

ESSAY

FROM HOSPITALS TO PRISONS: A NEW EXPLANATION

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Deinstitutionalization from state mental hospitals was largely over by 1980, but the percentage of prisoners with mental illness did not begin to skyrocket until 1990. The leading theories for the criminalization of mental illness cannot fully explain this gap.

This Essay offers a new theory: the Supreme Court in 1990 reduced the costs of incarcerating the severely mentally ill by approving the cheap and easy forced medication of prisoners. We show that this theory is supported by time-series and cross-sectional data.

Our theory has implications beyond simply raising the bar for forcible medication standards in the prison context. Prison reform litigation increases the costs of incarceration and puts pressure on states to decriminalize mental illness. A second deinstitutionalization may be coming.

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INTRODUCTION

Jamie Lee Wallace was sentenced to twenty-five years in prison for shooting and killing his mother only weeks after being released from a mental hospital on a new medication.¹ Jamie suffered from paranoid schizophrenia, bipolar disorder, ADHD, and intermittent explosive disorder,² and spent a full year at a psychiatric hospital after a court initially found him incompetent to stand trial.³ After entering prison in 2010, Jamie was placed on suicide watch over 60 times.⁴ In December 2016, he was the first to testify in a federal trial alleging that the Alabama prison system fails to provide constitutionally adequate mental health care.⁵ During his testimony he became so agitated that he had to be removed from court and the judge asked the attorneys to arrange for an evaluation. It did not happen in time.⁶ After testifying, Jamie was placed on suicide watch for three days, but then released from observation. He hanged himself two days later.⁷

Such tragedies are likely to recur given the alarming number of mentally ill prisoners nationwide.⁸ A 2005 study

¹ Jeremy Gray, *The Sad, Short, Violent Life of Jamie Lee Wallace: We Fail Those Who Most Need Help*, AL.COM (Dec. 23, 2016, 7:00 AM), http://www.al.com/opinion/index.ssf/2016/12/the_sad_short_violent_life_of.html [https://perma.cc/MC9D-PFFQ].

² *Dunn v. Dunn*, No. 2:14cv601-MHT (WO), 2016 WL 6949598, at 29* (M.D. Ala. Nov. 25, 2016).

³ Fifth Amended Complaint at 50, *Dunn v. Dunn*, No. 2:14-cv-00601-MHT-TFM (M.D. Ala. Sept. 28, 2016).

⁴ Plaintiffs' Emergency Motion for a Temporary Restraining Order or Preliminary Injunction Regarding Suicidal Prisoners at 11, *Braggs v. Dunn*, No. 2:14-CV-00601-MHT-TFM (M.D. Ala. Dec. 22, 2016).

⁵ Gray, *supra* note 1.

⁶ Amy Yurkanin, *SPLC: Emergency Action Needed After Suicide of Mentally Ill Alabama Prison Inmate*, AL.COM (Dec. 22, 2016, 11:19 AM), http://www.al.com/news/index.ssf/2016/12/attorneys_seek_emergency_actio.html [https://perma.cc/2HFB-DDJ3].

⁷ Gray, *supra* note 1.

⁸ See Dahlia Lithwick, *Prisons Have Become America's New Asylums*, SLATE (Jan. 5, 2016), http://www.slate.com/articles/news_and_politics/jurisprudence/2016/01/prisons_have_become_warehouses_for_the_mentally_ill.html [https://perma.cc/NAG3-JKMF] (noting that in 2012, approximately 356,000 "inmates with severe mental illness were in prisons and jails, while about 35,000 severely ill patients were in state psychiatric hospitals").

found that 49.2% of inmates in state prisons reported symptoms of major depressive disorder, mania disorder, or psychotic disorder.⁹ Nearly a quarter, 24.3%, had a recent history of mental health problems, which was defined to include a diagnosis, an overnight hospital stay, prescription drug use, or therapy within the year before incarceration.¹⁰ The study did not separately assess “severe mental illness,” but 15% met the criteria for psychotic disorder.¹¹ It was not always like this. “[A] 1930 study of almost 10,000 arrestees reported that just 1.5 percent of them were psychotic at the time of arrest.”¹²

Many factors have contributed to the modern mass incarceration of people with mental illness. A leading explanation is “transinstitutionalization”: the downsizing and closure of state mental hospitals known as deinstitutionalization, coupled with patient reinstitutionalization in jails and prisons—in other words, shifting the mentally ill from one institution to another.¹³ There is clearly some truth to this explanation.¹⁴ But one under-appreciated gap in this theory is the timing: deinstitutionalization had slowed dramatically by 1980, but rapid growth in the percentage of prison inmates with mental

⁹ Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, B.J.S. SPECIAL REPORT 3 tbl.1 (Sept. 2006).

¹⁰ *Id.*

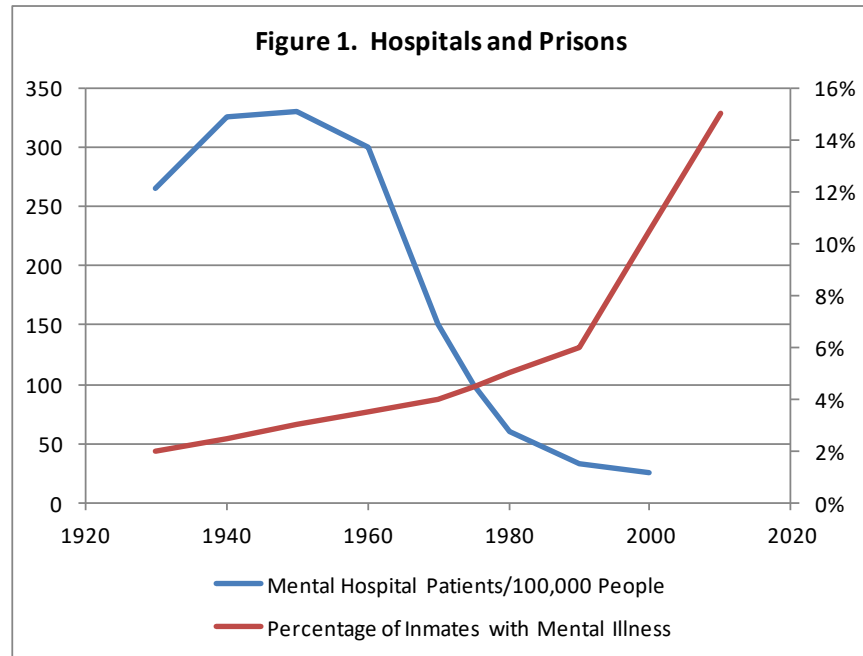
¹¹ *Id.* at 1.

¹² E. FULLER TORREY ET AL., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 14 (May 2010) (citing W. Bromberg & C.B. Thompson, *The Relation of Psychosis, Mental Defect and Personality Types to Crime*, 28 J. CRIM. L. & CRIMINOLOGY 70 (1937)) http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf [<https://perma.cc/M93K-F9P3>].

¹³ See Ralph Slovenko, *The Transinstitutionalization of the Mentally Ill*, 29 OHIO NORTHERN U. L. REV. 641, 654 (2003) (explaining how law enforcement agencies serve functions previously handled by mental health authorities).

¹⁴ See generally 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. LEGAL STUD. 187, 188–91 (2013) (graphing yearly data on mental health patients, of which we extracted values at five-year intervals).

illness did not begin until after 1990 (Figure 1).¹⁵



This Essay evaluates traditional explanations for the increase in mentally ill prisoners against this timeline (Section I). Some explanations fit better than others and even in combination they leave room for other factors. We offer an entirely new theory (Section II): in 1990, the Supreme Court in *Washington v. Harper*,¹⁶ by approving lax requirements for forced medication in prison, made it cheaper and easier for prisons to manage inmates with severe mental illness. *Harper* made mass incarceration of the mentally ill more attractive than alternatives that may have achieved some success through the 1980s. We assess this novel theory using national data and find strongly suggestive support. We then attempt to confirm the theory by close analysis of a single state, Alabama. In addition to being one of the worst prison systems in the country (and not coincidentally), Alabama has a history of litigation that could provide insights not present in other states. Our conclusion is that *Harper* belongs among the cast of villains, at least in a supporting role.

A brief conclusion follows. Although our project is primarily historical, it has important implications for today. Proponents of the transinstitutionalization hypothesis argue

¹⁵ *Id.* at 188 fig.1; TORREY ET AL., *supra* note 12, at 13 (graphing inmate data for 1930, 1985, 1990, and 2010, which we reproduced with interpolation).

¹⁶ 494 U.S. 210, 227 (1990).

that without increasing the number of inpatient beds—in other words, rolling back deinstitutionalization—“the criminalization of large numbers of severely mentally ill persons will continue.”¹⁷ Though more inpatient beds surely are needed, how many? Moreover, a significant reduction in the mentally ill prison population is unlikely to materialize without addressing the other factors that have contributed to the criminalization of mental illness. *Harper* and prison conditions more generally may be an important part of the story, largely absent from the discussion to date. Understanding what happened in the 1980s and what changed in the 1990s is crucial in charting the best course forward.

I

CURRENT THEORIES FOR CRIMINALIZATION

A. Under-Reporting Mental Illness

Some have speculated that the surge in mentally ill prisoners started before 1990, but was not detected due to poor or nonexistent mental health screening in the criminal justice system. “It may be that in recent years, correctional staff have become better able to recognize signs of mental disturbance and, as a result, refer more of these individuals to mental health professionals. Thus, better recognition may also contribute to the prevalence rate of inmates identified as mentally ill.”¹⁸ In other words, under-reporting artificially deflated the 1980 and 1990 data points in Figure 1. Under-reporting in early periods was no doubt real, but it should be noted at the outset that it continues in many jurisdictions.¹⁹ The 2000s estimate of 15% is also likely to be an under-count.

Still, there is support for the view that there was significant under-reporting before the 1990s. A 1986 Bureau of Justice Statistics report found that around 15% of prisoners had

¹⁷ H. Richard Lamb & Linda E. Weinberger, *The Shift of Psychiatric Inpatient Care From Hospitals to Jails and Prisons*, 33 J. AM. ACAD. PSYCHIATRY L. 529, 533 (2005).

¹⁸ H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVS. 483 (1998), reprinted in H. RICHARD LAMB & LINDA E. WEINBERGER, EDS., DEINSTITUTIONALIZATION: PROMISE AND PROBLEMS 32 (2001); see also SASHA ABRAMSKY & JAMIE FELLNER, HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 101–03 (2003) (noting poor screening and tracking of mentally ill prisoners); Megan Testa, *Imprisonment of the Mentally Ill: A Call for Diversion to the Community Mental Health System*, 8 ALB. GOV'T L. REV. 405, 422–23 (2015).

¹⁹ See e.g., *Dunn v. Dunn*, No. 2:14cv601-MHT (WO), 2016 WL 6949598, at *22–23 (M.D. Ala. Nov. 25, 2016) (summarizing the opinion of expert Dr. Kathryn Burns).

overnight mental health hospitalization or treatment.²⁰ Of course, that is not the same thing as currently suffering from severe mental illness. Other sources are more on point. As early as 1993, clinical studies suggested that 10-15% of state prisoners had severe mental illness.²¹ This is perhaps the best evidence that the 7% for 1990 in Figure 1 may be understated.

But this is arguably an apples-to-oranges comparison. Clinical studies focus on relatively small and perhaps not representative samples. And even taking the 15% high-end estimate for 1993, there is strong evidence that this figure increased dramatically later in the 1990s. A broader 2002 study reported that in 1995, 13-27% of state prisoners suffered from severe mental illness.²²

Data for several states with good information are consistent with this story. In Texas, “between 1988 and 1998, the state prison population increased by 262 percent while the number of mentally ill offenders in prison . . . increased by . . . 429 percent.”²³ In New York prisons, the mental health caseload has increased by 73% since 1991—five times the prison population increase.²⁴ In Colorado, the proportion of

²⁰ Richard C. McCorkle, *Gender, Psychopathology, and Institutional Behavior: A Comparison of Male and Female Mentally Ill Prison Inmates*, 23 J. CRIM. JUST. 53, 55 tbl.1 (1995).

²¹ Lamb & Weinberger, *supra* note 18, at 32.

²² See NAT'L COMM. ON CORRECTIONAL HEALTH CARE, THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES: A REPORT TO CONGRESS 24 tbl.3-3 (2002) <https://www.ncjrs.gov/pdffiles1/nij/grants/189735.pdf> [<https://perma.cc/CVW4-TFBR>] (reporting percentage ranges for prevalence of state prisoners with schizophrenia/psychosis, major depression, and bipolar (manic), which were added to calculate the percentage range of state prisoners with serious mental illness, assuming perfect overlap (13%) and no overlap (27%) of illness to account for comorbidity).

The only source we found reporting a constant percentage mentally ill actually reinforces our point. Frank and Glied list the percentage with serious and persistent mental illness in correctional institutions at 7% in 1950, 1970, 1990, and 2000. RICHARD G. FRANK & SHERRY A. GLIED, BETTER BUT NOT WELL: MENTAL HEALTH POLICY IN THE UNITED STATES SINCE 1950 127 tbl.7.6 (2006). But the notes reveal that this “assum[ption]” is based on one 2001 review of the literature. *Id.* at 126 (citing Pamela M. Diamond et al., *The Prevalence of Mental Illness in Prison*, 29 ADMIN. & POL'Y IN MENTAL HEALTH 21 (2001)). The most recent U.S. prison study covered by that review was published in 1989. Diamond et al., *supra*, at 27 tbl.1. It may have been reasonable to assume based on past studies that the percentage mentally ill would have remained constant between 1990 and 2000, but that is not what happened.

²³ Slovenko, *supra* note 13, at 657 (quoting Elizabeth Daigneau, *Criminal Hospital/Growth in Mentally Ill Prisoners Sparks Debate Over Incarceration vs. Treatment*, GOVERNING (Sept. 2002), <http://www.governing.com/topics/health-human-services/Criminal-Hospital.html> [<https://perma.cc/HGE5-R3PY>]).

²⁴ ABRAMSKY & FELLNER, *supra* note 18, at 19 (citing Mary Beth Pfeiffer, *Mental Care Faulted in Six Prison Deaths*, POUGHKEEPSIE J., June 28, 2003, at

prisoners with major mental illness was 10% in 1998—five to six times the proportion identified in 1988.²⁵ Between 1993 and 1998 the population of seriously mentally ill prisoners in Mississippi doubled and it rose by 30% in the District of Columbia.²⁶ In Connecticut, the number of prisoners with serious mental illness increased from 5.2 percent to 12.3 percent of the state’s prison population from 1991 to 1999.²⁷

In sum, the more persuasive view is that the extraordinary upsurge began (or at least picked up speed) in the 1990s, since “[n]ineteen of thirty-one states responding to a 1998 survey reported a disproportionate increase in their seriously mentally ill population during the previous five years.”²⁸ “While some portion of the increase may be attributable to improved mental health screening and diagnosis of mental health problems, there is a consensus in corrections that the numbers also reflect a real change in the rate at which the mentally ill are being sent to prison.”²⁹ The post-1990 spike is real.

B. State Hospital Closure

Another alternative explanation for the 1990s upsurge is the closure of entire state institutions.³⁰ Although the number of beds had been substantially curtailed by 1980, the number of admissions declined only slightly.³¹ Patients were simply staying for much shorter periods of time. By leveraging even a few beds for short-term stabilization of the most seriously mentally ill, state institutions continued through the 1980s to provide essential gap-filling services. With no inpatient beds available, jail—often leading to prison—becomes the first option. One county sheriff explained, “In Alabama, if you (want to) protect someone from themselves, you charge them with harassment and put them in jail.”³² In our view, the closure of

A1).

²⁵ *Id.* (citing COLO. DEP’T OF CORR., OFFENDERS WITH SERIOUS MENTAL ILLNESS (1998)).

²⁶ *Id.*

²⁷ U.S. DEP’T OF JUSTICE & NAT’L INST. OF CORR., PROVISION OF MENTAL HEALTH CARE IN PRISONS 5 tbl.1 (2001).

²⁸ Jamie Fellner, *A Corrections Quandary: Mental Illness and Prison Rules*, 41 HARV. C.R.-C.L. L. REV. 391, 393 (2006) (citing ABRAMSKY & FELLNER, *supra* note 18, at 19).

²⁹ *Id.*

³⁰ Seth J. Prins, *Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illness in the Criminal Justice System?*, 47 COMMUNITY MENTAL HEALTH 716, 718 (2011).

³¹ *Id.* at 719.

³² Lee Roop, *As Alabama Cuts Mental Health Care, Sheriffs Say Jails Overwhelmed*, AL.COM (Aug. 8, 2016, 7:24 AM),

state hospitals is a quite plausible explanation. It has important implications for moving forward—namely, providing even a small number of additional inpatient beds could potentially counteract much of the trend toward incarceration.

C. Releasing the Sickest Patients Last

Some hypothesize that the last patients who left mental institutions were the least able to survive on the outside and therefore more likely to end up in jail or prison.³³ There is support for this hypothesis. Perhaps the best study of transinstitutionalization estimated that 4-7% of incarceration growth between 1980 and 2000 can be attributed to deinstitutionalization.³⁴ This is the right-hand tail of deinstitutionalization when the sickest patients would have been released.

To fill out this theory, many patients released before 1980 were older and stable enough to live in nursing homes, where large numbers ended up. This earlier transinstitutionalization from hospital to nursing home has been well documented.³⁵ By 1984, “more than 50% of nursing homes [we]re populated by persons with primary or secondary diagnoses of mental disorder.”³⁶

This is a good theory, but it cannot be the whole story. The numbers don’t add up. The size of the mentally ill prison population increased in this timeframe by much more than 4-7%. And, unfortunately, due to data limitations, the study mentioned above was unable to parse between the 1980s and 1990s. This means that it is impossible to test this theory against the delayed upsurge that took place.

D. Community-Based Options Dried Up

The lack of community-based mental health treatment

http://www.al.com/news/huntsville/index.ssf/2016/08/alabama_sheriffs_on_the_front.html [<https://perma.cc/4UJM-QXFJ>].

³³ Raphael & Stoll, *supra* note 14, at 200. Cf. Mark R. Pogrebin & Eric D. Poole, *Deinstitutionalization and Increasing Arrest Rates Among the Mentally Disordered*, 15 J. PSYCHIATRY & L. 117, 121 (1987) (arguing that community-based mental health centers geared toward less disturbed clients were unprepared for the deinstitutionalized seriously and chronically ill patients).

³⁴ Raphael & Stole, *supra* note 14, at 189–90.

³⁵ Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 87 (2011).

³⁶ John A. Talbott, Editorial, *Psychiatry’s Agenda for the 80s*, 251 JAMA 2250, 2250 (1984).

options surely leads to higher rates of incarceration.³⁷ But this fact alone cannot explain the timing. Community-based programs had their legs cut out from under them in 1981 when federal direct support was eliminated and indirect support was slashed.³⁸ This has been described as “probably the biggest policy mistake of all” in mental health.³⁹ Under the new block grant approach, “significant community-based treatment programs failed to materialize on a nationwide basis, and reform efforts stagnated.”⁴⁰ And while the demand for good community programs outpaced supply during the 1980s,⁴¹ the percentage of prisoners with mental illness climbed only moderately.

On the other hand, two trends in funding may have exacerbated the situation during the 1990s. First, the percentage of mental health spending by Medicaid rose from 18.8% in 1991 to 27.4% in 2001.⁴² “The reliance on Medicaid funding has shifted the focus of state mental health authorities toward Medicaid-eligible populations: poor women and children and those disabled by mental illness”⁴³ States may have lost sight of poor men, the group most likely to be imprisoned.⁴⁴ Second, a new funding entity, the Managed

³⁷ THOMAS G. BLOMBERG & KAROL LUCKEN, *AMERICAN PENOLOGY: A HISTORY OF CONTROL* 222 (2d ed. 2010). See generally Paul J. Carling, *Major Mental Illness, Housing, and Supports*, 45 AM. PSYCHOLOGIST 969, 971 (1990) (concluding from prior studies that “community-based treatment is virtually always as effective or more effective than hospital-based treatment”).

³⁸ CHRIS KOYANAGI, *LEARNING FROM HISTORY: DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS AS PRECURSOR TO LONG-TERM CARE REFORM* 8 (2007).

³⁹ *Id.* at 19.

⁴⁰ Bryan Redfern, *To Wait or to Litigate? The Ethical Implications of Utilizing Litigation as a Vehicle for Reforming State Mental Health Care Systems*, 29 GEO. J. LEGAL ETHICS 1279, 1284 (2016); see also Carling, *supra* note 37, at 969 (stating in 1990 that “model community support programs are rare”); KOYANAGI, *supra* note 38, at 12 (“In 1988, a former state mental health commissioner called the system ‘fragmented, uncoordinated and disorganized’ and reported that a great deal of federal, state and local money was spent poorly and often in the wrong places.”).

⁴¹ Redfern, *supra* note 40, at 1284; see also Pogrebin & Poole, *supra* note 33, at 121 (citing in 1987 “inadequate governmental funding” for community mental health programs).

⁴² Richard G. Frank & Sherry Glied, *Changes in Mental Health Financing Since 1971: Implications for Policymakers and Patients*, 25 HEALTH AFF. 601, 606 Exhibit 1 (2006).

⁴³ *Id.* at 609.

⁴⁴ Paul Guerino, Paige M. Harrison & William J. Sabol, *Prisoners in 2010*, B.J.S. BULLETIN 7 (Dec. 2011) (reporting that males in 2010 had an imprisonment rate fourteen times higher than the rate for females); *THE REAL WAR ON CRIME: THE REPORT OF THE NATIONAL CRIMINAL JUSTICE COMMISSION* 27 (Stephen R. Donziger, ed., 1996) (stating that the “majority of the people filling our prisons come from impoverished backgrounds and lack a formal education”).

Behavioral Health Care Organization (MBHO), started in the late 1980s to control costs by cutting back on relatively expensive hospital care and psychotherapy in favor of cheaper pharmacologic treatment in outpatient settings.⁴⁵ Structured outpatient programs were lacking. As to the bigger picture, some commentators conclude that even though the 1990s saw “larger networks of community-based providers,” “insufficient services” continued.⁴⁶ In short, we cannot assess the overall impact of good community-based approaches during this timeframe because they did not exist widely either before or after 1990.

E. Higher Civil Commitment Standards

Some blame increased criminalization on more rigorous requirements for involuntary hospitalization.⁴⁷ This theory may hold for some marginal cases, but it cannot explain the trend over time. California in 1969 led the charge by adopting higher standards,⁴⁸ and within a decade every state and Puerto Rico had followed suit.⁴⁹ Thus, if higher civil commitment standards were the only source of the problem, rapidly increasing imprisonment of the mentally ill would have started no later than 1980. It did not.

F. The War on Drugs

Many argue that the War on Drugs disproportionately impacts people with mental illness.⁵⁰ One commentator explains, “Due to co-morbidity of drug addiction and mental illness, when more drug offenders were sentenced to prison, the number of inmates with mental illness rose.”⁵¹ At least

⁴⁵ Frank & Glied, *supra* note 42, at 608.

⁴⁶ Michael P. Accordino, Dion F. Porter & Torrey Morse, *Deinstitutionalization of Persons with Severe Mental Illness: Context and Consequences*, 67 J. REHAB. 16, 17 (2001).

⁴⁷ BLOMBERG & LUCKEN, *supra* note 37, at 222. See generally Danielle Laberge & Daphne Morin, *The Overuse of Criminal Justice Dispositions: Failure of Diversionary Policies in the Management of Mental Health Problems*, 18 INT’L J.L. & PSYCHIATRY 389, 389–91 (1995) (suggesting that limited access to social services and health care are a contributing factor to criminalization of mental illness).

⁴⁸ Testa, *supra* note 18, at 410.

⁴⁹ Lamb & Weinberger, *supra* note 18, at 29, 35.

⁵⁰ BLOMBERG & LUCKEN, *supra* note 37, at 222, 224; Fred Osher & Yu Ling Han, *Jails as Housing for Persons with Serious Mental Illness*, AM. JAILS 36, 37 (Mar./Apr. 2002); KOYANAGI, *supra* note 38, at 10; Arthur J. Lurigio, *People with Serious Mental Illness in the Criminal Justice System: Causes, Consequences, and Correctives*, 91 PRISON J. (SUPP.) 66S (2011).

⁵¹ Testa, *supra* note 18, at 411–12. But see Paul F. Stavis, *Why Prisons Are*

with respect to the war on drugs, the timing at first blush looks promising: “The ‘War on Drugs’ was declared in the late 1980s”⁵²

A closer look, however, reveals a problem with this theory. The percentage of state prisoners serving time for drug offenses actually went down between 1990 and 2010.⁵³ It is possible, of course, that the percentage of drug offenders with mental illness went up during this timeframe, but it is not at all clear why that would be. Still, it should be conceded that the percentage of prisoners with drug offenses rose meteorically in the 1980s,⁵⁴ so the War on Drugs could have explained a steep increase in mentally ill prisoners during that time period. But again, that is not what we observed.

G. Jail Then Prison

A related theory is that mentally ill individuals receiving inadequate care in the community were arrested for mostly minor offenses and sent to jail during the 1980s but not prosecuted or convicted in large numbers, and therefore they didn’t end up in prison.⁵⁵ One mechanism by which this might have happened is harsher treatment of repeat arrestees.⁵⁶ Perhaps those minor offenses eventually added up and led to prosecutions. If that were true, the uptick should have happened sooner.⁵⁷ Nor can a shift in criminal behavior from misdemeanors in the 1980s to felonies after 1990 be the explanation.⁵⁸ But perhaps the most fundamental flaw in this

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, 177 (2000) (“Mentally ill inmates are nearly half as likely to be in prison for a drug related offense than other inmates (12.8% versus 22.2%)”).

⁵² Testa, *supra* note 18, at 405.

⁵³ John Pfaff, *The War on Drugs and Prison Growth: Limited Importance, Limited Legislative Options*, 52 HARV. J. LEGIS. 173, 181 fig.2 (2015).

⁵⁴ *Id.*

⁵⁵ See Pogrebin & Poole, *supra* note 33, at 121 (focusing on jail).

⁵⁶ See Lamb & Weinberger, *supra* note 17, at 531 (stating that having a criminal record “may influence the actions of the police in subsequent encounters with the individual and reinforce the tendency to choose the criminal justice system over the mental health system”); *cf.* Pogrebin & Poole, *supra* note 33, at 121 (explaining that the higher arrest rates observed for former mental patients “is primarily due to the very high rates of subsequent arrest of those patients with prior arrest records”).

⁵⁷ In one study published in 1985, 92% of jail inmates referred to a mental health unit had prior histories of arrest. Pogrebin & Poole, *supra* note 33, at 123.

⁵⁸ See *id.* at 123 (reporting that in one jail in the mid-1980s, 75% of those suspected of mental illness had been arrested for felonies as compared with just 17% for misdemeanors); Lamb & Weinberger, *supra* note 18, at 30 (“[I]t is clear that persons who have committed serious offenses, no matter how mentally ill,

theory is that Figure 1 above includes jail inmates and the percentage of mentally ill still grew only slowly through 1990.⁵⁹

H. Diminished Capacity & Insanity

Another theory for the increase in incarceration of the mentally ill is the contraction or elimination in some states of the so-called “diminished capacity defense.”⁶⁰ In few states is this actually a defense, but in many states evidence of mental illness can be introduced by a criminal defendant to negate mens rea. As of 2006, around thirteen states imposed significant restrictions on the introduction of such evidence for this purpose.⁶¹ The question for our purposes is when these restrictions were adopted.

Since one would expect longer sentences to increase prison populations only after a delay period equal to the previous, shorter sentence, changes in the 1980s would provide the best support for this theory. In several states, the restrictions arguably came too early: Louisiana (1945),⁶² Arizona (1965),⁶³ Wisconsin (1975),⁶⁴ D.C. (1976),⁶⁵ and Delaware (1978).⁶⁶ In others, they plainly came too late: Indiana (1996)⁶⁷ and Michigan (2001).⁶⁸ But many other changes fit the timeline: Florida (1981),⁶⁹ Georgia (1981),⁷⁰ Minnesota (1982),⁷¹ Ohio (1982),⁷² Mississippi (1984),⁷³ Alabama (1985),⁷⁴ and Virginia (1985).⁷⁵ In sum, one cannot reject the diminished capacity theory based on timing alone. But it seems very unlikely that

would normally be processed in the criminal justice system.”).

⁵⁹ See *supra* note 15 and accompanying figure.

⁶⁰ Lamb & Weinberger, *supra* note 18, at 40.

⁶¹ Clark v. Arizona, 548 U.S. 735, 800 (2006) (Kennedy, J., dissenting).

⁶² State v. Gunter, 23 So. 2d 305, 307 (La. 1945).

⁶³ State v. Schantz, 403 P.2d 521, 524–528 (Ariz. 1965).

⁶⁴ Hughes v. State, 227 N.W.2d 911, 914 (Wis. 1975).

⁶⁵ Bethea v. United States, 365 A.2d 64, 85 (D.C. 1976).

⁶⁶ Bates v. State, 386 A.2d 1139, 1142–43 (Del. 1978).

⁶⁷ Holmes v. State, 671 N.E.2d 841, 857–58 (Ind. 1996).

⁶⁸ People v. Carpenter, 627 N.W.2d 276, 280 (Mich. 2001). Michigan continues to follow this rule, and the Supreme Court continues, unjustly, to uphold it. Fredrick E. Vars, *When God Spikes Your Drink: Guilty Without Mens Rea*, 4 CALIF. L. REV. CIR. 209, 209–10 (2013).

⁶⁹ Zeigler v. State, 402 So. 2d 365, 373 (Fla. 1981).

⁷⁰ Wallace v. State, 282 S.E.2d 325, 329–31 (1981).

⁷¹ State v. Bouwman, 328 N.W.2d 703, 705 (Minn. 1982).

⁷² State v. Wilcox, 436 N.E.2d 523, 523 (Ohio 1982).

⁷³ Cannaday v. State, 455 So. 2d 713, 720 (Miss. 1984).

⁷⁴ Neelley v. State, 494 So. 2d 669, 682 (Ala. Crim. App. 1985), *aff'd*, 494 So. 2d 697 (Ala. 1986).

⁷⁵ Stamper v. Commonwealth, 324 S.E.2d 682, 688 (Va. 1985).

the national trend can be explained by seven states making it easier to obtain a long sentence for a fraction of crimes.

Other commentators lay much of the blame on the contraction of the insanity defense.⁷⁶ Indeed, “[s]eventy-five percent of all states made some sort of substantive change in insanity defense in the 1978-85 period.”⁷⁷ That is certainly enough states to have a potential impact on incarceration of the mentally ill. The timing is in the ballpark, but perhaps a bit too early to explain the post-1990 upsurge. And while the insanity defense benefits people with mental illness almost exclusively, it did so rarely even before the reforms.⁷⁸

II

NEW THEORY: WASHINGTON V. HARPER

Existing theories do not seem to provide a full explanation for the observed trend in the incarceration of people with mental illness, particularly the rapid increase after 1990. Our new theory is that the 1990 Supreme Court decision in *Washington v. Harper* may have contributed to this upsurge by reducing the cost of housing mentally ill inmates. This Section evaluates that theory.

A. The Harper Holding

In the landmark case of *Washington v. Harper*, the Supreme Court held that while the involuntary administration of antipsychotic medication implicates a significant liberty interest, the regulations permitting such administration need only be “reasonably related to legitimate penological interests.”⁷⁹ Under the *Harper* standard, a prisoner may be forcibly medicated where he is deemed a danger to himself or others and the treatment is in his medical interest, even if the prisoner has the mental capacity to make treatment decisions.⁸⁰ Procedurally, the Court held that due process does not require a judicial hearing to determine whether a

⁷⁶ See generally Michael L. Perlin, “*Wisdom Is Thrown into Jail*”: Using Therapeutic Jurisprudence to Remediate the Criminalization of Persons with Mental Illness, 17 MICH. ST. U. J. MED. & L. 343, 353–57 (2013) (describing how the insanity defense has been shrinking).

⁷⁷ *Id.* at 355.

⁷⁸ AM. PSYCHIATRIC ASS’N, STATEMENT ON THE INSANITY DEFENSE 5 (1982) (“Successful invocation of the defense is rare (probably involving a fraction of 1 percent of all felony cases).”).

⁷⁹ 494 U.S. 210, 221–24 (1990).

⁸⁰ *Id.* at 221–22.

prisoner meets this substantive standard.⁸¹ Rather, it upheld an internal review procedure.

The new theory advanced in this Essay is that *Harper* accelerated the mass incarceration of individuals with mental illness. By setting the procedural and substantive bars so low for forced medication of prisoners, *Harper* significantly reduced the cost of managing them. We accept that in theory causation could have run in the reverse direction: the increasing numbers of mentally ill prisoners produced severe overcrowding so that only minimal protections were affordable. However, the timing favors a causal role for *Harper*. The beginning of the rapid rise in the mentally ill prisoner population around 1990 coincides with the *Harper* decision. We evaluate this new theory first using national statistics, then as applied to Alabama.

But before we attempt an empirical assessment, we must concede an important practical objection at the outset: prisons have so many ways to coerce prisoners into taking medication that the legal standards in *Harper* may be of little relevance. We have no doubt that coercion is widespread.⁸² A federal court in Alabama recently found that state prisoner plaintiffs offered enough evidence to create a dispute of material fact as to whether “there is a practice of coercing prisoners to take psychotropic medication and failing to inform them adequately about their medication.”⁸³ As the Alabama case demonstrates, though, sometimes impermissible coercion is detected and the state must defend itself. The risk of detection becomes a cost of doing business. *Harper* reduces that cost by providing a cheap and easy safe harbor.

B. National Evidence

The national evidence in favor of our theory is both time-series and cross-sectional. The timing evidence is simple: *Harper* was decided in 1990, right before the percentage of mentally ill in prison started its steep upward trajectory.⁸⁴ That might be a coincidence, but it is a clear advantage over some of the alternative theories discussed above that do not fit the timeline as well.

⁸¹ *Id.* at 228, 235.

⁸² Cf. Fredrick E. Vars, *Illusory Consent: When an Incapacitated Patient Agrees to Treatment*, 87 OR. L. REV. 353, 354–57 (2008) (describing flaw in “voluntary” admissions to psychiatric hospitals).

⁸³ *Dunn v. Dunn*, No. 2:14cv601-MHT (WO), 2016 WL 6949598, at *40 (M.D. Ala. Nov. 25, 2016).

⁸⁴ See *supra* Figure 1.

The cross-sectional evidence may be more persuasive. Our analysis of raw data from a 2010 report reveals that the average odds of a mentally ill person being in jail or prison versus in a hospital were 3.6 to 1 in states following *Harper*, but only 2.7 to 1 in states with more rigorous standards for forcible medication in prison.⁸⁵ In other words, states with higher standards for forcible medication in prison tend to incarcerate fewer people with mental illness. This is exactly what our hypothesis would predict.

One objection to this cross-sectional evidence is that it may omit important confounding variables. To take one example, perhaps a state's enlightened view toward mental illness is driving both a lower incarceration rate and the adoption of high standards for forcible medication. This story sounds plausible, but it is worth noting that the eighteen states with standards higher than *Harper* include Florida, Louisiana, South Carolina, and Virginia,⁸⁶ which one would not expect to be the most protective of the rights of mentally ill individuals in other areas. Still, we have no direct test of this or other omitted variable theories.

C. Alabama Evidence

Alabama was chosen as a case study because its current regulations are based on *Harper* and because it has a long history of litigation that sheds light on its mental health and prison systems. If a state-level empirical approach fails after a deep dive into Alabama's history, it is unlikely to succeed in other states.

1. *Deinstitutionalization & Civil Commitment*

In 1949, Alabama's two primary mental health hospitals had roughly 5,732 patients with only ten full-time staff physicians—"the largest patient load of any state in the nation at the time."⁸⁷ The state hospital population declined only

⁸⁵ TORREY ET AL., *supra* note 12, at 14 tbl.1 (providing state-by-state ratios); E. FULLER TORREY ET AL., TREATMENT ADVOCACY CTR. & NAT'L SHERIFFS' ASS'N, THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 27 (2014) (classifying eighteen states as having more rigorous standards for forced medication than *Harper*).

⁸⁶ *Id.*

⁸⁷ *Bryce Hospital Historic Preservation Project-History Time Line*, ALA. DEP'T MENTAL HEALTH, <http://www.mh.alabama.gov/BryceHospitalProject/history.html> [<https://perma.cc/H256-TPVA>]. Even in these dire circumstances, patients found ways to express themselves. See e.g., Fredrick E. Vars, *Subversive Apologia*, 35 LAW & PSYCHOL. REV. 109, 109–12 (2011) (describing a newsletter

slightly over the next twenty years, and in 1970, Alabama was spending less on care for persons with mental illness and intellectual disabilities in public institutions than any other state.⁸⁸ The abysmal state of Alabama's mental health care system led to *Wyatt v. Stickney*, a federal class action lawsuit filed on behalf of those involuntarily committed to Bryce Hospital. In 1971, the court held that persons who are civilly committed have a constitutional right to treatment and issued an order requiring the Alabama Department of Mental Health (ADMH) to bring its state facilities into compliance with certain constitutional minimum standards.⁸⁹ The *Wyatt* litigation led to "a massive shift" of patients out of Bryce hospital and back into their communities.⁹⁰

In 1975, the Alabama legislature also enacted more stringent civil commitment laws.⁹¹ These standards were repealed in 1991, leaving Alabama with a civil commitment statute that was less stringent than its earlier counterpart, but still fairly strict.⁹² Not only does Alabama's current scheme make it more difficult to civilly commit patients than in the years before 1974, but it also makes such commitment more expensive given the procedural protections afforded to the patient.⁹³ Still, the civil commitment standards that existed between 1975 and 1991 were more protective of patients than

produced by patients at Bryce Hospital).

⁸⁸ *Bryce Hospital Historic Preservation Project History Time Line*, *supra* note 87 (allotting 50 cents a day per patient); Stonewall B. Stickney, *The Inception of Wyatt and the State's Response*, in *WYATT V. STICKNEY: RETROSPECT AND PROSPECT* 11, 13 (L. Ralph Jones & Richard R. Parlour eds., 1980).

⁸⁹ *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974); *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972).

⁹⁰ See Meredith Cummings, *Changes Loom for Mental Health*, TUSCALOOSA NEWS (Mar. 9, 2003), [http://www.tuscaloosanews.com/article/DA/20030309/News/606101038/TL/\[https://perma.cc/6SDM-G3AB\]](http://www.tuscaloosanews.com/article/DA/20030309/News/606101038/TL/[https://perma.cc/6SDM-G3AB]); Harcourt, *supra* note 35, at 71 ("Because [Alabama] was unable to meet the judicially-mandated standards of minimally required care, thousands of patients were released.").

⁹¹ In 1974, Alabama's then-existing law was struck down on due process grounds. *Lynch v. Baxley*, 386 F. Supp. 378, 387 (M.D. Ala. 1974). The Alabama legislature subsequently adopted the procedural and substantive standards articulated by the *Lynch* court as the constitutional floor, *see id.* at 388-97, in Ala. Code § 22-52-10 (1975). See *Walker v. Dancer*, 386 So. 2d 475, 477 (Ala. Civ. App. 1980). The timing of the change in Alabama is consistent with the overall picture painted above. See *supra* notes 48-49 and accompanying text.

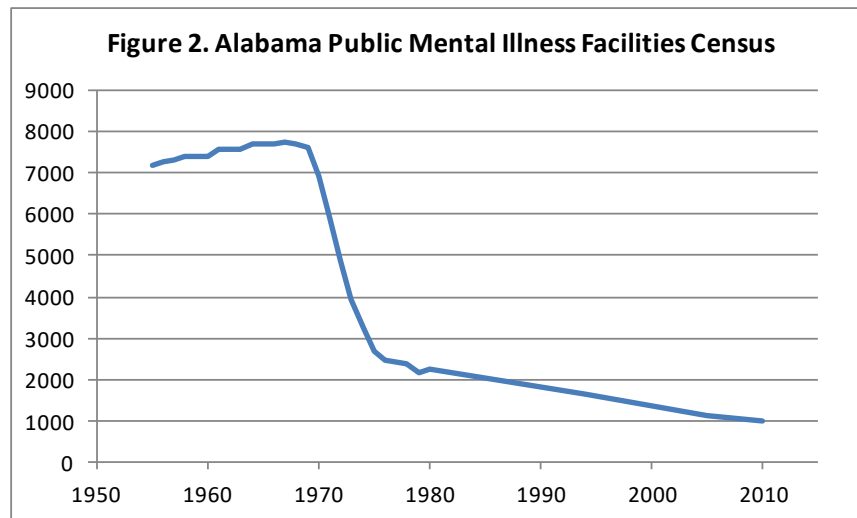
⁹² See 1991 Alabama Laws Act 91-440 (H.B. 423). The current statute is Ala. Code § 22-52-10.4.

⁹³ See, e.g., Ala. Code § 22-52-10.5 (inpatient treatment order may not exceed 150 days); *id.* § 22-52-10.6 (outlining procedure for filing petition of renewal and requirements of renewal hearing).

the pre-1975 standard. This heightened protection, along with the overall lack of mental health funding in the state and the looming *Wyatt* injunction governing staff-to-patient ratios in state hospitals, arguably hindered Alabama's ability (or at least reduced its incentive) to civilly commit during this time frame.

The *Wyatt* case—and to a lesser degree, the more stringent civil commitment standards—radically reduced the patient population at state mental health facilities.⁹⁴

Deinstitutionalization in Alabama was very rapid in the early



1970s, then slow and steady since. By the early 2000s, the number of patients at Bryce, for example, had dropped to 330.⁹⁵

Notably, in 1989, the Alabama Supreme Court further held that involuntary civil commitment, without more, would not justify the administration of medication without the patient's informed consent.⁹⁶ By making it harder to forcibly medicate civilly committed patients, *Nolen* may have inadvertently

⁹⁴ See Philip J. Leaf & Michael M. Holt, *How Wyatt Affected Patients*, in WYATT V. STICKNEY: RETROSPECT & PROSPECT 73 tbl.3 (L. Ralph Jones & Richard R. Parlour, eds., 1981); E. FULLER TORREY ET AL., NO ROOM AT THE INN: TRENDS AND CONSEQUENCES OF CLOSING PUBLIC PSYCHIATRIC HOSPITALS, 2005–2010 22 tbl.1 (2012); E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS app. (1997). The graph reflects yearly data from 1956–1980 and interpolation between values for 1994, 2005, and 2010.

⁹⁵ Cummings, *supra* note 90. The *Wyatt* standards influenced states across the country and arguably even international law. Michael L. Perlin, "Abandoned Love": *The Impact of Wyatt v. Stickney on the Intersection Between International Human Rights and Domestic Mental Disability Law*, 35 LAW & PSYCHOL. REV. 121, 124–26 (2011).

⁹⁶ See *Nolen v. Peterson*, 544 So. 2d 863, 866 (Ala. 1989).

turned prison into a financially attractive institutional alternative only months before the Supreme Court's endorsement of a policy that made it harder for *prisoners* to avoid the unwanted administration of medication.

2. *The Mentally Ill Prisoner Population*

The percentage of prisoners with mental illness before and after *Harper* is much harder to chart. Some studies have estimated that only 5% of Alabama prisoners suffered from mental illness in 1971.⁹⁷ But the litigation surrounding the state of the Alabama prison system at the time suggests otherwise. In 1971, a federal district court in Alabama considered mental illness to be one of the most prevalent problems in the Alabama Department of Corrections (ADOC), noting that an estimated 10% of inmates were psychotic at the time and an estimated 60% were disabled enough to require treatment.⁹⁸

The final expert report in a 1990s case against ADOC, *Bradley v. Haley*, is of particular relevance here because it details the numerous problems that plagued the system at the time, such as psychotropic medication being the only consistently available treatment.⁹⁹ The experts also found that medications were improperly administered (and sometimes even prescribed without the physician ever seeing the inmate) and required monitoring was often not done.¹⁰⁰ According to a report published by the Bureau of Justice Statistics (BJS), in June 2000, 2.5% of Alabama's inmate population was receiving twenty-four-hour care, 8.4% was receiving therapy or counseling, and 4.9% was receiving psychotropic medications.¹⁰¹ The *Bradley* expert reports confirm that in 2001, "the mental health services [were] still in crisis," with only three psychiatrists serving a prison population of over

⁹⁷ TORREY ET AL., *supra* note 12, at 4 (relying on an estimate from Alabama's mental health commissioner).

⁹⁸ See *Newman v. Alabama*, 349 F. Supp. 278, 284 (M.D. Ala. 1972) (finding the level of mental health staff in the state's prisons to be unconstitutionally low), *aff'd in part*, 503 F.2d 1320 (5th Cir. 1974), and *vacated on other grounds*, 522 F.2d 71 (5th Cir. 1975).

⁹⁹ ABRAMSKY & FELLNER, *supra* note 18, at 135, 138 (noting that ADOC's director was informed as such by its private mental health contractor).

¹⁰⁰ *Id.* (internal citations omitted). In addition, the experts found that medication was not supplemented with adequate therapy or programming in any facility they visited. *Id.*

¹⁰¹ See ALLEN J. BECK & LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH TREATMENT IN STATE PRISONS, 2000 6 (2001) (explaining that the number of involuntary medication orders was not studied).

20,000.¹⁰²

In 2000, the parties in the *Bradley* case finally reached a settlement agreement, which in turn incorporated an agreement of the experts addressing the provision of treatment to seriously mentally ill inmates, staffing levels, mental health policies and procedures to be adopted by the ADOC, contract oversight, and a host of other issues.¹⁰³ Specifically, the *Bradley* agreement stipulated that one of the elements of adequate treatment for inmates with serious mental illness is “access to the most effective and appropriate psychotropic medication recommended by the treating physician,” accompanied by documentation of informed consent.¹⁰⁴ Most importantly, the agreement required ADOC to develop a policy titled “Administrative Review for Involuntary Psychotropic Medication (*Harper*).”¹⁰⁵ To that end, the agreement also required ADOC to produce quarterly logs to the plaintiff’s consultant reflecting the number of incidents of forced medication as well as the use of the involuntary medication procedure.¹⁰⁶

These provisions of the *Bradley* agreement are telling because they suggest that the ADOC did not have a non-emergency forced medication policy or procedure—or at least not a constitutionally adequate one—in place prior to 2000. Indeed, the ADOC did not promulgate this administrative regulation (AR-621) until 2004.¹⁰⁷ AR-621 cites the *Bradley* agreement, as well as *Harper*, as its authority.¹⁰⁸ While the substantive standards set out in AR-621 may be more protective than the constitutional floor set in *Harper*,¹⁰⁹ it is unclear whether ADOC adheres to its own standards.¹¹⁰

¹⁰² ABRAMSKY & FELLNER, *supra* note 18, at 136.

¹⁰³ Settlement Agreement, *Bradley v. Haley*, No. 92-A-70-N, August 8, 2000, at 1–2.

¹⁰⁴ *Id.* at Ex. A, p. 4.

¹⁰⁵ *Id.* at Ex. A, p. 5.

¹⁰⁶ *Id.* at 6.

¹⁰⁷ Ala. Dep’t of Corr., Admin. Reg. No. 621 (2004) [hereinafter AR-621].

¹⁰⁸ AR-621 §§ V.D, IX.A; *see also* Expert Report of Dr. Kathryn A. Burns at 40, *Dunn v. Dunn*, No. 2:14-cv-00601-MHT-TFM (M.D. Ala. July 13, 2016) (“The non-emergency involuntary medication procedure is supposedly modeled after . . . *Harper*.”).

¹⁰⁹ Under AR-621, a prisoner must demonstrate symptoms of serious mental illness; have been transferred to a SU for less intrusive treatment; have a “high likelihood of serious harm to self, others or property”; be unable to perform basic life sustaining functions; and manifest severe deterioration in routine functioning. AR-621 § V.A.

¹¹⁰ *See Dunn v. Dunn*, No. 2:14cv601-MHT (WO), 2016 WL 6949598, at *39–*40 (M.D. Ala. Nov. 25, 2016) (finding a dispute of material fact as to plaintiff’s

Procedurally, involuntary medication orders are to be determined through a true *Harper* administrative proceeding by an Involuntary Medication Review Committee.¹¹¹ There is no judicial review prior to forced medication.

Overall, the lack of data regarding the incarceration rate of persons with serious mental illness in the 1980s and 90s, let alone data regarding the number of involuntary medication orders, at either the national or state level, make it necessary to rely on *Bradley* as the main source of information. On the one hand, *Bradley* was about the *failure* to provide mental health treatment. One might argue that there was a cost-driven incentive to not provide seriously mentally ill inmates with psychotropic medication at all, choosing instead to isolate them for long periods of time with little to no treatment. Indeed, shortly after the *Bradley* litigation ended, Alabama was ranked thirty-fifth among states in expenditures for mental health care.¹¹² If the ADOC's expenditures on psychiatric medications were similarly low, then denial of medication may have been the bigger problem.

On the other hand, *Bradley* itself, along with the experts' characterization of ADOC's mental health system as "primitive" after eight years of litigation,¹¹³ suggests systemic abuse. If the current state of the ADOC is in any way reflective of its state from 1990 to 2004, then its delivery of mental health services may have consisted almost entirely of the administration of medication.¹¹⁴ The fact that the *Bradley* agreement required the ADOC to implement an involuntary medication policy also suggests that any procedures in place after 1990, when Alabama arguably had no policy at all, were constitutionally inadequate, and continued to be constitutionally problematic even after 2004, when Alabama essentially adopted the *Harper* standard.

3. *Harper in Alabama*

Because Alabama adopted its *Harper* policy in 2004, one

substantive and procedural due process claims and denying defendants' motion for summary judgment); *id.* at *41 (finding another plaintiff created "a material dispute as to whether his consent on many past occasions has been voluntary, and as to whether defendants[] have an unconstitutional practice of allowing staff to coerce prisoners into taking psychotropic medication").

¹¹¹ AR-621 § V.D.

¹¹² TORREY ET AL., *supra* note 12, at tbl.1 (measuring 2002 per capita expenditures by state mental health authority).

¹¹³ ABRAMSKY & FELLNER, *supra* note 18, at 136.

¹¹⁴ See Expert Report of Dr. Craig Haney at 68, *Dunn v. Dunn*, No. 2:14-cv-00601-MHT-TFM (M.D. Ala. July 13, 2016).

must look not only at the prevalence of mental illness within the ADOC post-1990, but post-2004 as well. This Sub-Part will examine the data regarding the number of prisoners suffering from mental illness in ADOC facilities.

Between 2004 and 2005, the odds of a person with serious mental illness being in jail or prison rather than in a hospital were roughly four to one in Alabama.¹¹⁵ With no solid Alabama data available for the 2004–2005 year, the authors of this study based the number of Alabama prisoners with serious mental illness in jails and state prisons on a national estimate of 16%.¹¹⁶ According to a BJS special report, over half of state prisoners nationwide (56%) met the diagnostic criteria for a mental illness in 2005.¹¹⁷ Specifically, 43% reported symptoms meeting the criteria for mania, 23% for major depression, and 15% for a psychotic disorder.¹¹⁸

In 2007, several years after the adoption of AR-621, ADOC's Commissioner reported that the percentage of inmates thought to be mentally ill had risen from 5 percent in 1971 to 20 percent.¹¹⁹ Alabama's mental-health commissioner, in turn, told a state legislative committee on mental health that "the short and simple answer [was to] get more beds" for mental-health patients outside of the penal system.¹²⁰ Yet by 2013, only 12.2% of Alabama prisoners were identified as having *any* mental health issue, with 9% taking psychotropic medications.¹²¹

It is hard to believe that the number of prisoners with

¹¹⁵ TORREY ET AL., *supra* note 12, at tbl.1. Those odds were greater in only ten states. *Id.*

¹¹⁶ *Id.* The 16% figure used to calculate this ratio is slightly different than the 15% figure later relied upon by the Treatment Advocacy Center as it factors in the number of Alabama prisoners in jail as well. *Compare id.* at 7 (citing Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVS. 761, 761 (2009), accounting for the prisoners in jail), with TORREY ET AL., *supra* note 85, at 27 (citing JAMES & GLAZE, *supra* note 9, to conclude that 15% of inmates have serious mental illnesses).

¹¹⁷ JAMES & GLAZE, *supra* note 9, at 1. This is the most recent BJS report on mental health problems in U.S. prisons and jails.

¹¹⁸ *Id.*

¹¹⁹ *Official Says State Prisons Like A 'Mental Health Center,'* NEWS COURIER (Dec. 21, 2007), http://www.eneWSCourier.com/news/local_news/official-says-state-prisons-like-a-mental-health-center/article_b4633aac-a82c-5177-8e16-99d075989f2d.html [<https://perma.cc/6EL7-Z73P>].

¹²⁰ *Id.*

¹²¹ MARIA MORRIS ET AL., S. POVERTY LAW CTR. & ALA. DISABILITIES ADVOCACY PROGRAM, *CRUEL CONFINEMENT: ABUSE, DISCRIMINATION, AND DEATH WITHIN ALABAMA'S PRISONS* 13 (2014) [hereinafter *CRUEL CONFINEMENT*]. While these numbers appear to be growing, they have not varied significantly since 2013. Expert Report of Dr. Kathryn A. Burns, *supra* note 108, at 23.

mental illness decreased from 2007 to 2013, especially considering the 36% cut to Alabama's general-fund mental health budget during this timeframe.¹²² More importantly, the 2007 and 2013 numbers reported by the ADOC are dramatically different than the national averages in the most recent BJS report, showing that in 2005, over half of state prisoners met these criteria. These differences call into question the reliability of ADOC's reporting, as "[i]t is highly unlikely that Alabama's prisoners suffer from mental illness at just one-quarter of the rate of most state prison populations."¹²³

To be sure, underreporting by the ADOC also affects the reliability of its later data concerning the number of prisoners with *serious* mental illness (who presumably face greater risk of forcible medication). In fact, ADOC's own documents suggest that the acuity of mental illness is understated. For example, in 2013, roughly 3% of the inmate population was diagnosed with a psychotic disorder, but less than 1% was classified as having more than a mild impairment in mental functioning (i.e., a code greater than "MH-2").¹²⁴ Thus, to the extent that the number of prisoners with a particular mental health code is available for the target years in question, these numbers cannot serve as reliable evidence of the number of prisoners with severe mental illness at a given time. Instead of classifying prisoners by the severity of their illness, ADOC's coding system is apparently based on a prisoner's presumed housing needs.¹²⁵

Dr. Kathryn Burns, who also served as an expert in *Bradley*, echoed these concerns in her report in the recent case filed as *Dunn v. Dunn*, a lawsuit against ADOC. She explains that while ADOC's private mental health contractor trains its staff that "10-15% of inmates have mental illnesses but 'not

¹²² See *State Report Card on Mental Health Care*, USA TODAY (Jan. 8, 2013), <http://www.usatoday.com/story/news/nation/2013/01/07/states-mental-health/1805023/> [<https://perma.cc/8C2B-NEX3>] (reporting results from NAMI study). In fact, in 2016, Alabama contributed \$25 million less to the ADMH than it did in 2006. Megan Wiebold, *The Investigators: How Funding Cuts Have Impacted Mental Health in Alabama*, ABC WAAY 31 (Feb. 14, 2016), http://www.waaytv.com/appnews/the-investigators-how-funding-cuts-have-impacted-mental-health-in/article_2c63b79c-d140-11e5-8c11-c7ebea8f0635.html [<https://perma.cc/KT8S-B98Y>].

¹²³ CRUEL CONFINEMENT, *supra* note 121, at 13.

¹²⁴ *Id.* at 13–14; see ADOC MENTAL HEALTH SERVS., REQUEST FOR PROPOSAL NO. 2013-02, at 98–99 (2013), <http://www.doc.state.al.us/docs/MentalHealthRFP2013.pdf> [<https://perma.cc/LT4R-CZSK>] [hereinafter ADOC RFP No. 2013-02].

¹²⁵ Expert Report of Dr. Kathryn A. Burns, *supra* note 108, at 26.

all . . . are considered serious,” there is “simply no reason to believe that prevalence rates of mental illness and serious mental illness in ADOC would be any different than rates found in studies and reported in other states.”¹²⁶ Indeed, there is even more reason to believe that the prevalence rates are higher than those found in other state systems “due to the status of the community treatment system in Alabama when compared with that in other states.”¹²⁷

Given the shortcomings in ADOC’s self-reporting, we assume that the national averages from 2005 are representative of Alabama’s numbers after the adoption of its own *Harper* policy in 2004: approximately 55% male and 73% female inmates reporting a mental health problem, with 15% of state prisoners reporting symptoms that met the criteria for a psychotic disorder.¹²⁸ In 2014, the Treatment Advocacy Center (TAC) found 15% was still a reasonable estimate for the number of state prisoners with severe mental illness.¹²⁹

In sum, it is nearly impossible to gauge the impact of *Harper* in Alabama. First and foremost, credible data on the percentage of prisoners with mental illness are not available, particularly from before the decision in *Harper* or its subsequent adoption in Alabama. Second, Alabama was apparently applying a standard even lower than *Harper* both

¹²⁶ *Id.* at 24. In her experience in other states, the prevalence rate has been roughly 25-30% for male inmates, with 10-15% having a serious mental illness, and 80% for female inmates, with 30% having a serious mental illness. *Id.*

¹²⁷ *Id.*

¹²⁸ JAMES & GLAZE, *supra* note 9, at 4.

¹²⁹ TORREY ET AL., *supra* note 85, at 27. Dr. Burns relies on this figure from the 2014 TAC survey in her report. See Expert Report of Dr. Kathryn A. Burns, *supra* note 108, at 24. It is worth noting that in defining the percentage of prisoners who are seriously mentally ill in its methodology, the TAC survey explicitly states that the average numbers are taken from the 2006 BJS report and its finding that 15% of prisoners reported symptoms meeting the criteria for psychotic disorder. TORREY ET AL., *supra* note 85, at 24. The TAC survey concludes that this number is still reasonable based on the authors’ review of studies done before and after the BJS report. *Id.* Importantly, however, both the Dr. Burns report and the ADOC regulations recognize that serious mental illness is not limited to psychotic disorder, and includes other disorders such as major depression, which *were* included in the 2006 BJS report. See Expert Report of Dr. Kathryn A. Burns, *supra* note 108, at 24; ALA. DEP’T OF CORR., ADMIN. REG. NO. 602 (2007) (defining “serious mental illness”); see also *supra* note 118 and accompanying text (determining that 23% report symptoms that meet criteria of major depression). Nevertheless, this potential discrepancy is not fatal. First, if the authors are basing their finding of “seriously mentally ill” prisoners in 2014 off of the same variable relied upon for 2006 (i.e., symptoms of psychosis), then we have succeeded in measuring some degree of change from 2006 to 2014. Second, the national average of 15% for the year 2014 does not deviate significantly from Dr. Burns’ estimates based on her experience in other states. See *supra* note 126.

before and for many years after *Harper*. For this reason we would expect the ultimate adoption by Alabama of standards generally in line with *Harper* to slow rather than speed up mass incarceration. Perhaps the most that can be said is that *Harper* did not improve the dire situation in Alabama.

More significantly, our frustration in Alabama suggests that a state-level, empirical approach is unlikely to be an effective test of our theory. A non-quantitative approach may have a better chance of success: interviews with long-time participants in the criminal justice system could shed light on whether our theory rings true. For example, one could ask a long-time prison warden whether it is easier to manage mentally ill prisoners with forced medication than with alternative methods and whether *Harper* affected their practices.

CONCLUSION

The traditional explanations for the mass criminalization of mental illness leave room for a new theory. Two of the existing theories happened too soon to explain the upsurge since 1990: higher civil commitment standards and the war on drugs. Several states restricted the diminished capacity defense at about the right time to account for some of the 1990s upsurge. More states limited insanity, but the effect should have been observed sooner. The lack of good community-based treatment options is almost certainly an important factor, but it existed both before and after 1990. The common explanation that best fits the timing is the shutdown of state mental hospitals. The number of inpatient beds had already contracted dramatically by 1980, but the remaining beds apparently filled an important gap and may have staved off incarceration for many with severe mental illness. All of this suggests that adding new inpatient beds and improving community-based programs should be high priorities going forward.

Our new theory—relatively easy forced medication under *Harper*—fits the timeline and is supported by current cross-sectional data showing higher incarceration rates for the mentally ill in jurisdictions that follow *Harper* than in jurisdictions with greater protections. That said, our in-depth analysis of one jurisdiction, Alabama, demonstrates that a state-by-state empirical analysis is likely impossible. Inadequate screening for mental illness and systematic under-reporting leaves us guessing as to the extent of the problem in Alabama prisons. Still, we have added to the

transinstitutionalization literature the notion that decreased costs associated with mentally ill inmates could exacerbate over-incarceration. On the flip side, adopting a standard more exacting than *Harper*, which we urge states to do, is associated with smaller mentally ill prisoner populations.¹³⁰

This phenomenon may apply to prison conditions generally, not just to forced medication. Another significant legal change in the 1990s was the enactment in 1996 of the Prison Litigation Reform Act (the PLRA), which “undermined prisoners’ ability to bring, settle, and win lawsuits.”¹³¹ The rate of prisoner civil rights filings in federal district court dropped from 23.3 per 1000 prisoners in 1996 to 15.1 in 1997 and stabilized around 10 from 2002 to 2012.¹³² Moreover, the PLRA had a disproportionately negative impact on prisoners with mental illness.¹³³ The PLRA may have contributed to increased incarceration of people with mental illness.

Notwithstanding the PLRA, some mentally ill prisoner lawsuits are beginning to achieve success. In *Brown v. Plata*,¹³⁴ the Supreme Court held that a court-mandated prison population limit was necessary to remedy the constitutional violations created by grossly inadequate medical and mental health care. This is obviously the direct route to reducing prison populations. But our analysis of *Harper* suggests an indirect route. By simply requiring prison systems to provide adequate mental health care, prison litigation can exert financial pressure against over-criminalization. Conditions inside prison may affect who ends up there, much as the *Wyatt* standards helped fuel deinstitutionalization from mental hospitals across the country.¹³⁵

Prisons today are as atrocious for people with mental illness as mental hospitals used to be.¹³⁶ And the remedies

¹³⁰ Cf. Stavis, *supra* note 51, at 196, 201 (arguing for easier forced treatment—indeed, endorsing *Harper*—but observing that “[i]n simple economic terms, the more costly the system makes state intervention, the higher the disincentive to its use or the tendency toward less expensive forms of care”).

¹³¹ Margo Schlanger, *Trends in Prisoner Litigation, as the PLRA Enters Adulthood*, 5 U.C. IRVINE L. REV. 153, 153 (2015).

¹³² *Id.* at 157 tbl.1.

¹³³ *Developments in the Law—The Law of Mental Illness, The Impact of the Prison Litigation Reform Act on Correctional Mental Health Litigation*, 121 HARV. L. REV. 1114, 1145–46 (2008).

¹³⁴ 563 U.S. 493, 502 (2011).

¹³⁵ See *supra* notes 89–90 and accompanying text.

¹³⁶ Paul Davis, *Wyatt v. Stickney: Did We Get It Right This Time?*, 35 LAW & PSYCHOL. REV. 143, 148 (2011) (describing Bryce Hospital as a “hellhole”); *SPLC Begins Trial on Behalf of Alabama Prisoners with Mental Health Needs*, SOUTHERN POVERTY LAW CENTER (Dec. 5, 2016),

sought by plaintiffs in prison reform litigation could be quite expensive for the state.¹³⁷ Alternative treatment in the community may finally be seen as the more attractive option.¹³⁸ It will be too late for Jamie, but if our theory is correct and if prison litigation succeeds more broadly, we may incline toward a second deinstitutionalization—this time from prison rather than mental hospitals.

<https://www.splcenter.org/news/2016/12/05/splc-begins-trial-behalf-alabama-prisoners-mental-health-needs> [https://perma.cc/Q3P4-RSMG] (quoting expert Dr. Craig Haney on an Alabama prison: “I saw prisoners living in barren ‘Suicide Watch Cells’ who had been kept there for months on end, and a prisoner residing in complete darkness, lying on an office floor in a room labeled ‘Mental Health’ and urinating in a plastic bucket.”).

¹³⁷ For example, the ADOC in the *Dunn* case after Jamie’s death agreed to hire one mental health worker for every prison and two for every prison with a mental health unit, and to provide constant monitoring for prisoners on suicide watch, an evaluation by a health care professional before release from suicide watch, and a follow-up visit three days later. Amy Yurkanin, *Settlement Reached to Prevent Suicides in Alabama Prisons*, AL.COM (Jan. 13, 2017, 9:06 AM), http://www.al.com/news/index.ssf/2017/01/settlement_reached_to_prevent.html [https://perma.cc/9CNH-JWD2].

¹³⁸ Better policing will also be essential. *Compare, e.g., How Memphis has changed the way police respond to mental health crises*, PBS NEWSHOUR (Nov. 7, 2015, 3:19 PM), <http://www.pbs.org/newshour/bb/memphis-changed-way-police-respond-mental-health-crises/> [https://perma.cc/FJ4H-ULBM] (highlighting the success of Memphis’s Crisis Intervention Team in helping police officers deal with mental health issues in the community), *with supra* note 33 and accompanying text (discussing the theory that the last patients to leave mental institutions following deinstitutionalization were the least able to survive on the outside and therefore more likely to end up in jail or prison).