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while [they] participate[d] in treatment or receive[d] services”).

76. TORREY, *supra* note 14, at 14; see also David Mechanic & David A. Rochefort, *Deinstitutionalization: An Appraisal of Reform*, 16 ANN. REV. SOC. 301, 302 (1990) (identifying deinstitutionalization “as one of the era’s most stunning public policy failures”).

77. BELLIN, *supra* note 1, at 6.

78. TORREY, *supra* note 14, at 10.

79. *Id.*

80. See *id.*

half of the community mental health centers were ever built, and even those were grossly underfunded.⁸¹ As it turned out, community care was not, in fact, cheaper than institutionalized care; it was just more disaggregated, which made its impact harder to measure and its programs easier to target for cuts.⁸² President Richard Nixon did all he could to slash funding for the community mental health centers in 1968⁸³—his priority was law and order, not expanding the social safety net—and President Ronald Reagan dealt a critical blow shortly after assuming the presidency in 1981, converting federal funding to block grants that shifted costs back to states and decreased federal subsidies by a third.⁸⁴ During the Great Recession of 2008, states themselves defunded community mental health programs, cutting \$4.5 billion in services for people who were mentally ill even as mental illness intakes rose by nearly 10 percent.⁸⁵

The damage was incalculable. Community mental health centers were nowhere near equipped to handle the hordes of discharged mental institution patients who would be coming their way.⁸⁶ Those patients had a wide range of needs—drug regimens and therapeutic treatment were just the most obvious—and they faced unique

81. See Kim, *supra* note 62, at 7; Sherry Siller, *Deinstitutionalization, Mental Health, and Criminal Populations: How the Process of Deinstitutionalization Affected Current Incarceration Rates of the Mentally Ill*, CONTINUED EVIDENCE-BASED EDUC. BLOG (Sept. 2017), <https://www.ebpsociety.org/blog/education/349-deinstitutionalization-mental-health-and-criminal-populations> [https://perma.cc/353R-N5DA].

82. See H. Richard Lamb & Leona L. Bachrach, *Some Perspectives on Deinstitutionalization*, 52 PSYCHIATRIC SERV. 1039, 1040 (Aug. 2001) (“We have also begun to understand that if all the hidden costs associated with responsible programming are considered, it is generally not accurate to conclude that community services will result in substantial savings over hospital care.”); GROB, *supra* note 12, at 281-82 (discussing President Nixon’s hostility to social programs more generally, which were associated with “liberal political ideology”).

83. See TORREY, *supra* note 14, at 179 (“A major fight erupted in 1973, when President Nixon impounded and refused to spend funds that had been appropriated by Congress for the CMHCs; the National Council of Community Mental Health Centers went to federal court and obtained an injunction ordering the Nixon administration to release the impounded funds.”); GROB, *supra* note 12, at 282-83.

84. See Pan, *supra* note 18; GROB, *supra* note 12, at 301-02.

85. See Ford, *supra* note 23; ROTH, *supra* note 14, at 94 (at the same time states were cutting spending on mental health services, “a million more people reportedly sought treatment at public mental health care facilities”).

86. See ISAAC & ARMAT, *supra* note 20, at 82, 105; Mark R. Pogrebin & Eric D. Poole, *Deinstitutionalization and Increased Arrest Rates Among the Mentally Disordered*, 22 J. PSYCHIATRY & L. 117, 121 (1987).

challenges adjusting to community life.⁸⁷ Their worlds had been highly regimented. Now they were free-falling, and the community mental health centers that were supposed to be their safety net were nothing of the sort. As the General Accounting Office reported in 1977, community mental health centers were mostly serving “a new type of patient who was not very ill and not a candidate for hospitalization in a state institution.”⁸⁸ The centers had become a glorified “national counseling service,” and that would have been fine but for the fact that they were supposed to replace state hospitals in caring for people who were severely mentally ill.⁸⁹

In theory, the patients’ rights movement of the 1960s and 1970s could have advocated for the right of mentally ill people to receive outpatient treatment services just as it advocated for their right *not* to receive inpatient treatment. After all, the two were not unconnected. Freedom from institutionalization was only meaningful if people who were mentally ill could survive without it, and people who suffered from severe mental illness generally did not have the wherewithal to navigate even the most basic services on their own.⁹⁰ But by and large, the lawyers who were litigating these suits did not see it that way. “Lawyers are not ‘morning after’ people,” an attorney for the APA explained.⁹¹ “They’re people who are wonderful

87. See ISAAC & ARMAT, *supra* note 20, at 82; TORREY, *supra* note 14, at 10; Pogrebin & Poole, *supra* note 86, at 121; Lamb & Bachrach, *supra* note 82, at 1040.

88. ISAAC & ARMAT, *supra* note 20, at 97 (quoting 1997 GAO report) (internal quotations omitted); TORREY, *supra* note 14, at 145-46 (discussing the “worried well” as a new class of mental patients); GROB, *supra* note 12, at 284-85 (discussing President Carter’s Commission on Mental Health, which issued a report that preceded the GAO report in 1977 and came to the same conclusion).

89. ISAAC & ARMAT, *supra* note 20, at 98 (acknowledging that community mental health centers served “a broad range of clients,” but noting that “Congress—and taxpayers—did not intentionally fund a national counseling service; it intended to fund a program to substitute for state hospitals in caring for the severely mentally ill”). For an in-depth discussion of the ambiguity surrounding the question of who community health centers would serve and other challenges from the start, see GROB, *supra* note 12, at 258-64.

90. See ISAAC & ARMAT, *supra* note 20, at 309 (“Seriously mentally ill people cannot be expected to negotiate a bureaucratic maze to obtain unconnected, scattered services from disparate authorities, none of which takes any overall responsibility for their welfare.”); PARSONS, *supra* note 21, at 82 (“[T]he era brought a spate of negative rights—new freedoms from confinement and medical coercion, the growing right to the least restrictive environment, and a right to self-determination. The right to adequate medical care, social services, and an income, however, did not emerge in the same way to meet the needs of many people who left the hospitals.”).

91. ISAAC & ARMAT, *supra* note 20, at 158 (quoting Joe Klein, attorney for the American

the night before ... and then they go their own way and say to the psychiatrists and patients, 'Now you people work this out.'⁹² Having secured "freedom" for their clients, the lawyers who comprised the mental health bar generally considered their work done.

All this is to say that hundreds of thousands of severely mentally ill people were discharged from state hospitals with no support structure in place for their care in the community setting.⁹³ "Among the lessons learned from deinstitutionalization are that successful deinstitutionalization involves more than simply changing the locus of care," one set of researchers writes, adding that "although these lessons are now widely—if not universally—accepted, they were virtually unknown in the days before deinstitutionalization."⁹⁴ An expert in the field echoes that sentiment, stating: "As deinstitutionalization was getting started, we ... should have anticipated—but we didn't—that the community would now have to provide an extensive array of services for chronic mental patients."⁹⁵

How anyone remotely paying attention could have missed this is hard to fathom, but the reality is that states reduced the population in their mental hospitals by 92 percent without first figuring out how (or even whether) deinstitutionalization would work.⁹⁶ No extensive studies. No pilot projects. No services in place for discharged patients when they arrived.⁹⁷ As the president of the APA stated in 1985, the "precipitous attempt to move large numbers of

Psychiatric Association).

92. *Id.* (quoting Klein); *see also id.* at 140-41 ("But the mental patient liberation bar did not put comparable effort into suits seeking to force establishment of community programs ... overall, it did not push for such programs with anything like the zeal it directed toward depopulating hospitals.").

93. *See* Siller, *supra* note 81.

94. Lamb & Bachrach, *supra* note 82, at 1039, 1044.

95. ISAAC & ARMAT, *supra* note 20, at 287 (quoting Leona Bachrach).

96. *See* TORREY, *supra* note 14, at 86 ("In thinking about the failures of deinstitutionalization, keep in mind that deinstitutionalization was implemented as a policy in the United States although virtually no studies had been done on it.... It seems incredible that a policy that has led to the effective deinstitutionalization of three-quarters of a million people, 92 percent of all patients in American public psychiatric hospitals, was launched on the basis of a single study of 20 selected patients, but that is in fact the case."); Siller, *supra* note 81 ("The policies surrounding the closure of these institutions did not have any real strategic plan for the transfer of individuals into community care.... Today, we are feeling the effects of that poor planning.").

97. *See* TORREY, *supra* note 14, at 10.

[mental institution] charges into settings that in fact did not exist must be seen as incompetent at best and criminal at worst.”⁹⁸

Yet the lack of a plan for community treatment was just one of deinstitutionalization’s major failings; the other was housing. “No one asked the question ‘Where will all those people live once they get out of the state mental hospital?’” marveled a program director at the National Institute of Mental Health.⁹⁹ Deinstitutionalization started with the “easy” cases—the ones where the patient had a place to go.¹⁰⁰ Elderly patients went to nursing homes; so long as the home was not dedicated to the treatment of mental illness, the federal government would foot the bill.¹⁰¹ But the same feature that made nursing homes eligible for federal funding also made them ill-suited for the care of elderly mental institution patients. Most nursing homes did not have staff trained in how to handle the challenges of severe mental illness, and the care that elderly mentally ill residents received was all too often even worse than what they had received at the state mental hospital.¹⁰²

Other discharged patients had families who could care for them, and back home is where they went.¹⁰³ For these individuals, family members became the functional equivalent of doctor, nurse, and social worker, but without any training, backup, or breaks.¹⁰⁴ “Nobody has yet estimated the number of families and marriages that have fallen apart because of deinstitutionalization and the inability to get a severely mentally ill family member rehospitalized,”

98. ISAAC & ARMAT, *supra* note 20, at 102 (alteration in original). *See also* Scull, *supra* note 52, at 72 (“[Deinstitutionalization] took place with virtually no advance planning or provision for the housing or other needs of those with disabling mental illnesses. ‘Community Care’ ... was a shell game with no pea.”).

99. ISAAC & ARMAT, *supra* note 20, at 79.

100. *See id.* at 140.

101. *See id.*; PARSONS, *supra* note 21, at 75; *supra* text accompanying note 51. For an in-depth discussion of the transinstitutionalization of elderly mental hospital patients to nursing homes, see generally William Gronfein, *Incentives and Intentions in Mental Health Policy: A Comparison of Medicaid and Community Mental Health Programs*, 26 J. HEALTH & SOC. BEHAV. 192, 196 (1985).

102. *See* TORREY, *supra* note 14, at 103; ISAAC & ARMAT, *supra* note 20, at 101; GROB, *supra* note 12, at 289-90 (discussing problems with nursing home care and noting that “the relocation of elderly patients from mental hospitals to extended care facilities was often marked by increases in the death rate”).

103. ISAAC & ARMAT, *supra* note 20, at 250.

104. *See* TORREY, *supra* note 14, at 77; ISAAC & ARMAT, *supra* note 20, at 250-52.

one psychiatrist observes, “but anecdotal data suggest it is legion.”¹⁰⁵ In theory, deinstitutionalization meant leveraging the strength of families to support and sustain the severely mentally ill population. In practice, it often meant the destruction of those families, with mentally ill adult children left to “vegetate in the homes of their increasingly desperate parents.”¹⁰⁶

Over time, parents died, families fell apart, and state hospitals turned to discharging the mentally ill patients with nowhere to go.¹⁰⁷ Group homes, boarding houses, and seedy hotels were the next stop for this cohort of the severely mentally ill population,¹⁰⁸ leading one psychiatrist to say that deinstitutionalization was more accurately a “transinstitutionalization” as “the chronic mentally ill patient [had] his locus of living and care transferred from a single lousy institution to multiple wretched ones.”¹⁰⁹ With little holding them to their assigned places of squalor, many discharged patients just wandered off to live in the streets, moving (as the saying goes) “from the back ward to the back alley.”¹¹⁰

Study after study has shown a direct link between deinstitutionalization and the plight of homelessness among those who are severely mentally ill.¹¹¹ In Massachusetts, 27 percent of severely mentally ill patients became homeless within just six months of

105. TORREY, *supra* note 14, at 77.

106. ISAAC & ARMAT, *supra* note 20, at 106; *see also id.* at 160 (“[W]e have consigned many persons to lives of quiet desperation, have destroyed the mental and emotional health of those who love and care for them, and destroyed families—to the ultimate detriment and even destruction of the disabled person.” (quoting Judge Caesar)).

107. *Id.* at 287-88.

108. *See id.* For an excellent discussion of the rise of group homes, halfway houses, room-and-board facilities, and “welfare” hotels to house discharged mental institution patients, see Scull, *supra* note 52, at 76-77.

109. TORREY, *supra* note 14, at 88 (alteration in original).

110. Numerous sources have used the term, *see, for example*, ISAAC & ARMAT, *supra* note 20, at 101, although it appears to have been coined in G. Klerman, *Better, but Not Well: Social and Ethical Issues in the Deinstitutionalization of the Mentally Ill*, 3 SCHIZOPHRENIA REV. 617 (1977). Indeed, the term is so common that it was the title of a 1978 report by the New York State Assembly. *See* Ellen Rulseh, *Mental Health Budget Cuts Seen as Breach of Trust*, N.Y. TIMES (Mar. 25, 1990), <https://www.nytimes.com/1990/03/25/nyregion/mental-health-budget-cuts-seen-as-breach-of-trust.html> [<https://perma.cc/VA7V-QMDN>] (citing the 1977 report titled, “From the Back Wards to the Back Alleys”).

111. TORREY, *supra* note 14, at 23. For an in-depth discussion, *see generally* MICHAEL J. DEAR & JENNIFER R. WOLCH, *LANDSCAPES OF DISPAIR: FROM DEINSTITUTIONALIZATION TO HOMELESSNESS* (1987).

their discharge from a state mental hospital.¹¹² In Ohio, that percentage was 36 percent, and a similar study in New York City found that 38 percent of discharged mental hospital patients had “no known address” just six months after their discharge.¹¹³ Slicing the data somewhat differently, one mega-study of other studies reported that between 22-24 percent of all homeless persons had previously resided in a mental hospital, and among certain segments of the homeless population—people who slept in parks as opposed to shelters, for example—the rate of prior mental hospitalization was astronomically high, hitting over 70 percent in places like Los Angeles and New York City.¹¹⁴ “The result is not what we intended,” the chief architect of Kennedy’s 1963 plan later stated.¹¹⁵

By the 1980s, the disastrous consequences of deinstitutionalization without a community support system had become a scandal of its own. Forty years after *Life Magazine* had published its jaw-dropping exposé on state mental institutions, it published another exposé on the plight of people suffering from severe mental illness, this time documenting the deplorable conditions of their lives on the street.¹¹⁶ “The mentally ill have become our cities’ lost souls,” the magazine declared,¹¹⁷ while the *Philadelphia Inquirer* stated matter-of-factly: “The United States is in its third decade now of ‘deinstitutionalizing’ the mentally ill, which is a polite way of saying that it has quit warehousing them out of sight and started doing it in plain view.”¹¹⁸ Mentally ill homeless people were seemingly everywhere—huddled over grates, sleeping on sidewalks, loitering in parks, and riding the subways, much to the public’s dismay.¹¹⁹ A billboard in one California city blared to passersby on the street: “You are now walking through America’s newest mental institution.”¹²⁰

112. See TORREY, *supra* note 14, at 23.

113. See *id.*

114. See *id.* at 22-23.

115. ISAAC & ARMAT, *supra* note 20, at 101.

116. David Friend, *Emptying the Madhouse: The Mentally Ill Have Become Our Cities’ Lost Souls*, LIFE MAGAZINE, May 1981, at 56, 60 (with photographer Michael O’Brien); see also TORREY, *supra* note 14, at 62 (discussing Friend’s article); PARSONS, *supra* note 21, at 123.

117. Friend, *supra* note 116.

118. TORREY, *supra* note 14, at 62 (quoting *Philadelphia Inquirer*).

119. See *id.* at 14, 16.

120. See *id.* at 18. (“Homeless shelters and city streets have become the ‘de facto mental

The state of homelessness among people suffering from mental illness had become a national disgrace. “[T]he presence of thousands of severely and chronically mentally ill and gravely disabled Americans wandering aimlessly across our nation’s landscape attests to the failure of our state governments’ policy of mental hospital depopulation,” the president of the APA stated in his 1985 presidential address.¹²¹ Deinstitutionalization was supposed to give mentally ill people their freedom, not abandon them to the lowest echelons of survival, where (to borrow from one researcher’s articulation of the point) they would be “‘free’ to be slaves to their illness, delusions, and life in the streets.”¹²² “What kind of ‘freedom’ is it to be wandering the streets severely mentally ill, deteriorating, and getting warmth from a steel grate or food from a garbage can?” one contemporary observer asked.¹²³ “It’s the biggest tragedy I’ve ever encountered,” another stated, adding: “How we can get to the point where we can allow people who are so ill to just wander, wander, wander, all under the guise of supposed freedom is beyond me.”¹²⁴

Suffice it to say that the poor handling of deinstitutionalization gave way to a mental health crisis that in turn exacerbated a homelessness crisis, and we are still suffering the consequences today. Studies show that between 30-40 percent of the nation’s homeless population suffers from a severe mental illness, and that may be a conservative estimate given that many mentally ill people are too paranoid to go to shelters, where they can be counted, and too combative to cooperate with the people trying to study them.¹²⁵

institutions’ of the 1980s and 1990s.” (quoting the Boston mayor)).

121. ISAAC & ARMAT, *supra* note 20, at 102.

122. Stavis, *supra* note 61, at 198.

123. ISAAC & ARMAT, *supra* note 20, at 283 (quoting psychiatrist Darold Treffert).

124. *Id.* at 337 (quoting Norma Wanucha, mother of two mentally ill children who works with the mentally ill homeless population in Ohio).

125. *See id.* at 4; TORREY, *supra* note 14, at 17-18; Lamb & Bachrach, *supra* note 82, at 1041. For an argument that homelessness is more about marginalization than mental health, and that focusing on those who are severely mentally ill diverts attention from the underlying socio-economic inequalities and deprivations that lead to homelessness more broadly, see Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 139 (1991) (focusing on the homeless population that is mentally ill “perpetuate[s] the stereotype that the homeless are all ‘insane’” and allows us to “avoid examining the fundamental economic and social questions underlying homelessness and look, instead, for easy targets to blame”).

What we do know is that homelessness makes the plight of people suffering from severe mental illness even worse. Homeless people who suffer from severe mental illness are more likely to be victimized, and also three times more likely to die on the street, largely because when they are injured or freezing, they are too mentally impaired to seek help.¹²⁶ Even when they seek help, getting it can be a challenge. “There is a hierarchy among the shelter’s clients,” one report on homeless shelters observes, “and the visibly mentally ill are the lowest caste, untouchables among the outcast.”¹²⁷ Little wonder that a third or more of the severely mentally ill population suffers from a dual diagnosis of substance abuse, filling the gap in their medication by self-medicating instead.¹²⁸

All this brings us to how people who are severely mentally ill get caught in the crosshairs of the criminal legal system, and it happens in three ways. The first is that they commit offenses that would get most anyone arrested. People who suffer from severe mental illness tend to have poor judgment and poor impulse control, both of which put them at risk of committing criminal offenses, and they are even more at risk if they also suffer from a dual diagnosis of substance abuse.¹²⁹ Now add delusional thoughts. A mentally ill person might assault a bystander because they think they are about to be attacked, or refuse to pay for a meal because they think they are a divine power, or destroy property because they think monsters are inside—and the list goes on.¹³⁰ Studies show that people who are

126. See TORREY, *supra* note 14, at 19-20 (“the homeless in general ... have a 3 times higher risk of death than the general population and severely mentally ill people in general have a 2.4 times higher risk of death during any year,” noting that those suffering from severe mental illness while experiencing homelessness are 3 times more likely to obtain some of their food from garbage cans, and also more likely to use garbage cans as their primary food source; for severely mentally ill women experiencing homelessness, life is even more difficult, with 22 percent of schizophrenic women becoming victims of rape, and two-thirds having been raped multiple times).

127. *Id.* at 20.

128. See ISAAC & ARMAT, *supra* note 20, at 271; Roth, *supra* note 15.

129. See ISAAC & ARMAT, *supra* note 20, at 271-72.

130. These are generalized depictions of actual examples. See TORREY, *supra* note 14, at 28 (relaying instances of “a man who ... ‘smashed the plate-glass window of a retail store because he saw a dinosaur jumping out at him’; a woman who refused to pay her restaurant bill because she believed that ‘she was the reincarnation of Jesus Christ’; a man who harassed two other men whom he believed to be ‘CIA agents who had kidnapped his benefactress’; and a woman with paranoid delusions who went up to a man on the street and ‘struck the victim in the right buttocks’ with a hat pin”); *id.* at 38 (“People who suffer from paranoid schizo-

severely mentally ill have higher arrest rates for violent crime.¹³¹ In California, for example, discharged mental institution patients were arrested for violent crime at ten times the national rate.¹³²

In short, the arrests in this first category of cases are for offenses that threaten public safety or private property in some way, and these sorts of offenses would attract the attention of law enforcement even if the perpetrator was not mentally ill. Police are tasked with protecting the community, and removing those who threaten the community is the primary way they do it. As one team of researchers observes, mentally ill offenders “are still viewed as requiring incapacitation to protect the community”—it is just that now, the criminal legal system, as opposed to involuntary commitment, is the means by which that incapacitation occurs.¹³³

Granted, the sorts of arrests in this first category can occur whether a severely mentally ill person is housed or not. Homelessness might put this population more at risk of committing certain offenses, but it does not directly feed into a reason for arrest. In the next two categories of cases, homelessness plays a much more central role.

A second way in which people with severe mental illness get caught in the crosshairs of the criminal legal system is that they commit offenses that would *not* result in the arrest of most anyone. Disorderly conduct, loitering, trespassing—these and other minor offenses are the charges at issue here.¹³⁴ Turns out, the communities

phrenia, in particular, are likely to be arrested for assault because they may mistakenly believe someone is following them or trying to hurt them and will strike out at that person.”).

131. See ISAAC & ARMAT, *supra* note 20, at 271 (“But studies in the era of deinstitutionalization ... show[.]... consistently higher arrest rates for mental patients, and higher rates for violent crime. And while individual studies can be, and have been, faulted, the pattern of findings is too consistent for serious challenge.”).

132. See TORREY, *supra* note 14, at 45.

133. Pogrebin & Poole, *supra* note 86, at 124; see also PARSONS, *supra* note 21, at 101 (“Instead, the meaning of institutions changed as their role became focused on removing people from society in order to protect the public.”).

134. See TORREY, *supra* note 14, at 37 (reporting a study “that mentally ill jail inmates were four times more likely to have been incarcerated for less serious charges such as disorderly conduct and threats[,] ... 5 times more likely to have been charged with trespassing, and 10 times more likely to have been charged with harassment” (internal quotations omitted)); *id.* at 38 (reporting that in Wisconsin, the most common charges brought against the mentally ill who are taken to jail are “lewd and lascivious” conduct (urinating on a street), defrauding an innkeeper (not paying for a meal), disorderly conduct (being loud and disruptive), panhandling, property damage, loitering, and petty theft). For a historical account of how

to which discharged mental hospital patients returned were not as warm and welcoming as President Kennedy thought.¹³⁵ “Society has a limited tolerance for mentally disordered behavior,” two psychiatrists observe,¹³⁶ and this much is clear from the sheer volume of mental-illness-related calls to the police.¹³⁷ Police are first responders, and that makes them the first point of contact not just for criminal behavior, but disordered behavior as well.¹³⁸ When some sort of disturbance occurs and people do not know who to call, they call the police. Local businesses call the police to remove “undesirables” who are scaring off customers.¹³⁹ Citizens call the police to report frightening encounters with bizarre-acting individuals.¹⁴⁰ In Philadelphia, mental-illness-related complaints increased 227 percent between 1975 and 1979.¹⁴¹ In New York City, the number of police-initiated mental hospital evaluations went from 1,000 in 1976 to 18,500 in 1986.¹⁴²

As psychiatrists have noted, deinstitutionalization created a “mental illness crisis [that] has had major effects on many public services.... [b]ut no public service has been as profoundly affected by this crisis as the task of policing the streets.”¹⁴³ This is unfortunate not only because it has diverted police resources from more serious crimes and given the police a role for which they have little training or expertise.¹⁴⁴ Most relevant to the discussion here, shunting mental illness incidents to the police is unfortunate because arrest is, as a practical matter, the only tool that police have.¹⁴⁵

vagrancy laws were used to remove “undesireables” and enforce a variety of unwritten codes of conduct, see generally RISA GOLUBOFF, *VAGRANT NATION: POLICE POWER, CONSTITUTIONAL CHANGE, AND THE MAKING OF THE 1960S* (2016).

135. See Roth, *supra* note 15.

136. Lamb & Bachrach, *supra* note 82, at 1042.

137. See TORREY, *supra* note 14, at 73.

138. See Siller, *supra* note 81; TORREY, *supra* note 14, at 73-74.

139. See TORREY, *supra* note 14, at 39.

140. See *id.* at 73-74; Pogrebin & Poole, *supra* note 86, at 118.

141. See TORREY, *supra* note 14, at 73 (quoting a report from Upper Darby Township in suburban Philadelphia).

142. See *id.* at 73-74. In California, 15 percent of all arrestees brought to the Los Angeles Police Department’s Mental Evaluation Unit “were nude at the time of their arrest.” *Id.* at 74.

143. See *id.* at 73.

144. See *id.* at 74; Pogrebin & Poole, *supra* note 86, at 120.

145. Pogrebin & Poole, *supra* note 86, at 118 (“Arrest was the only practical method of dealing with the sorts of problems these individuals manifested.”).

As others have recognized, the law has made it exceedingly difficult to involuntarily commit a person suffering from severe mental illness but exceedingly easy to arrest them.¹⁴⁶ Stories are legion of mental hospitals refusing to admit a severely mentally ill person who is disturbing the peace in some way, so police took them to jail instead.¹⁴⁷ In one study, around half of all arrests of severely mentally ill individuals followed a failed attempt by the police to admit the person to a mental hospital.¹⁴⁸ “Growing numbers of former mental patients and individuals whose bizarre behavior might have landed them in a state hospital bed a few years ago are now being arrested and ending up in jail,” researchers in the *Journal of Psychiatry and the Law* reported in 1987.¹⁴⁹ A statement released by the American Correctional Association explained why:

With the trend towards deinstitutionalization, the mentally ill are being discharged from state mental institutions, with no place to go. So, they go to the bus station, the subway, and the streets. When they act crazy at midnight, someone calls the police or the sheriff. The police officer, with no place else to take them, takes them to jail. And there they languish with no help—charged with disorderly conduct or trespassing.¹⁵⁰

Deinstitutionalization has placed tremendous pressure on the police to do something about mentally ill people living on the streets.¹⁵¹ All too often, their only options are to walk away and do nothing, or to effectuate an arrest for some insignificant offense. The former being unacceptable, the latter is what they do.¹⁵²

A third way that severely mentally ill people become entangled in the criminal legal system is so-called “mercy bookings”—arrests not to serve an annoyed or endangered public, but rather the mentally

146. See Roth, *supra* note 15.

147. See TORREY, *supra* note 14, at 150-51; Roth, *supra* note 15; see also ISAAC & ARMAT, *supra* note 20, at 283 (“[W]hat kind of ‘liberty’ is it to be jailed for disorderly conduct, crazed and delusional, because that is all the law will allow, instead of being hospitalized, treated, and released? That’s not liberty; that’s imprisonment for the crime of being sick.” (quoting psychiatrist Darold Treffert)).

148. See TORREY, *supra* note 14, at 151.

149. Pogrebin & Poole, *supra* note 86, at 117.

150. PARSONS, *supra* note 21, at 147 (quoting American Correctional Association).

151. See TORREY, *supra* note 14, at 39.

152. See *id.*

ill individual themselves.¹⁵³ These are arrests to provide what is colloquially known as “three hots and a cot”—food and shelter, at least for a time.¹⁵⁴ One officer explains:

You arrest somebody for a crime because you know at least they'll be put in some kind of facility where they'll get food and shelter. You don't invent a crime, but it's a discretionary decision. You might not arrest everybody for it, but you know that way they'll be safe and fed.¹⁵⁵

Another officer notes that mentally ill people who are homeless are often “suffering from malnutrition, with dirt-encrusted skin and hair or bleeding from open wounds.” “It's really, really pitiful,” he says. “You get people who are hallucinating, who haven't eaten for days.... They get shelter, food, you get them back on their medications.... It's crisis intervention.”¹⁵⁶ The problem with this sort of crisis intervention is that it serves the mentally ill population not at its time of need, but rather at the time of some menial offense.

All too often, arrest is also the only way for people with severe mental illness to get the psychiatric services they need, which has led families with mentally ill members to initiate “mercy bookings” of their own.¹⁵⁷ “[F]or a family seeking treatment for an ill family member, having the person arrested may be the most efficient way to accomplish their goal,” one psychiatrist writes, adding that “numerous family members confided that either the police or mental health officials had encouraged them in pressing charges against their family members to access psychiatric care for them.”¹⁵⁸ As one investigative journalist explains:

153. *Id.* at 40.

154. ROTH, *supra* note 14, at 107.

155. TORREY, *supra* note 14, at 40.

156. *Id.*

157. *Id.* at 34, 40-41; Chaimowitz, *supra* note 19, at 4 (“People with mental illness, with limited access to psychiatric hospital beds ... were diverted into the forensic system where they at least could get psychiatric care, albeit by acquiring a criminal justice history. Whatever rights to treatment psychiatric patients had, many believed that the only way they could receive treatment was by charging them and getting them placed in the forensic system.”).

158. TORREY, *supra* note 14, at 40.

Often, it's a person's family ... who calls 911 for help: To keep somebody who is threatening suicide from killing himself. To ask for protection when a relative with mental illness is threatening. To calm a person down. Or to help the person getting admitted to the hospital. Or just to get the person *to* the hospital.¹⁵⁹

If the criminal justice system is the place to get psychiatric care, then desperate family members seeking help for their mentally ill loved ones are going to call the police to get their loved ones there.

These are the three ways in which severely mentally ill people get caught in the crosshairs of the criminal legal system, and together, they account for a shocking statistic: *one in every two* people who suffer from severe mental illness will be arrested for something at some point in their lifetimes.¹⁶⁰

Now we can see how it came to be that many mentally ill people made their way from state hospitals back to secure beds, but in the nation's jails instead. As the mayor of New York City put the point in 1981: "The state policy of releasing patients without adequate support has turned the city's neighborhoods into mental wards and the police into hospital orderlies."¹⁶¹ In a relatively short period of time, jails became surrogate repositories for those who were severely mentally ill, absorbing the very same people that had been committed to state mental institutions.¹⁶² "Deinstitutionalization doesn't work," one jail official stated, adding: "We just switched places. Instead of being in hospitals the people are in jail. The whole system is topsy-turvy and the last person served is the mentally ill person."¹⁶³

California's experience in this regard is instructive. As Bellin notes in *Mass Incarceration Nation*, California is "one of the biggest contributors to Mass Incarceration."¹⁶⁴ As it turns out, California was at the forefront of the deinstitutionalization movement as well. Progressive California passed legislation in 1967 that barred involuntary psychiatric treatment in all but the most extreme

159. ROTH, *supra* note 14, at 234.

160. Roth, *supra* note 15, at 3.

161. PARSONS, *supra* note 21, at 123 (quoting New York mayor Ed Koch).

162. See TORREY, *supra* note 14, at 28-29, 42; PARSONS, *supra* note 21, at 105.

163. TORREY, *supra* note 14, at 25.

164. See BELLIN, *supra* note 1, at 112.

circumstances, stating that its intent was “[t]o end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders.”¹⁶⁵ In California’s first year of deinstitutionalization, the number of severely mentally ill people entering its criminal legal system doubled.¹⁶⁶ By 1975, the number of severely mentally ill people in its jails and prisons had grown 300 percent.¹⁶⁷ One prison psychiatrist in California lamented:

We are literally drowning in patients, running around trying to put our fingers in the bursting dikes, while hundreds of men continue to deteriorate psychiatrically before our eyes into serious psychoses.... The crisis stems from recent changes in the mental health laws allowing more mentally sick patients to be shifted away from the mental health department into the department of corrections.¹⁶⁸

Mental health advocates denounced “criminalization of the mentally ill” and incarcerating people “for the crime of being sick,”¹⁶⁹ but it was too little, too late. By then, the devastating effects of deinstitutionalization were already well underway.

165. Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE §§ 5000-5121 (1967). Ironically, the governor who signed the act into law was Ronald Reagan. See Vern Pierson, *Hard Truths About Deinstitutionalization, Then and Now*, CALMATTERS (Jan. 12, 2022), <https://calmatters.org/commentary/2019/03/hard-truths-about-deinstitutionalization-then-and-now/> [<https://perma.cc/JP6U-VFXV>].

166. See TORREY, *supra* note 14, at 36.

167. See *id.*

168. *Id.*

169. Megan Wolff, *Fact Sheet: Incarceration and Mental Health*, WEILL CORNELL MED. PSYCH. (May 30, 2017), <https://psychiatry.weill.cornell.edu/research-institutes/dewitt-wallace-institute-psychiatry/issues-mental-health-policy/fact-sheet-0> [<https://perma.cc/LG4D-M2C9>] (“The term ‘criminalization of the mentally ill’ was coined in 1972 to describe the increasing arrest and prosecution rate of individuals with mental [disorders].”) (citing Marc F. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 HOSP. & CMTY. PSYCHIATRY 101 (1972)); ISAAC & ARMAT, *supra* note 20, at 283; see also PARSONS, *supra* note 21, at 107 (discussing Abramson’s work and noting “[t]he criminalization of mental illness was well underway”). Ironically, criminalization of the mentally ill population is where we started—jails are where Dorothy Dix found mentally ill people languishing in 1841. See *supra* text accompanying notes 15 and 16. See Stavis, *supra* note 61, at 163 (noting the “socially archaic ... reversion to criminalizing the mentally ill rather than treating them” and observing “an eerie similarity to the societal attitudes and government policies of centuries ago, at a time when the mentally ill and other ‘social deviants and undesirables’ such as the poor, sick, unemployed, etc. were jailed or exiled rather than treated.”).

Research shows that California's experience was no anomaly. "There is a consistent link between mental illness, homelessness, and incarceration," one white paper noted, discussing a fifty-state survey which showed that the number of mentally ill persons in jails and prisons rose by double digits after deinstitutionalization, with some states recording as much as a 77 percent increase.¹⁷⁰ Deinstitutionalization may have been successful in reducing involuntary commitments, the paper concluded, but it was "a complete failure in many other respects," particularly given that the harms of deinstitutionalization fall disproportionately on those already marginalized along the lines of class and race.¹⁷¹

Study after study has reported similar findings.¹⁷² One took the percentage of newly admitted prisoners with prior mental illness hospitalizations in 1968 and held that percentage constant while adjusting for population growth ten years later, in 1978.¹⁷³ Based on 1968 figures, the expected number of admissions of ex-mental institution patients in Texas prisons in 1978 was thirty-five.¹⁷⁴ The actual number of such admissions in 1978 was 1,004.¹⁷⁵ Another study performed a multivariate analysis using a sample of eighty-one cites, concluding that "as a result of deinstitutionalization, the mentally ill who would have been previously institutionalized in mental hospitals are at risk of being homeless, involved in crime, subject to arrest, and finally held up in jails and prisons due to a lack of personal and community resources."¹⁷⁶

170. Siller, *supra* note 81. For an in-depth discussion of the phenomenon, see generally H. Richard Lamb & Linda E. Weisenberger, *The Shift of Psychiatric Inpatient Care from Hospitals to Jails and Prisons*, 33 J. AM. ACAD. PSYCHIATRY L. 529 (2005).

171. Siller, *supra* note 81.

172. See PARSONS, *supra* note 21, at 107 (discussing similar findings of studies conducted in California and Colorado); Siller, *supra* note 81 (discussing results of a similar study in Ohio); Raphael & Stoll, *supra* note 62, at 197 (reporting results of study that "mentally ill prison inmates are more likely to indicate that they suffered a spell of homelessness in the year preceding the arrest leading to their current incarceration"); Linda A. Teplin, *The Criminalization of the Mentally Ill: Speculation in Search of Data*, 94 PSYCH. BULL. 54, 55-58 (1983) (discussing a similar study of the increasing population of incarcerated individuals with severe mental illness).

173. See Steadman et al., *supra* note 67, at 475-76.

174. See *id.* at 483.

175. See *id.*

176. Kim, *supra* note 62, at 10 (summarizing results of Fred E. Markowitz, *Psychiatric Hospital Capacity, Homelessness, and Crime and Arrest Rates*, 55 CRIMINOLOGY 45 (2006)).

None of this would have come as a surprise to British psychiatrist Lionel Penrose, who in 1939 published a study of eighteen European countries that demonstrated an inverse relationship between mental hospital and prison population rates.¹⁷⁷ Society has a need to isolate and confine antisocial, disordered behavior, he posited, so reducing the population in one institution that serves that purpose will simply result in a “ballooning” effect in the other.¹⁷⁸ (Ironically, his takeaway was that by *increasing* the number of mental hospital beds, society could reduce its imprisonment rates).¹⁷⁹

One cannot read the literature on deinstitutionalization and incarceration of the mentally ill without reading about the “Penrose effect” (also known as the “balloon theory”).¹⁸⁰ Numerous studies have shown that as state mental hospitals shrank their populations, the population of mentally ill inmates in jails and prisons grew dramatically.¹⁸¹ “[E]pidemiologic data on population shifts in the criminal justice and mental health systems in the U.S. appear to confirm an interdependent relationship,” one study reported,¹⁸² while another study noted that the correlation was both strong and statistically significant.¹⁸³ An extensive analysis of the Penrose effect in 1991 using data on U.S. mental hospitals, jails, and prisons reported that “[t]he number of mentally ill in American jails and

177. See L.S. Penrose, *Mental Disease and Crime: Outline of a Comparative Study of European Statistics*, 18 BRIT. J. MED. PSYCH. 1, 3 (1939).

178. *Id.* at 1-3; see also Raphael & Stoll, *supra* note 62, at 198 (discussing Penrose’s “balloon theory”).

179. See Penrose, *supra* note 177, at 12.

180. See generally Gregory Grecco & R. Andrew Chambers, *The Penrose Effect and Its Acceleration by the War on Drugs: A Crisis of Untranslated Neuroscience and Untreated Addiction and Mental Illness*, 9 TRANSLATIONAL PSYCHIATRY 320 (2019); Raphael & Stoll, *supra* note 62, at 198 (discussing Penrose’s “balloon theory”).

181. See PARSONS, *supra* note 21, at 45 (“At the very moment that mental hospitals shrank their role in the carceral state, the criminal legal system grew.”); Steadman et al., *supra* note 67, at 474 (“Since [1939, when Penrose published his study], the belief that the criminal justice and mental health systems are functionally interdependent has gained widespread acceptance among commentators and researchers.”); Grecco & Chambers, *supra* note 180, at 320 (“This relationship, later termed the ‘Penrose Effect,’ has proven remarkably predictive of modern trends which have manifested as reciprocal components, referred to as ‘deinstitutionalization’ and ‘mass incarceration.’”); Chaimowitz, *supra* note 19, at 2 (“By 1994, there were only 72,000 state hospital beds for a population of 250 million people. The beds per 100,000 had dropped dramatically from 339 to 29. Contemporaneously, the number of people in jails and prisons also rose significantly.”).

182. Steadman et al., *supra* note 67, at 475.

183. See Raphael & Stoll, *supra* note 62, at 198.

prisons supports the thesis of progressive transinstitutionalism,” with the authors adding that “the statistical evidence derived from the national census data corroborates the ... clinical observation that jails have become a repository of pseudo-offenders—the mentally ill.”¹⁸⁴

If, as law professor Bernard Harcourt has argued, the essence of institutionalization is “spatial exclusion and confinement,” then one might say (as he does) that the United States has not deinstitutionalized the mentally ill population at all.¹⁸⁵ Aggregate institutionalization rates have remained remarkably stable over time.¹⁸⁶ We have just moved the locus of confinement.

None of this is to suggest that the move from one institutional setting to another was an even trade. Deinstitutionalization resulted in a much more punitive approach to mental illness and social disorder. As one psychiatrist stated matter-of-factly:

If the mental health system is forced to release mentally disordered persons into the community prematurely, there will be an increase in pressure for use of the criminal justice system to reinstitutionalize them. Those who castigate institutional psychiatry for its present and past deficiencies may be quite ignorant of what occurs when mentally disordered patients are forced into the criminal justice system.¹⁸⁷

Treating mentally ill people like criminals was a mismatch of epic proportions. It took a bad situation and made it worse.

It is worth pausing to appreciate that none of this was what policymakers intended—the move from one institution to another as a repository for the mentally ill population was a product of benign neglect, not deliberate policymaking. As the former Secretary of

184. TORREY, *supra* note 14, at 35-36 (quoting George Palermo, Maurice B. Smith & Frank J. Liska, *Jails Versus Mental Hospitals: A Social Dilemma*, 35 INT. J. OFFENDER THERAPY & COMP. CRIMINOLOGY 97, 103 (1991)).

185. Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution*, 84 TEX. L. REV. 1751, 1756 (2006); *id.* at 1776 (discussing findings).

186. *See id.* at 1752, 1756, 1776; *see also* PARSONS, *supra* note 21, at 3 (“The asylum did not disappear; it returned in the form of the modern prison industrial complex.”).

187. TORREY, *supra* note 14, at 36 (quoting psychiatrist Marc Abramson); *see also* PARSONS, *supra* note 21, at 3 (“[T]he United States has shifted to a more punitive—but still institutional—approach to social disorder.”).

Health, Education, and Welfare stated: “We got into much of the current mess by acting on the best of intentions without foreseeing the worst of unintended effects.”¹⁸⁸ A team of researchers came to the same conclusion, writing that jails “seemed to have inherited responsibility for these persons by default rather than preference.”¹⁸⁹ Jails supplanted hospitals as a repository for the mentally ill population because they had become the place that could not say no. Police took these people to jail because there was nowhere else for them to go.

That brings us to where we stand now. Today, jails and prisons are the largest residential institutions for severely mentally ill people in the country.¹⁹⁰ In Virginia, for a local perspective, the Hampton Roads Regional Jail houses more severely mentally ill people than the state mental hospital.¹⁹¹ The same is true of forty-three other states and the District of Columbia.¹⁹² In fact, a 2010 study reported that there are now three times as many severely mentally ill people in America’s jails and prisons as in its mental hospitals.¹⁹³ In Florida, that ratio is almost five to one, and in Texas,

188. TORREY, *supra* note 14, at 91 (quoting Joseph A. Califano).

189. *Id.* at 28 (alteration in original) (quoting Glenn Swank and Darryl Winer’s assessment of Denver County Jail); *see also* Lamb & Bachrach, *supra* note 82, at 1042 (noting that “in this era of deinstitutionalization, the criminal justice system has largely taken the place of the state hospitals in becoming the system that can’t say no”).

190. Newt Gingrich & Van Jones, *Mental Illness Is No Crime*, CNN (May 27, 2015, 7:57 AM), <https://www.cnn.com/2015/05/27/opinions/gingrich-jones-mental-health/index.html> [<https://perma.cc/C5FD-EVX4>].

191. *See* Dave Ress, *Hampton Roads Regional Jail: By Default, Virginia’s Largest Mental Hospital*, DAILYPRESS (July 9, 2016, 5:40 PM), <https://www.dailypress.com/2016/07/09/hampton-roads-regional-jail-by-default-virginias-largest-mental-hospital/> [<https://perma.cc/M24M-U7SF>].

192. *See* Gingrich & Jones, *supra* note 190 (“Today, in 44 states and the District of Columbia, the largest prison or jail holds more people with serious mental illness than the largest psychiatric hospital.”); Ana Swanson, *A Shocking Number of Mentally Ill Americans End up in Prison Instead of Treatment*, WASH. POST (Apr. 30, 2015), <https://www.washingtonpost.com/news/wonk/wp/2015/04/30/a-shocking-number-of-mentally-ill-americans-end-up-in-prisons-instead-of-psychiatric-hospitals/> [<https://perma.cc/DA2V-9HZ5>].

193. *See The Criminalization of Mental Illness*, HOGG FOUND. FOR MENTAL HEALTH (Aug. 8, 2011), <https://hogg.utexas.edu/the-criminalization-of-mental-illness> [<https://perma.cc/WLZ5-4C9Y>] (reporting findings of a 2010 50-state survey by the National Sheriff’s Association and the Treatment Advocacy Center that “for every individual with serious mental illness in a psychiatric hospital, three with serious mental illness are in jail or prison”).

it is more than seven to one.¹⁹⁴ As one jail official observed: “We’ve become the bottom-line mental health provider.”¹⁹⁵

Another way to slice the data is to consider the proportion of severely mentally ill people in our nation’s jails and prisons. In 1999, the Department of Justice estimated that 16 percent of all inmates in state and federal jails and prisons suffered from a severe mental illness.¹⁹⁶ Since that time, studies have estimated that 20 percent of the nation’s jail population suffers from a severe mental illness, and 15 percent of the state prison population suffers from a severe mental illness.¹⁹⁷ A 2002 report to Congress estimated that between 16 and 24 percent of all U.S. inmates suffered from severe mental illness.¹⁹⁸

To be clear, this is not to say that deinstitutionalization is responsible for all, or even most, of the current mass incarceration problem. The raw numbers of discharged mental hospital patients do not come anywhere close to explaining the explosive growth of our prison population that *Mass Incarceration Nation* documents,¹⁹⁹ and there are important demographic differences as well. Deinstitutionalization proceeded in a selective fashion, with the elderly, least mentally ill, and those who had families to care for them

194. See *id.* (reporting that the ratio in Texas is 7.8:1); *From Prisons to Hospitals-And Back: The Criminalization of Mental Illness*, PRISON POLY INITIATIVE, <https://www.prisonpolicy.org/searchresults.html?cx=015684313971992382479%3Aa3be84yykbq&cof=FORID%3A11&q=criminalization+of+mentally+ill> [<https://perma.cc/GFE9-DNEK>] (reporting that the ratio in Florida is nearly 5:1).

195. TORREY, *supra* note 14, at 42; see also Pogrebin & Poole, *supra* note 86, at 122 (“To a great extent, the jail has assumed the role of delivering psychiatric services to poor, mentally disturbed offenders.”).

196. See PAULA M. DITTON, BUREAU OF JUST. STAT., SPECIAL REPORT: MENTAL HEALTH AND THE TREATMENT OF INMATES AND PROBATIONERS 3 (1999), <https://bjs.ojp.gov/library/publications/mental-health-and-treatment-inmates-and-probationers> [<https://perma.cc/SKC5-2HSN>].

197. Treatment Advocacy Center, *Serious Mental Illness Prevalence in Jails and Prisons* (Sept. 2016), <https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf> [<https://perma.cc/S7JZ-7375>] (“Overall, approximately 20% of inmates in jails and 15% of inmates in state prisons are now estimated to have a serious mental illness.”); Raphael & Stoll, *supra* note 62, at 192 (“The prevalence of severe mental illness (manic depression, bipolar disorder, or a psychotic disorder) among state prisoners and local jail inmates is very high (nearly 15 percent of each population[]).”); see also Siller, *supra* note 81 (noting that 14.5 percent of men and 31 percent of women in jails suffer from a severe mental illness).

198. Wolff, *supra* note 169.

199. See BELLIN, *supra* note 1, at 13, 28.

discharged first.²⁰⁰ Thus, data on the age, sex, and race of those who were deinstitutionalized in the early years does not map well with the demographics of mass incarceration, which was happening at the same time.²⁰¹

Moreover, the deleterious effects of deinstitutionalization took time—not only because of *who* was being discharged *when*, but also because there was a time lag as the severely mentally ill population moved from state hospitals to seedy hotels and group homes, to life on the street, to the carceral setting.²⁰² These wrinkles are the reason why studies examining the early years of deinstitutionalization found little evidence of transinstitutionalization, while those

200. Raphael & Stoll, *supra* note 62, at 200 (“These changes suggest that deinstitutionalization proceeded in a nonrandom fashion, with institutionalization rates declining first for those who are perhaps the least likely to be transinstitutionalized (for example, women and/or the elderly.)”; *id.* at 209 (“[I]t is likely that deinstitutionalization followed a chronologically selective path, with the least ill and perhaps the least prone to felonious behavior deinstitutionalized first.”); *see also supra* text accompanying note 99 (“Deinstitutionalization started with the ‘easy’ cases—the ones where the person had ‘a place to go.’”).

201. *See* Raphael & Stoll, *supra* note 62, at 200-01 (discussing “several notable differences between the inpatient and correctional populations” and highlighting differences in age, race, and sex of the two populations); *see* Harcourt, *supra* note 185, at 1781 (“Certainly there are important demographic differences. The gender distribution, for instance, ... [t]here were also sharp differences in racial and age composition.”); *id.* at 1783 (“But the demographic distributions changed over time, and this gradual change calls for explanation.”).

202. Kim, *supra* note 62, at 15-16 (“Lagged effects also theoretically account for the temporal process in which mentally ill persons are deinstitutionalized, become homeless, are involved in deviant behaviors, and are subject to arrest and incarceration.”). One study, which found “little evidence to support a straightforward inverse relationship between prison and mental hospital population levels” from 1968 to 1978, explained in its conclusion:

[The evidence suggests] a process whereby changes in the size of each type of institutional population are *indirect*.... [I]nstead of institutionalizing the newly discharged patients, other groups previously in the community—in board and care homes, community residences, and men’s shelters—are arrested and incarcerated. Thus, it is segments of such “buffer” groups that are sent to state institutions.... The local jail populations may be one primary “buffer” group.... Such frontline institutions would be expected to bear the brunt of the initial impact of a large-scale social change such as mental patient deinstitutionalization. When society’s tolerance level for deviants is tested by something such as deinstitutionalization, it may be in local community facilities, such as jails, where the impact is first evident.... Rather than direct relationships between correctional and mental health institutions, it appears that the interrelationships are indirect, mediated by community reaction towards all types of socially marginal groups when the societal tolerance level for deviance is exceeded.

Steadman et al., *supra* note 67, at 489-90.

examining subsequent years showed considerable effects.²⁰³ Indeed, one study considering both early and later time periods reported “a large positive and statistically significant effect” of declining mental hospital populations on prison population growth from 1980-2000, adding that the data “suggests a near one-for-one transfer rate from mental hospital to prisons for white men over this time period.”²⁰⁴ Deinstitutionalization may not be responsible for all (or even most) of our mass incarceration problem, but studies estimate that it accounts for anywhere from 4.5 to 14 percent of the growth in our nation’s incarcerated population.²⁰⁵ That is hundreds of thousands of people.²⁰⁶

Even so, deinstitutionalization may not have been such a carceral disaster if it weren’t for the fact that at the same time we were neglecting outpatient services for this fragile population, we were also expanding the horizontal and vertical footprint of the criminal law, as *Mass Incarceration Nation* so powerfully demonstrates. Simply put, the problem was not only that we failed to provide the community support system that this population so desperately needed; it was also that the criminal law became increasingly severe and rigid, leaving less room for mentally ill offenders to escape the criminal law’s net.²⁰⁷ “Policies that increase the extensiveness and

203. Raphael & Stoll, *supra* note 62, at 211-12, 215-16 (“[W]e conclude that during the early phases of deinstitutionalization, there is no evidence that the declining mental hospital population counts contributed to prison population growth” but finding “a large positive and statistically significant effect of changes in mental hospitalization on incarceration” in the later years).

204. *Id.* at 215-16.

205. Harcourt, *supra* note 185, at 1780; *see also* Raphael & Stoll, *supra* note 62, at 208, 219 (noting that “these tabulations indicate that deinstitutionalization over this period can account for no more than 13 percent of the corresponding growth in incarceration” but when considering gender and race, “our models suggest that the incarceration of those who would have formerly been hospitalized accounts for 7 percent of the prison population growth between 1980 and 2000”).

206. There are currently an estimated 350,000 people with severe mental illness in our nation’s jails and prisons. *See* Treatment Advocacy Center, *supra* note 197 (citing numbers from 2014); *see also* Harcourt, *supra* note 185, at 1780 (estimating that deinstitutionalization accounted for between 48,000 and 148,000 additional state prisoners between 1971-1996 alone); Raphael & Stoll, *supra* note 62, at 219 (“For the year 2000, there [were] 40,000-72,000 incarcerated individuals who in years past would have been mental hospital inpatients.”).

207. *See* PARSONS, *supra* note 21, at 108 (“Yet, the rising numbers of people in prisons and jails were not just the unintended consequences of deinstitutionalization. This criminalization of mental illness also occurred because of new police and prison policies.”); *id.* at 122 (“The wave of law-and-order politics only grew stronger in the 1980s ... making it ever harder to

intensity of the use of prison as punishment will increase the likelihood that an untreated mentally ill person gets caught up in the criminal justice system,” one team of researchers writes, concluding that “[w]hile a significant contributor, mental health policy is of second-order importance when compared with the contribution by shifts in sentencing policy occurring in most states.”²⁰⁸ In short, it was the combination that was so tragic—the free-fall of a population whose essence was disordered thinking just as policymakers were taking an exceedingly punitive approach to social disorder.

So ends our review of the history of deinstitutionalization and its effects. We now know where we have been and where that puts us today. All that remains is to bring these insights back into conversation with *Mass Incarceration Nation*. How does the story I have told enrich Bellin’s account?

III. BACK TO *MASS INCARCERATION NATION*

To be clear at the outset, I do not think *Mass Incarceration Nation* was deficient in some way for not considering the role of deinstitutionalization in our mass incarceration crisis. Mass incarceration is a problem with numerous causes and contours. Bellin’s interest is the role that the *criminal law* played in creating this crisis, and that itself warranted book-length treatment (which, again, was exceptionally well done).

My interest is the role that deinstitutionalization played in our mass incarceration crisis, and in particular, how deinstitutionalization—or, more accurately, our failed implementation of it—intersects with the observations and claims that *Mass Incarceration*

advocate for noninstitutional responses to individuals diagnosed with mental illnesses who also broke the law.”); ROTH, *supra* note 14, at 92 (“People with mental illness have simply been caught up—albeit sometimes in disproportionately higher numbers than the rest of the population—by the same forces that have driven the rise of mass incarceration, among them the War on Drugs, broken windows policing, and mandatory minimum sentencing.”). *See also* Grecco & Chambers, *supra* note 180, at 320 (concluding that the “War on Drugs” exacerbated the propensity of those suffering from mental illness to be caught in the criminal legal system’s snare).

208. Raphael & Stoll, *supra* note 62, at 217, 219. However, the authors go on to say in the next line: “Nonetheless, it is certainly the case that a relatively high proportion of the currently incarcerated mentally ill would not have been incarcerated in years past and would likely be receiving inpatient treatment in a mental health facility.” *Id.* at 219.

Nation makes. In some ways, deinstitutionalization amplifies the points that Bellin makes—it offers a “yes, and.” In other ways, deinstitutionalization complicates the points that Bellin makes—it offers a “yes, but.” In this last Part, I articulate both of these responses.

A. “Yes, And.”

My main response to *Mass Incarceration Nation* falls into the category of “yes, and.” I first explore two macro-level ways that deinstitutionalization has contributed to our mass incarceration crisis, discussing how deinstitutionalization contributed to the punitivism that drove changes in the criminal law and how it powered the modern prison industrial complex. I then engage with Bellin’s book on more of a micro-level, discussing the ways in which deinstitutionalization amplifies a number of the cogent claims that *Mass Incarceration Nation* makes.

1. Macro-Level Effects of Deinstitutionalization

Thus far, my discussion of the impact of deinstitutionalization on our mass incarceration crisis has focused on *people*. Specifically, I have focused on the plight of severely mentally ill people, and what happened when we did not provide the support structures to care for them when they returned to their communities. But deinstitutionalization contributed to our mass incarceration crisis in two other macro-level ways as well.

First, deinstitutionalization fed the punitivism that drove the harsh criminal laws and sentencing policies that are the focus of Bellin’s book. *Mass Incarceration Nation* points to a temporary spike in crime as causing this punitivism,²⁰⁹ and that may well be. But visible disorder in the streets clearly gave rise to a punitivism as well, and this cause was not a temporary blip like the spike in crime. By the early 1980s, episodes of violence by discharged mental institution patients were dominating headlines and stoking fears of crime and chaos.²¹⁰ Mentally ill homeless people were accosting

209. BELLIN, *supra* note 1, at 6.

210. TORREY, *supra* note 14, at 14; *see also* PARSONS, *supra* note 21, at 8 (noting a 1980

people on the subway, urinating in the streets, and masturbating on park benches.²¹¹ They were conspicuous and they were scary, presenting what columnist George Will called “a spectacle of disorder and decay.”²¹² As *Time Magazine* observed in 2005, homelessness—particularly among the mentally ill population—was “a kind of broken social window announcing that suffering and chaos will be tolerated.”²¹³ Their very presence was an indication that “the cycle of urban decay is under way,” *Time* stated, adding ominously, “[a]s formal controls break down, muggers move in, and stable families move out.”²¹⁴

This was precisely what the public feared, and it drove calls for a more punitive approach to social disorder.²¹⁵ Mentally ill people were dangerous—or at least they *could* be, and that was enough for the public at large.²¹⁶ So closely connected was the problem of homeless mentally ill people to the public’s fear of crime that one study of deinstitutionalization was titled “*Fear of the Mentally Ill: Empirical Support for the Common Man’s Response*.”²¹⁷

But deinstitutionalization did more than just populate jails and feed the punitivism that drove changes in the criminal law—it also powered the rise of the modern prison industrial complex. As historian Anne Parsons has persuasively shown, deinstitutionalization—or more to the point, our failure to provide services for mentally ill patients upon their discharge—was part of a larger

Philadelphia news story titled “Keeping the Maniacs off the Streets,” which fueled public anxiety following its account of a man who killed someone shortly after being freed on probation from a state mental hospital).

211. See TORREY, *supra* note 14, at 64, 68 (describing various accounts of disturbances caused by mentally ill homeless people on the streets of Ocean Grove, New Jersey, and New York City in the wake of deinstitutionalization).

212. ISAAC & ARMAT, *supra* note 20, at 336 (quoting George Will).

213. Charles Krauthammer, *When Liberty Really Means Neglect*, TIME MAG. (June 21, 2005), <https://content.time.com/time/subscriber/article/0,33009,1074776-4,00.html> [<https://perma.cc/Z48H-ACNQ>].

214. *Id.*

215. See PARSONS, *supra* note 21, at 125-26.

216. See TORREY, *supra* note 14, at 60 (“What is perhaps most striking about media accounts, however, is how strongly they reinforce the public’s association of violent acts with severe mental illnesses.”); *id.* (“Recent research data on contemporary populations of ex-mental patients supports these public fears [of dangerousness] to an extent rarely acknowledged by mental health professionals.”) (alteration in original) (statement of psychologist Henry Steadman).

217. *Id.*

reallocation of public funds away from health and welfare programs and towards the criminal legal system.²¹⁸ Allowing social welfare programs to languish freed up money to spend on other priorities, like policing, jails, and prisons.²¹⁹ As jails and prisons housed more and more severely mentally ill people, officials came to realize that they needed specialized psychiatric units to handle their new cohort of prisoners, so they added mental health wards and hired psychiatrists, further investing in these carceral spaces.²²⁰ In the end, deinstitutionalization and its failed implementation siphoned money away from mental health services and invested it in jails and prisons, paving the way for the nation's newest growth industry: the carceral state.²²¹

As a striking example of how deinstitutionalization powered the modern prison industrial complex, Parsons notes that a number of abandoned state mental hospitals have literally been repurposed into correctional facilities.²²² It was far cheaper for states to utilize an existing infrastructure than build from scratch, she explains, and most mental hospitals were located on large swaths of land in rural communities that welcomed the work.²²³ At least seventy former state medical and mental health institutions have been converted to state correctional facilities nationwide.²²⁴ Incredibly, some of these correctional facilities have been designated to house “prisoners with special needs,” including severe mental illness.²²⁵ The cells of these former mental institutions have gone back to holding their original clientele, but as part of the modern prison industrial complex instead.

218. See PARSONS, *supra* note 21, at 7-8, 17.

219. *Id.* at 6-8, 125-26.

220. See *id.* at 107-08, 125, 147.

221. See *id.* at 125-26.

222. *Id.* at 146-47 (listing correctional institutions built on the sites of former mental institutions, developmental centers, and tuberculosis sanatoria).

223. See *id.* at 9, 142-45.

224. *Id.* at 145.

225. *Id.* at 144 (quoting Pennsylvania Governor Thornburgh).

2. *Micro-Level Effects of Deinstitutionalization*

Reading *Mass Incarceration Nation* with deinstitutionalization in mind, I found myself thinking *Bellin is right, even more right than he knows*. In a number of areas, considering the severely mentally ill population just exacerbates the micro-level problems of mass incarceration that Bellin explores in the book. In this section, I briefly name five of these areas to accentuate the story that *Mass Incarceration Nation* tells.

I start with the book's discussion of the futility of particularly harsh criminal laws. *Mass Incarceration Nation* identifies a paradox: increasingly severe criminal laws should, in theory, make crime increasingly unattractive and thus lead to less crime and less incarceration, but as Bellin notes, "that didn't happen."²²⁶ *Mass Incarceration Nation* explains why, showing that the American criminal legal system is not particularly good at deterrence.²²⁷ "The biggest obstacle," Bellin writes, "is that the odds of getting caught for most crimes are low."²²⁸ Another reason, he says, is that "people who commit crimes often aren't thinking rationally. They are angry, scared, or under the influence of drugs and alcohol."²²⁹ Yes to this. In fact, yes to the "odds of getting caught" point too.

I would just add that yet another reason why some people who commit crimes are not thinking rationally is that they are not rational thinkers from the start. People who suffer from severe mental illness are not going to respond to an increase in the horizontal and vertical footprint of the criminal law in the way that deterrence theory presupposes they will.²³⁰ By definition, these

226. BELLIN, *supra* note 1, at 68 ("Politicians didn't sell a war on crime as a way to fill prisons. They claimed that aggressive enforcement and severe penalties would make these crimes go away. But that didn't happen.")

227. *Id.* at 5 ("Deterrence—preventing crime through punishment—works when people expect to be caught. That's not the system we've built."); *id.* at 68 ("[T]he American criminal justice system isn't good at deterrence.... All the penalties in the world have only a marginal impact on crime unless people expect to be caught.")

228. *Id.* at 68.

229. *Id.*

230. See AM. BAR ASS'N, DEATH PENALTY DUE PROCESS REVIEW PROJECT, SEVERE MENTAL ILLNESS AND THE DEATH PENALTY 26 (2016), https://www.americanbar.org/groups/crsj/projects/eath_penalty_due_process_review_project/severe-mental-illness-initiative/resources/ ("[A]ny possible deterrent effect is ... diminished among people who, as with people [with] intellectual disability, have a 'diminished ability to understand and process information, to learn from

people have severe impairments in mental functioning,²³¹ so any theory of deterrence that relies on mental functioning is not going to work on people who are severely mentally ill.

Next, *Mass Incarceration Nation* points to the enormous cost of mass incarceration. As Bellin notes, between 1980 and 2013, annual spending for federal corrections alone grew from under \$1 billion to almost \$7 billion.²³² Now add the cost of incarcerating people with severe mental illness to the mix. In 1996, the Department of Justice reported that it cost taxpayers a staggering \$15 billion per year to house people with serious psychiatric disorders in America's jails and prisons—around \$50,000 per person, multiplied by an estimated 300,000 mentally ill prisoners.²³³ A study of Florida's jails and prisons estimated that it costs \$40,000 per year to provide minimum care for a mentally ill person in jail, and \$60,000 per year to provide minimum care for a mentally ill person in prison.²³⁴ By contrast, the study estimated that it would cost around \$20,000 per person, per year, to provide intensive community mental health treatment for the mentally ill population.²³⁵ “We’ve really just re-allocated the money into a different type of spending that’s actually more expensive,” one policymaker stated.²³⁶ “The way we spend money now is ludicrous,” one judge says of the way mental illness is treated.²³⁷ A local sheriff agreed, stating: “Just think about how financially and fiscally dumb it is.”²³⁸

Then there is the terrible damage that incarceration does to the people who are subject to it. *Mass Incarceration Nation* does an especially depressing job of reminding us of “the deprivation of

experience, to engage in logical reasoning, or to control impulses.” (quoting *Atkins v. Virginia*, 536 U.S. 304, 320 (2002)).

231. See *supra* notes 9-12 and accompanying text.

232. BELLIN, *supra* note 1, at 11.

233. E. Fuller Torrey, *Criminalization of Individuals with Severe Psychiatric Disorders*, MENTAL ILLNESS POL’Y ORG., <https://mentalillnesspolicy.org/consequences/criminalization.html#:~:text=The%20best%20studies%20suggest%20that,prisons%20at%20any%20given%20time> [https://perma.cc/69RB-BSF2].

234. PRISON POL’Y INITIATIVE, *supra* note 194.

235. *Id.*; see also Torrey, *supra* note 233 (noting that incarcerating the severely mentally ill costs twice as much as treating them through community treatment programs).

236. Ford, *supra* note 23 (quoting executive director of NAMI Greater Chicago Alexa James).

237. ROTH, *supra* note 14, at 186 (quoting Steve Leifman, a Miami-Dade County judge).

238. Ford, *supra* note 23 (quoting Cook County Sheriff Tom Dart).

incarceration”—the host of harms that mass incarceration inflicts on the 2.2 million people in our prisons and jails.²³⁹ “It is no small thing to lock up a human being,” Bellin writes, recounting story after story of abuse and hardship, while noting “countless other instances of human misery that never find their way into the pages of books.”²⁴⁰

Now consider the fact that 15 to 20 percent of the population in these carceral spaces suffers from a severe mental illness.²⁴¹ Jails and prisons are notoriously dangerous places for severely mentally ill people, who are at a high risk of being victimized by other inmates.²⁴² “We try to keep them separated,” one jail official states, “but lack of room sometimes prohibits this.”²⁴³ In addition, jails and prisons are regimented, rule-driven places that punish noncompliance, and severely mentally ill people are especially susceptible to being caught in the noncompliance net.²⁴⁴ A study of Ohio prisons in 1994 found that hundreds of mentally ill prisoners had been “abandoned in isolation units for violating prison rules they were incapable of comprehending,” noting that more than 20 percent of the 1,877 prisoners languishing in punishment cells were mentally ill.²⁴⁵ As one federal judge observed, placing a mentally ill person in

239. BELLIN, *supra* note 1, at 17, 19.

240. *Id.* at 19.

241. Treatment Advocacy Center, *supra* note 197. For an excellent in-depth discussion of just how damaging incarceration is for those who are mentally ill, see generally ROTH, *supra* note 14.

242. See TORREY, *supra* note 14, at 31-33 (explaining that inmates with mental illness are more vulnerable to abuse, assault, and rape, by both other inmates and guards; quoting one jail official as saying, “[t]he bad and the mad just don’t mix.”); ISAAC & ARMAT, *supra* note 20, at 282 (“Putting [the mentally ill] in with the general prison population would be like sacrificing them to a wild angry mob.” (quoting former inmate Jay Centifanti)); Stavis, *supra* note 61, at 183 (“Mentally ill prisoners are not only inherently vulnerable to abuse, but they are also often provocatively irritating and offensive to other prisoners and prison guards.”).

243. TORREY, *supra* note 14, at 32.

244. *Id.* at 31; Raphael & Stoll, *supra* note 62, at 220; see also Natalie Bonfine, Amy Blank Wilson & Mark R. Munetz, *Meeting the Needs of Justice-Involved People with Serious Mental Illness Within Community Behavioral Health Systems*, 71 PSYCHIATRIC SERV. 355, 357 (2020) (“[Mentally ill people] remain incarcerated for longer periods for the same charges, are more likely to be viewed as noncompliant, and have more difficulties with correctional or jail staff and other inmates while incarcerated.”); Wolff, *supra* note 169 (noting the higher frequency of rule violations among inmates with mental illness compared to other inmates).

245. TORREY, *supra* note 14, at 84 (quoting report).

an isolation cell is “the mental equivalent of putting an asthmatic in a place with little air to breathe.”²⁴⁶

Yet even outside the isolation cell setting, jails and prisons are wildly inappropriate places to house people who are severely mentally ill (and this is setting aside the immorality of criminalizing mental illness in the first place). Jails and prisons are harsh, inherently punishing places, and the mentally ill population is the least equipped to endure in those carceral spaces. Incarceration has been shown time and again to exacerbate the symptoms of mental illness, trigger psychotic episodes, and cause mentally ill prisoners to suffer extreme distress.²⁴⁷ As one jail official put the point: “If you have someone diagnosed with a mental illness, can you think of a worse place to put them than a jail?”²⁴⁸

Incarceration makes sick people sicker, and jails and prisons are not equipped to deal with the fallout or serve as surrogate mental hospitals. “Jails and prisons are not designed or operationalized for the caretaking that comes with housing the mentally ill,” one report explains, adding: “They often do not have the resources, staff or budgets that are required to meet the needs of the incarcerated who have serious mental illnesses.”²⁴⁹ *Mass Incarceration Nation* tells appalling stories of what happens to people in our jails and prisons. Sadly, the stories of what happens to severely mentally ill prisoners in those places are more horrifying yet.²⁵⁰

246. *Id.* at 35.

247. *See id.* at 34-35; ROTH, *supra* note 14, at 189 (noting that jails are “psychogenic—that is, psychosis-inducing”); PRISON POLY INITIATIVE, *supra* note 194.

248. Ford, *supra* note 23 (quoting Cook County Sheriff Tom Dart).

249. Siller, *supra* note 81; *see also* PARSONS, *supra* note 21, at 1 (“America’s prisons have become our new asylums—only worse, because they’re not equipped to handle the needs of people in psychiatric crisis.” (quoting Ronnie Polaneczky of the *Philadelphia Daily News*)); Steadman et al., *supra* note 67, at 476 (noting that the population of severely mentally ill in our prisons “presents special management needs that prisons are ill-equipped to meet”); ROTH, *supra* note 14, at 111-21 (discussing shortage in corrections officers generally, and how that shortage has “catastrophic effects” on mentally ill prisoners).

250. *See* ROTH, *supra* note 14, at 132-35, 140 (discussing instances of inmates dying of starvation, being scalded to death, and amputating their body parts and eating them). Harcourt, *supra* note 31, at 72 (“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. Another inmate, schizophrenic, gouged his eyes out after waiting weeks for transfer to a mental hospital in Clearwater, Florida.”) (citations omitted).

Next is *Mass Incarceration Nation's* discussion of recidivism. Repeat offenders are “the norm,” Bellin writes, showing in no uncertain terms that recidivism “is a critical and often overlooked element of Mass Incarceration.”²⁵¹ Bellin’s focus is the underappreciated impact of probation and parole revocations on the surging number of prison admissions,²⁵² but if we *really* want to talk about recidivism, we should talk about people who are severely mentally ill. People who suffer from a mental disorder, regardless of the severity of the diagnosis, have recidivism rates between 50 to 230 percent higher than the general population.²⁵³

Bellin writes about the “revolving door” of jails and prisons,²⁵⁴ but researchers writing on mental illness are talking about how this same revolving door swings especially fast for the severely mentally ill population.²⁵⁵ “We in the criminal justice system use the expression ‘life on the installment plan’ to describe the cycle,” one policy analyst says, explaining:

Offenders would commit low level crimes and be incarcerated. Jail or prison for many [meant] stabilization through regular sleep, food, hopefully no alcohol or drugs, and for some, much needed mental health treatment. Then, they’d be released. Back on the streets, they would decompensate, get arrested again and continue to serve life on the installment plan. The connection between deinstitutionalization and incarceration is all too obvious.²⁵⁶

In the end, the problem is not just the fact that mentally ill people have a much higher rate of reoffending (although stories are legion of mentally ill people reoffending, including some being arrested over *100 times*).²⁵⁷ The problem is also that by cycling through the

251. BELLIN, *supra* note 1, at 141, 146.

252. *See id.* at 147.

253. *See* Wolff, *supra* note 169. *See also* ROTH, *supra* note 14, at 226 (noting that just over 1 percent of people account for 20 percent of arrests, and that among the characteristics that they have in common, one is severe mental illness).

254. BELLIN, *supra* note 1, at 37.

255. PARSONS, *supra* note 21, at 123; Chaimowitz, *supra* note 19, at 4; PRISON POL’Y INITIATIVE, *supra* note 194; Pogrebin & Poole, *supra* note 86, at 125; Ford, *supra* note 23.

256. Pierson, *supra* note 165.

257. *See* TORREY, *supra* note 14, at 25; ROTH, *supra* note 14, at 209.

criminal legal system without getting the mental health services that they need, severely mentally ill people are especially susceptible to being treated more harshly under habitual offender statutes.²⁵⁸ Here again, it is the combination that is the killer—the mix of a revolving door population with revolving door policies designed to catch more people in the criminal law’s net.

Fifth and finally, *Mass Incarceration Nation* talks about the “mindlessness of jail”—the fact that almost two-thirds of the people sitting in jail are not even there as punishment, but rather are just waiting for trial.²⁵⁹ But jail is especially mindless for the severely mentally ill population—not just because it is a punitive response to a medical problem, but also because severely mentally ill people are even *more* likely to be held in jail for reasons other than punishment. A study from 1992 found that almost one-third of American jails were holding at least one inmate with no charges against them whatsoever; these were mentally ill people being held for a psychiatric evaluation, mental hospital bed, or transportation to a mental hospital.²⁶⁰ In 1990, Idaho officials estimated that the state’s jails that year held approximately 300 people who had not been charged with any crime, but rather were waiting for a psychiatric referral, with the average time of incarceration being five days.²⁶¹

Experts say this phenomenon is common, particularly in states starved for mental health services.²⁶² “I have had mentally ill inmates in paper gowns in holding cells for close observation for up to six weeks before we could find a hospital bed for them,” a sheriff in Florida confided.²⁶³ Now add in the time it takes for competency evaluations, and the fact that some jail stays are more about mercy bookings than crime, and one begins to see just how astonishingly mindless our use of imprisonment for the mentally ill truly is.

All this is to say that considering the severely mentally ill population in our nation’s jails and prisons just adds to many of the persuasive points that *Mass Incarceration Nation* makes. That said,

258. See Pogrebin & Poole, *supra* note 86, at 125.

259. BELLIN, *supra* note 1, at 157-58.

260. See TORREY, *supra* note 14, at 37.

261. *See id.*

262. *See id.*

263. *Id.*

it also complicates some of the points that the book makes, and in the last section of this Article, I explain how.

B. “Yes, But.”

The “*Yes, but*” part of my response to *Mass Incarceration Nation* is quite brief. Here, I have just two points to make. One is discrete and concrete; the other is more broad and consequential. My first point—the one that is discrete and concrete—regards the dichotomy of criminal offenses that *Mass Incarceration Nation* delineates. Bellin breaks down the criminal law into two large categories of offenses: serious violent crimes on the one hand, and offenses that serve more policy-based, regulatory goals on the other.²⁶⁴ To reduce mass incarceration, he writes, “We can dramatically cut back on this second system, while preserving, and moderating the severity of, the first.”²⁶⁵ As noted in my introductory comments, I think Bellin is right in pointing out the dichotomy that marks the expansion of the criminal law’s footprint in the 1970s. Recognizing this dichotomy also does important work in helping us understand the complex role of race in mass incarceration.²⁶⁶

But the severely mentally ill population is a bit unwieldy when thinking about how it intersects with this dichotomy. In part, this is to be expected—Bellin’s focus is the criminal law, whereas mine is a population that is especially susceptible to being caught up in it. But in part, this is also a reflection of the fact that the dichotomy does not quite work when the criminal law is serving a multitude of purposes that cut across the clean lines that Bellin delineates. As we now know, some arrests of people who suffer from severe mental illness are a response to public demands to do something about disorder in the streets.²⁶⁷ Some are mercy bookings to get severely mentally ill people access to food, shelter, and psychiatric services.²⁶⁸ And some are an attempt to protect the public from mentally ill

264. See *supra* notes 4-5 and accompanying text.

265. BELLIN, *supra* note 1, at 163.

266. See generally BELLIN, *supra* note 1, at 77 (Chapter 9: The Role of Race).

267. See *supra* notes 133-41 and accompanying text.

268. See *supra* notes 152-58 and accompanying text.

people who are prone to violence but do not meet the extremely high threshold of current involuntary commitment statutes.²⁶⁹

In the context of the current discussion, this last point is especially important. To be clear, most mentally ill people are not dangerous. In fact, people who suffer from severe mental illness are much more likely to be the victims of violent crime than its perpetrators.²⁷⁰ But some mentally ill people are extremely dangerous and prone to violence. Indeed, data suggests that the rate of violence among the mentally ill population is around ten times that of the general population, and that the more severe the mental illness, the more likely a person is to exhibit violent behavior.²⁷¹ Yet involuntary commitment statutes require a showing of imminent danger, and showing that a danger is imminent (at least before it actually comes to fruition) is exceedingly hard.²⁷² In a world where the showing for involuntary commitment is so hard to meet, arresting for a trivial offense may be the only way the police have to protect the public (and family members) from violent offenses.²⁷³ In short, when it

269. See *infra* notes 270-72 and accompanying text.

270. See AM. BAR ASS'N, *supra* note 230, at 7 (“Less than 3 to 5% of crimes involve people with mental illness as defendants while people with severe mental illness are 11 times more likely to be victims of a violent crime than the general population.”); Corinna Barrett Lain, *Madison and the Mentally Ill: The Death Penalty for the Weak, not the Worst*, 31 REGENT U. L. REV. 209, 218 (2019); see also Wolff, *supra* note 169 (noting that people who suffer from schizophrenia have victimization rates 65 percent to 130 percent higher than the general public).

271. See TORREY, *supra* note 14, at 45-46; see also *id.* at 54 (“There are some ticking time bombs out there.” (quoting the director of the Center of Forensic Psychiatry)). As a data point, the severely mentally ill comprise around one-third to one-half of the capital murderers executed every year. See Lain, *supra* note 270, at 228. As another, nearly one-fourth of all police shootings that result in death involve a person with mental illness. See DORIS A. FULLER, H. RICHARD LAMB, MICHAEL BIASOTTI & JOHN SNOOK, *OVERLOOKED IN THE UNDERCOUNTED: THE ROLE OF MENTAL ILLNESS IN FATAL LAW ENFORCEMENT ENCOUNTERS 1* (Treatment Advocacy Center Office of Research & Public Affairs 2015).

272. See ISAAC & ARMAT, *supra* note 20, at 346 (“In practice, this standard does not even contain the dangerous effectively. As psychiatrist Steven Zavodnick puts it: ‘You’ve got to grab the patient between the time [he] fires the gun and the bullet hits the victim—and just hope he’s not a good shot.’”) (alteration in original); Stavis, *supra* note 61, at 192 (discussing “the impractical situation and sometimes-deadly dilemma” that the imminent danger standard creates, forcing others into “a waiting game until the person deteriorates or commits a dangerous act”); *id.* at 193 (“Proving ‘dangerousness’ is difficult and often impossible because it essentially involves an unscientific guessing game about future human behavior.”).

273. See TORREY, *supra* note 14, at 40 (“In Massachusetts, the mother of a man with schizophrenia wrote: ... Rather than wait for the patient to become so psychotic that disaster occurs, many families bring charges against a patient for making threats or damaging

comes to people who are severely mentally ill, the distinction between the work that some types of arrests are doing versus others is not as clean as one might think.

This is not so much a criticism as it is an observation: Bellin's core insight (which, again, does important work elsewhere) does not churn much water in telling us how, if at all, the criminal law should intersect with this sizeable slice of the mass incarceration population. Bellin treats trivial offenses as, well, trivial offenses. *Fair enough*. But when we consider the severely mentally ill population, this misses the fact that arrests for trivial offenses may be the only way to accomplish some very non-trivial things.

This brings me to my second and broader point, which goes to Bellin's policy prescription. To ameliorate the mass incarceration problem, *Mass Incarceration Nation* proposes that we turn back the clock on criminal law and go back to the 1970s, when incarceration was largely reserved for serious offenses.²⁷⁴ "Simply put," Bellin writes, "we can look at what changed between the 1970s and today and, with respect to incarceration, change things back to the way they were."²⁷⁵

For the record, I would love to go back to the 1970s. I *loved* the 1970s. In fact, I am probably the only one at this symposium who was even around in the 1970s (or at least the only one old enough to remember).

But I fear that turning back the clock on the criminal law's expansion is not the panacea that it seems. Changes in the criminal law were not the only thing that got us into this mess, and changes in the criminal law will not be the only thing that gets us out of it. Bellin writes that "it takes a village to incarcerate someone" and we

property. We have done this."); see also Roth, *supra* note 15 ("Judges have told me repeatedly that they fear offering bail or other alternatives to people with mental illness lest the person in question end up on the front page after committing some heinous crime.").

274. See BELLIN, *supra* note 1, at 163 (advocating that we "return the country to a criminal justice system not unlike the model that existed up until the 1970s. All that is needed is to undo the changes described in Parts II and III, recasting those Parts as a blueprint for reform").

275. *Id.* at 7; see also *id.* at 169 ("But we know that every State can return to its 1970s levels of incarceration, because they have been there before. The blueprint is clear. Parts II and III identified the changes that generated Mass Incarceration. Getting back to the 1970s requires reversing those changes.").

need to dismantle it.²⁷⁶ Yes, but when it comes to the severely mentally ill, it also takes a village *not* to incarcerate someone, and we need to build it. Bellin writes that “[a]s long as serious crimes are prevalent in our society, we need a place where people can go for justice—an alternative to vigilantism and civil disorder.”²⁷⁷ Yes, but so long as severe mental illness is prevalent in our society, we also need a place where people can go for mental health services—an alternative to jails and prisons. Bellin writes that we should be thinking about whether incarceration is the right tool for addressing society’s most pressing problems.²⁷⁸ Yes, but we should also be thinking about what happens when incarceration is the *only* tool for addressing society’s most pressing problems. Bellin writes that “[t]he easiest reform is doing nothing more often.”²⁷⁹ Yes, but when it comes to people who are severely mentally ill, doing nothing is the one thing we cannot do. To end mass incarceration, we have to do something about severely mentally ill people too.

We have to do something about mental illness in order to address mass incarceration not only because our current approach has resulted in severely mentally ill people pouring into our jails and prisons. We have to do something also because the perceived danger of this population was part of what drove the punitivism that led to the criminal law’s expansion in the first place.²⁸⁰ If we do not address the crisis of severe mental illness, we will continue to feed the public’s fear of crime and disorder in the streets, allowing politicians to capitalize on it and push for punitive responses. Bellin cannot turn back the clock when the most politically expedient thing to do is to continue to ride the wave of punitivism.

What, then, does it look like to “do something” in this scenario? It looks a lot like the integrated, wrap-around community mental health services that people assumed would follow deinstitutionalization, but did not. Successful community care for the severely mentally ill population would require an extensive array of mental

276. *Id.* at 184.

277. *Id.* at 167.

278. *See id.* at 187 (“The question policy makers need to revisit is whether the criminal courts and especially incarceration are the right tools to addressing [society’s problems].”).

279. *Id.* at 184.

280. PARSONS, *supra* note 21, at 2-3.

health services. It would require medication management, individualized outpatient treatment plans, mobile crisis intervention teams, social and vocational programs, attention to dual diagnoses, and a wide range of affordable housing with differing degrees of support and supervision, buttressed by other social services.²⁸¹ In short, it would require *comprehensive, continuous, coordinated* care.

That means it would take money (although again, we are already spending the money, we just are not spending it wisely). What experts say we need is an entire *system* of mental health care, and as one team of researchers reports: “Providing for the enormous range of needs of chronic patients in the community, who with treatment become better but not well, may not be as costly as state hospital beds, but does not come cheap.”²⁸²

And that means what it would *really* take is commitment. We have to decide as a society that spending money to help people who are severely mentally ill live in their communities is worth more than the quick fix of locking them up. Or more accurately, we have to decide that it is worth more than the quick fix of doing nothing,

281. See TORREY, *supra* note 14, at 196-200 (listing policy recommendations for care of the severely mentally ill); see also ROTH, *supra* note 14, at 203-05; PARSONS, *supra* note 21, at 7; ISAAC & ARMAT, *supra* note 20, at 329-33; Lamb & Bachrach, *supra* note 82, at 1041-44; Bonfine et al., *supra* note 244, at 361 (proposing an “integrated community-based behavioral health system” designed to “address the clinical, criminogenic, and social support services needs of people with serious mental illness who are involved in the justice system”); see also PARSONS, *supra* note 21, at 155 (recommending that “we work to make affordable and accessible housing, medical and mental health care, and social services available to people with psychiatric disabilities—providing a state response at the point of need rather than at the point of lawbreaking”).

So clear is the need to provide services to reduce incarceration as a response to mental illness that the scholarship has now come full circle, referring to deinstitutionalization as removing people from prisons and urging that policymakers provide the mental health services in the community to support it. It is the Penrose theory redux. See Beverly D. Frazier, Hung-En Sung, Lior Gideon & Karla S. Alfaro, *The Impact of Prison Deinstitutionalization on Community Treatment Services*, HEALTH & JUST., May 2015 at 1, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5151559/> [<https://perma.cc/98GH-YXGK>] (“[A] decrease in prison population will not go without a corresponding increase in community mental health and substance abuse services. Social voids like those created by deinstitutionalization must be filled; and with states deinstitutionalizing offenders the toll is on their corresponding communities to address the needs of those offenders who are reentering after being incarcerated. In devising a policy and practice strategy to address the projected increase in the reentry population, leadership within communities for social and supportive services to ex-prisoners, specifically treatment services should be of primary concern.”).

282. ISAAC & ARMAT, *supra* note 20, at 344.

which leaves the severely mentally ill population all too often homeless and untreated, leading to the longer fix of locking them up.²⁸³

It would also require changes in the law—and not just the changes that *Mass Incarceration Nation* has in mind. The consensus within the mental health community is that there needs to be a legal status between involuntary commitment in a psychiatric hospital, and total freedom in the community.²⁸⁴ “The state can make the psychiatric services as attractive and convenient as possible,” one pair of researchers observes, “but there will still remain a sizeable hard core of individuals who refuse treatment because they believe that nothing is wrong with them.”²⁸⁵ As another researcher puts the point: “There is no getting away from the reality that *judgment is impaired in mental illness....* The virtually voluntary system of mental health care we have tried to implement over the last thirty years is a proven failure.”²⁸⁶

To address this problem, mental health experts recommend limited guardianships just for medication and outpatient treatment, hybrid-style outpatient commitments, and compulsory medication and/or treatment court orders.²⁸⁷ They also recommend a new legal standard for compulsory mental health care that is focused less on imminent danger and more on whether the person is capable of understanding the risk that their mental illness poses to their health and safety.²⁸⁸

283. See Rothman, *supra* note 57, (“Ultimately, it is not greater coercion or a new kind of administrative structure that we need so much as a commitment to meet our responsibilities to those in need of care.... For the mentally ill are unlikely ever to wield enough influence by themselves.”).

284. See ISAAC & ARMAT, *supra* note 20, at 309-16, 331; TORREY, *supra* note 14, at 157-61.

285. ISAAC & ARMAT, *supra* note 20, at 310 (quoting Fuller Torrey and Sidney Wolfe); *id.* (“The part of their brain which allows a normal person to check beliefs against reality is damaged and the only way they will ever be treated is involuntarily.”) (quoting Torrey and Wolfe); Stavis, *supra* note 61, at 190-91 (noting that around half of those who suffer from severe mental illness have a condition called “anosognosia,” which is the impaired ability to even recognize that they have mental illness and need help for it).

286. ISAAC & ARMAT, *supra* note 20, at 331, 346; *see also id.* at 347 (quoting psychiatrist Richard Lamb as saying, “[w]e need to come to terms with the fact that we can’t maintain all the severely ill in the community, at least not freely in the community”).

287. See TORREY, *supra* note 14, at 157-61, 197 (discussing possibilities); ISAAC & ARMAT, *supra* note 20, at 310-16, 331-32; Stavis, *supra* note 61, at 198-202.

288. See TORREY, *supra* note 14, at 157-61, 197; ISAAC & ARMAT, *supra* note 20, at 310-16, 331-32; Stavis, *supra* note 61, at 198.

Experts in the field also recommend changes pertaining to those who enforce or otherwise implement the criminal law. Police need better training on how to respond to people in psychiatric distress, and they need more options for what to do when a mentally ill person needs to be removed from their surroundings.²⁸⁹ Emergency dispatchers need a staff of mental health providers who can accompany the police to mental health crisis calls or answer those calls without the police as part of a crisis intervention team.²⁹⁰ And courts need more mental health dockets and diversion programs.²⁹¹

Yet even if we did every one of these things, we would still need more beds in psychiatric hospitals. As it turns out, anti-psychotic drugs do not work well for around 10-20 percent of the severely mentally ill population, so long-term inpatient care continues to be a need for a sizable minority of those who suffer from severe mental illness.²⁹² As one research paper observes: “[t]here remains a minority of persons who have chronic and severe mental illness who need highly structured, 24-hour care, often in locked facilities, and these individuals must not be overlooked.”²⁹³ Experts estimate that states need around 50 beds per 100,000 people to accommodate the cohort of severely mentally ill people who need acute and long-term care.²⁹⁴

289. See ROTH, *supra* note 14, at 236-54 (discussing need for specialized training for police and the success of various training programs). Over 2,500 communities across the country have implemented crisis intervention team programs, teaching officers how to respond to psychiatric emergencies. Some jurisdictions, like St. Paul, Minnesota, send mental-health workers along with police officers. In Eugene, Oregon, unarmed social workers and medics respond to mental health crises rather than police officers. See Roth, *supra* note 15; see also Chaimowitz, *supra* note 19, at 5 (noting increasing recognition that police need better training in crisis management and better options for when they arrive at the scene). For an insightful discussion of the need for police to coordinate with mental health professionals and receive training on how to best respond to mental health-related calls, see generally H. Richard Lamb, Linda E. Weinberger & Walter J. DeCuir, *The Police and Mental Health*, 53 PSYCH. SERVS. 1266 (2002).

290. See Roth, *supra* note 15.

291. See *id.* (“In the more than 300 mental-health courts across the country, people who agree to certain conditions—usually treatment, including medication and regular check-ins with a judge—can avoid jail and prison time.”); Chaimowitz, *supra* note 19, at 5 (noting creation of diversion programs and mental health courts in Canada).

292. See ISAAC & ARMAT, *supra* note 20, at 344; TORREY, *supra* note 14, at 5-6.

293. Lamb & Bachrach, *supra* note 82, at 1044; ROTH, *supra* note 14, at 197-98.

294. See Daniel Yohanna, *Deinstitutionalization of People With Mental Illness: Causes and Consequences*, 15 AMA J. ETHICS 886, 886 (2013), <https://journalofethics.ama-assn.org/article/deinstitutionalization-people-mental-illness-causes-and-consequences/2013-10> [<https://perma.cc/Q23F-V3QK>]. Ironically, a large percentage of those beds are taken by

As it stands now, states have an average of 14 psychiatric beds per 100,000 people, and in some states, that number is just *five*.²⁹⁵

To be fair, *Mass Incarceration Nation* is not at odds with any of these recommendations. One might shrink the footprint of the criminal law *and* do all the things I have listed here. In fact, in one place, Bellin hints at wanting to do just that, noting that Seattle’s diversion program bypasses arrest for a number of low-level street crimes, and instead “connects [people] with intensive case managers who can provide crisis response, immediate psychosocial assessment, and long term wrap-around services including substance use disorder treatment and housing.”²⁹⁶ But that is as close as *Mass Incarceration Nation* gets to addressing the mental health crisis (again, the book’s focus is on the *law’s* role in mass incarceration, so this is not a criticism or surprise) and even Seattle’s diversion program comes nowhere close to the sort of comprehensive community mental health services that experts say are so desperately needed. But it is certainly a step in the right direction.

In the end, even my “*yes, but*” is more of a “*yes, and.*” Bellin’s larger point is that we should look at the past and see what we did wrong—and if we could just undo that, we would (or could) make substantial strides toward ending our mass incarceration crisis. “[M]ostly we need to just stop doing things that make the problem worse,” he writes in the concluding paragraph of the book.²⁹⁷ *Yes to that.* “The clearest path to recovery from Mass Incarceration,” he writes in the next line, “is to stop doing the things we started doing after the 1970s that increased incarceration.”²⁹⁸ *A hearty yes to that too.* My point is simply that our failed implementation of deinsti-

“forensic patients”—people who have been sent to a psychiatric hospital from the criminal justice system because they have been found to be incompetent to stand trial. ROTH, *supra* note 14, at 199 (“Numerous states report that a large percentage of patients in state hospitals today comprises people who have been found incompetent to stand trial and have been sent to those institutions by the courts to be restored to sanity.”). See also ISAAC & ARMAT, *supra* note 20, at 344 (“If enough programs were created in the community, including highly structured ones (in essence mini-institutions), the need for hospital beds would decline. But while that would cut hospital costs eventually, in the short run *both* would have to be available.”).

295. See Yohanna, *supra* note 294.

296. BELLIN, *supra* note 1, at 185 (quoting Seattle government website’s description of its prearrest diversion program).

297. *Id.* at 195.

298. *Id.*

tutionalization offers a number of lessons in this regard—not just about the needs of those who suffer from severe mental illness, but also about the necessity of funding programmatic initiatives and getting community stakeholders on board on the front side of community-based reentry programs. The lessons of deinstitutionalization’s failures can inform how our *decarceration* story plays out, allowing for a better outcome than the one marred by the mistakes of our past.

How fitting that the last part of Bellin’s book—the part that offers his roadmap for reform—is titled “The Road to Recovery.”²⁹⁹ As a final “*yes, and,*” I would just tweak that a tad so that it reads “The Road to Recovery Includes Mental Health.” For a book about law, *Mass Incarceration Nation* appears to have been quietly in conversation with this issue all along.

CONCLUSION

It has been said that the road to hell is paved with good intentions, and our failed implementation of deinstitutionalization is Exhibit A for that proposition being true. Bellin looks to the past to fix the future, and I agree that we should. Acknowledging our past—what we did and did not do, and how that turned out—is key to understanding the proper path forward. In this symposium contribution, I have endeavored to show that mental health and mass incarceration are not separate crises, but rather interconnected problems with an interconnected past that require an interconnected solution. Recognizing them as such is the best chance we have at moving toward a more just, humane, and equitable future—a future that takes the “mass” out of mass incarceration.

299. *Id.* at 163.