

DEVIANCY, DEPENDENCY, AND DISABILITY: THE FORGOTTEN HISTORY OF EUGENICS AND MASS INCARCERATION

LAURA I APPLEMAN[†]

ABSTRACT

Three widely discussed explanations of the punitive carceral state are racism, harsh drug laws, and prosecutorial overreach. These three narratives, however, only partially explain how our correctional system expanded to its current overcrowded state. Neglected in our discussion of mass incarceration is our largely forgotten history of the long-term, wholesale institutionalization of the disabled. This form of mass detention, motivated by a continuing application of eugenics and persistent class-based discrimination, is an important part of our history of imprisonment, one that has shaped key contours of our current supersized correctional system. Only by fully exploring this forgotten narrative of long-term detention and isolation will policy makers be able to understand, diagnose, and solve the crisis of mass incarceration.

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[†] Associate Dean of Faculty Research and Van Winkle Melton Professor of Law, Willamette University. J.D., Yale Univ.; B.A., M.A., English, Univ. of Pennsylvania. Many thanks to Ryan Bounds, Jeff Dobbins, David Friedman, Aaron Simowitz, and Robin Wilson for their helpful comments. I am deeply indebted to the late Dr. Jay Katz for his many years of mentorship in this area of scholarship.

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INTRODUCTION

Racism,¹ harsh drug laws,² and prosecutorial overreach³ offer three widely discussed explanations for our current, historically high levels of incarceration. These three narratives, even when considered together, only partially explain how our carceral system has had such explosive growth. Our discussion of mass incarceration often neglects a central history: our long-term, wholesale institutionalization of the disabled. This form of mass detention, motivated by a continuing *sub rosa* application of eugenics and persistent class-based discrimination, shapes our current correctional system in important and troubling ways. Only by fully exploring the forgotten history of the disabled's long-term detention and isolation will we be able to understand our mass-incarceration dynamic and resolve the myriad of associated problems.

Segregation and detention have always served to control those on the margins: the poor (in almshouses, workhouses, and ghettos), minorities (in convict farms and correctional institutions), and the disabled (in cages, asylums, and hospitals). Over time, attitudes about eugenics, class, and disability combined to create the policies that led to our current nationwide system of punitive detention. Until we fully understand our long history of forcibly institutionalizing the mentally ill, the cognitively and physically disabled, and the “socially undesirable,” we will remain ill-equipped to address the problem of mass incarceration.

As a whole, standard histories of American criminal justice give little attention to the role of eugenics.⁴ Additionally, few, if any,

1. See generally MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* (2010) (arguing that racial castes in America exist in new forms).

2. See generally JAMES FORMAN JR., *LOCKING UP OUR OWN: CRIME AND PUNISHMENT IN BLACK AMERICA* (2017) (discussing the war on crime).

3. See generally MARK GODSEY, *BLIND INJUSTICE: A FORMER PROSECUTOR EXPOSES THE PSYCHOLOGY AND POLITICS OF WRONGFUL CONVICTIONS* (2017) (arguing that prosecutorial overreach is a root cause of mass incarceration and highlighting a surge in felony charges brought against arrestees beginning in the mid-1990s); JOHN PFAFF, *LOCKED IN: THE TRUE CAUSES OF MASS INCARCERATION – AND HOW TO ACHIEVE REAL REFORM* (2017) (exploring previously unexamined causes of mass incarceration and challenging the traditional consensus that the War on Drugs, strict sentencing laws, and reliance on private prisons are the core factors leading to mass incarceration).

4. Cf. generally DAVID J. ROTHMAN, *CONSCIENCE AND CONVENIENCE: THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA* (1980) (discussing the influence of eugenics on progressive American law); Jonathan Simon, *Racing Abnormality, Normalizing Race: The Origins of America's Peculiar Carceral State and Its Prospects for Democratic Transformation Today*, 111 NW. U.L. REV. 1625, 1653 (2017) (noting that “[o]ur globally leading national embrace

analyses of the punitive carceral state and modern mass imprisonment have truly surveyed the role played by our policies for the disabled. Yet these policies have critically shaped our current system of imprisonment. The long tail of eugenics still explains our twenty-first-century incarceration policies.

The history of the detention and institutionalization of the disabled is an oft-missing link in the historical trajectory of broader mass incarceration. The rise of disability rights over the last 40 years and the large-scale construction of the carceral state coexist uneasily in the historiography of the United States, with little attention given to the former's effect on the latter. But the creation of the current carceral state rose simultaneously with the imprisonment of those considered either physically, mentally, or intellectually inferior.

This Article proceeds in four parts. Part I explains the history of detention and imprisonment of the disabled from the American Colonial period through the Progressive Era, illustrating how a motive of control and containment of “undesirables” sowed the seeds of our modern prison system. Part II explores the role of eugenics in our treatment of the disabled and how that movement directly hastened the journey toward mass institutionalization. Part II also shows how eugenic philosophy continues to persist in the penal complex, although in different form and name. Part III then links the problems of our modern mass incarceration to the more recent transinstitutionalization of the disabled. Part IV closely examines where and how we treat people with mental, physical, and cognitive disabilities today, showing how a substantial subset of them have returned to institutional life. Finally, I conclude that any reforms of the model of modern mass incarceration must account for the existence, past and present, of mentally ill and disabled offenders and prisoners.

As other scholars have noted, we are in a “wave of modern incarceration history.”⁵ Beginning with Michelle Alexander's *The New Jim Crow* in 2010 and appearing most recently in a number of new

of eugenics and scientific racism was especially deeply felt in criminal justice, where a racial hierarchy of criminal risk became an integral part of the expanded carceral state created during the Progressive Era (or what we should call the ‘eugenic’ era”); Michael Willrich, *The Two Percent Solution: Eugenic Jurisprudence and the Socialization of American Law, 1900-1930*, 16 *LAW & HIST. REV.* 63, 64 (1998) (discussing how there is very little mention of eugenics in criminal justice history).

5. Jonathan Simon, *Is Mass Incarceration History? From the War on Poverty to the War on Crime: The Making of Mass Incarceration in America*, 95 *TEX. L. REV.* 1077, 1089 (2017).

books examining different aspects of mass incarceration,⁶ legal scholars and historians alike have shown great interest in trying to determine why we are living in a punitive carceral state. Scholars have begun to define mass incarceration as one of the central—albeit disturbing—features of the twentieth and twenty-first centuries.⁷ And yet, with a few exceptions,⁸ there has been little attention paid to the parallel segregation and detention of the disabled. Those who wish to dismantle the carceral state must understand the history of its creation.

I. THE HISTORY OF EARLY DETENTION AND SEGREGATION: CONFINING THE DISABLED OTHER

Through a recent focus on the causes of modern mass incarceration, scholars and historians have taken a careful look at much of the history of imprisonment in the United States. One important narrative that has been overlooked, however, is the history of the care, forcible segregation, and frequent neglect of the disabled. This Part explores and expands upon the standard history of our carceral state by adding an overlooked strand: our treatment of those individuals we have always viewed as the other.

A. *Early Madhouses and Asylums*

1. *Europe.* From the very beginning, European society has aimed to confine and isolate those suffering from various poorly understood disabilities. Anglo-Europeans began segregating and confining the mentally ill and cognitively disabled from approximately the twelfth century. St. Bartholomew's hospital was founded in 1142 in London, and the Priory of St. Mary of Bethlehem, later known as "Bedlam," originated in England in 1247 and began taking "lunaticks" in 1403.⁹

6. See generally MARIE GOTTSCHALK, *CAUGHT: THE PRISON STATE AND THE LOCKDOWN OF AMERICAN POLITICS* (2015) (providing a comprehensive overview of the politics of mass incarceration in America); ELIZABETH HINTON, *FROM THE WAR ON POVERTY TO THE WAR ON CRIME: THE MAKING OF MASS INCARCERATION IN AMERICA* (2016) (analyzing the strength of the carceral state in America and examining the shortcomings of penal reform strategies); text accompanying *supra* notes 2–3.

7. See, e.g., Alex Lichtenstein, *Flocatex and the Fiscal Limits of Mass Incarceration: Toward a New Political Economy of the Postwar Carceral State*, 102 J. AM. HIST. 113, 113–14 (2015).

8. See generally Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution*, 84 TEX. L. REV. 1751 (2006) (arguing for alternative models for the U.S. prison system).

9. See RON POWERS, *NO ONE CARES ABOUT CRAZY PEOPLE* 59–60 (2017).

Likewise, twelfth-century Prussian records note that mentally afflicted people were routinely put in prison.¹⁰ During the same period, monasteries were frequently used by bishops and secular magistrates to confine difficult clerics and laypeople, in part to grant them “spiritual purification and moral renewal.”¹¹

By the middle of the seventeenth century, the insane and disorderly were viewed as an unquestionable threat to public health and order.¹² Incarcerating such individuals in institutions, along with others who did not neatly fit in to the polity, was believed necessary to support the emergence of the new nation-states in Europe.¹³ In line with this thinking, multiple charitable asylums housing the “mad” began to open around England in the eighteenth century.¹⁴ Along with the truly psychotic or disturbed, patients confined in these institutions included those who suffered from depression or alcoholism, the homeless, and disobedient wives.¹⁵ All of these asylums subjected their patients to unspeakable abuse, sometimes in the name of “treatment,” sometimes not.¹⁶ It took until the end of the eighteenth century for asylums to start treating the mentally ill in an ethical and moral manner—training attendants, providing sanitary housing, and doing away with the practice of chaining.¹⁷ Even this more humane treatment, however, was implemented through confinement.

10. See Catherine Slater, *Idiots, Imbeciles, and Intellectual Impairment: A History of Mental Handicap and Learning Disabilities*, FREESERVERS, <http://caslater.freeservers.com/disability1.htm> [<https://perma.cc/L7GS-T54U>]; see also Guy Geltner, *Medieval Prisons: Between Myth and Reality, Hell and Purgatory*, 4 HIST. COMPASS 1, 4 (2006) (noting how the mentally ill were also confined in medieval prisons).

11. Bettina Muenster & Jennifer Trone, *Why is America So Punitive? A Report on the Deliberation of the Interdisciplinary Roundtable on Punitiveness*, 28 FED. SENT. REP. 340, 345 (2016). Granted, the confinement was viewed not as retributive but as an opportunity for healing and reintegration.

12. See Jonathan Simon & Stephen A. Rosenbaum, *Dignifying Madness: Rethinking Commitment Law in the Age of Mass Incarceration*, 70 U. MIAMI L. REV. 1, 4 (2015).

13. *Id.* at 4.

14. POWERS, *supra* note 9, at 61.

15. *Id.* at 62.

16. *Id.* at 61–62. As Powers describes, the inmates were “stripped of clothing, kept alive on subsistence levels of food and water, and screamed . . . for mercy and release.” *Id.*

17. *Id.* at 63; see also Richard E. Gardner III, Comment, *Mind over Matter: The Historical Search for Meaningful Parity Between Mental and Physical Health Care Coverage*, 49 EMORY L.J. 675, 679 n.36 (2000) (“[T]he first general trend toward specialized treatment of the mentally ill probably came in the wake of the social, political, economic, and scientific reforms that characterize the latter half of the eighteenth century.”).

2. *America.* In the United States, our carceral state has roots that reach back to the early Republic.¹⁸ Indeed, from the time of the nation's formation, incarceration was seen simultaneously as "both a modern intervention and as an Enlightenment ideal for the expression of liberty by the negation of it."¹⁹ Paradoxically, "captivity was fundamental to American freedom from the beginning."²⁰

a. *Colonial Isolation and Control.* The treatment of the mentally ill and cognitively disabled was simple in the early colonial days. For colonial society, insanity and cognitive disability differed little from any other disability; the mentally ill were supported like any other needy individual.²¹ In short, mentally ill and disabled people were grouped with the indigent, vagrant, chronically ill, and other societal dependents.²² If no convenient attic or basement in a family's home was available, many communities built a little hut or shack in the middle of the commons for the confinement of the insane.²³ Occasionally, all the needy individuals were housed in a prison or almshouse and supported by the community.²⁴

The primary objective in taking care of the disabled in early colonial times was to preserve the peace of the community, not to treat the individual.²⁵ The focus was on preventative confinement: to prevent any dangerous or disturbing behavior that might bother others.²⁶ As 1676 legislation from Massachusetts addressing mental illness made very clear, the fear was that the mentally ill might contaminate other members of the community, sending them to damnation:

18. See Kelly Lytle Hernández, Khalil Gibran Muhammad & Heather Ann Thompson, *Constructing the Carceral State*, 102 J. AM. HIST. 18, 21 (2015).

19. See *id.*

20. See *id.*

21. See Alan M. Dershowitz, *Origins of Preventive Confinement in Anglo-American Law, Part II: The American Experience*, 43 U. CIN. L. REV. 781, 786 (1974).

22. See *id.*

23. See DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC* 43 (1971). The first recorded case of confining the mentally ill, taking place in the Pennsylvania colony in 1676, provided that "Jan Vorelissen, of Amesland, Complaying to ye Court that his son Erik is bereft of his naturall Senses and is turned qutt madd and yet, he being a poore man is not able to maintaine him; Ordered: yt three or four persons bee hired to build a little block-house at Amesland for to put in the said madman." Dershowitz, *supra* note 21, at 786.

24. See Dershowitz, *supra* note 21, at 786.

25. See ROTHMAN, *supra* note 23, at 43.

26. See Dershowitz, *supra* note 21, at 787.

Whereas, There are distracted perseons in some tounes, that are unruly, whereby not only the families wherein they are, but others suffer much damage by them, it is ordered by this Court and the authoritue thereof, that the selectment in all tounes where such persons are hereby impowred & injoynd to take care of all such persons, that they doe not damnify others.²⁷

The statute permitted families to control and contain mentally ill family members, paying the costs out of their own estates, or, if there was no family, granted such power to the town.²⁸

Eventually, local governments began taking responsibility for the unfit, using a system of poor laws.²⁹ The mentally ill and cognitively disabled were contained in a variety of institutions, including almshouses, poorhouses, and jails, with little to no effort made to separate them from other persons under supervision or dependency.³⁰ Minimal work was done to treat these individuals or even give them medical care.³¹ Surviving records of New York almshouse inmates from the early part of the eighteenth century show that one-quarter of the inhabitants were “lame, blind, insane or idiotic,” while another quarter were “senile and incapacitated.”³² The early American response to deviancy—whether the person was criminal, disabled, or insane—was to attempt to maintain order through insularity.³³

The practice of locking up the unfit or disabled had little to do with any knowledge about or desire to implement treatment; confinement of the mentally ill, the cognitively disabled, the poor, and the contagious well preceded the development of psychiatry.³⁴ None of the pre-nineteenth century statutes which regulated these individuals and permitted their incarceration had any mention of doctors, either as expert witnesses or as directors of treatment.³⁵ In truth, the containment of the insane was a type of “inward banishment,”³⁶

27. *Selectman's Power to Take Care for the Distracted*, 5 THE RECORDS OF THE GOVERNOR & COLONY OF MASSACHUSETTS BAY IN NEW ENGLAND 8, 80 (May 3, 1676).

28. *See id.* at 81.

29. *See* Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons From the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 61 (2011).

30. *Id.*

31. *Id.*

32. *See* ROTHMAN, *supra* note 23, at 39.

33. *See id.* at 48.

34. *See* Dershowitz, *supra* note 21, at 790.

35. *See id.*

36. *Id.* at 789.

removing them from the daily interactions of community life by confining them to a cell.

b. Early American Institutions. The eighteenth century gradually saw some shift of responsibility from the community to the institution. The first American incorporated hospital, Philadelphia Hospital, was opened in 1753.³⁷ Cofounded by Dr. Thomas Bond, a Quaker, and Benjamin Franklin, the hospital confined a small number of mentally ill patients in the basement.³⁸ In 1773, the Eastern Lunatic Asylum, the first American psychiatric hospital, was founded in Williamsburg, Virginia.³⁹ By 1813, the private Philadelphia Friends Asylum for the Relief of Persons Deprived of the Use of Their Reason was opened for the treatment of the mentally ill,⁴⁰ and public mental hospitals opened soon after in Baltimore, Boston, and New York.⁴¹ The confinement of mentally ill and disabled people into asylums would last for the next 150 years.⁴²

The creation of asylums on American soil was tied deeply into a belief system that was heavily based on class and heredity. Early American society was structured as a strict class hierarchy that included a belief in a permanent lower class, considered “rubbish,” “degenerate,” and a true bottom layer of society.⁴³ Indeed, the American colonies were originally seen as “a place where the surplus poor, the waste people of England, could be converted into economic assets.”⁴⁴ Originally, the Americas were seen as a vast fallow ground upon which to cast England’s poor and homeless, the “waste people” who were the dregs of society.⁴⁵ In sending their indigent, criminal, and mentally challenged classes to the new colony, the English envisioned colonial America as “one giant workhouse.”⁴⁶

37. See POWERS, *supra* note 9, at 67.

38. See *id.*

39. E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA’S MENTAL ILLNESS CRISIS* 81 (1998).

40. See POWERS, *supra* note 9, at 68.

41. See TORREY, *supra* note 39, at 81.

42. See *id.*

43. See NANCY ISENBERG, *WHITE TRASH: THE 400 YEAR-OLD UNTOLD HISTORY OF CLASS IN AMERICA* 102 (2016).

44. See *id.* at 21.

45. See *id.* at 20–21.

46. *Id.* at 21 (discussing Hakluyt, one of the chief promoters of American colonial migration).

Those who failed to be converted into workers—the physically disabled, the mentally ill, the cognitively challenged, and the simply lazy—would either be left to linger in their squalor or incarcerated into various asylums, workhouses, and jails. For mid-eighteenth-century colonial society, the easiest way to deal with the marginalized was through containment and segregation, either by placing them in local institutions, such as the almshouse, or sending them off to colonize new and dangerous lands, “fertilizing wasteland with their labor.”⁴⁷ Both New York and Boston officially established almshouses to treat the “exceptionally burdensome cases” among the inhabitants—those who were incapable of taking care of themselves and would be an “onerous responsibility” for their neighbors.⁴⁸

The reality of the new American states’ growth contrasted sharply with the desires of their founders. In the South, for example, impoverished, landless trespassers were viewed with the greatest of disgust and contempt, seen as “lazy and debauched” inhabiting “the spawning ground of a degenerate breed of Americans.”⁴⁹ A similar concern about how North Carolina’s poor created a space “overrun with sloth and poverty”⁵⁰ reflected early America’s anxiety over the great unwashed and uneducated class, running rampant over the untamed wilderness. Fear of these “swamp vagrants”⁵¹ and their potentially contagious laziness, inbred deformities, squalid living conditions, and regression to animalistic behavior⁵² helped shape the American attitude toward those who failed to thrive and provide in a capitalistic society.

And what was the best way to deal with such “ignorant wretches,”⁵³ a new, loathsome breed of human that lowered the good name and reputation of white settlers? Containment, control, and separation—the seeds of our modern mass incarceration system. For the nascent American Republic, one easy way to rid itself of bottom-feeders was to lure them westward in hopes of both forcing them

47. *Id.* at 24.

48. ROTHMAN, *supra* note 23, at 36. As Rothman points out, however, the almshouse in the early colonial days was a last resort for those who could not be supported by the community due to their extreme health or mental conditions. *See id.*

49. ISENBERG, *supra* note 43, at 47 (discussing in particular the problems of early colonial Carolina, especially North Carolina).

50. *Id.* at 50 (quoting an Anglican minister in 1709).

51. *Id.* at 53.

52. *See id.* at 53–54.

53. *Id.* at 54.

toward useful work (colonizing the West) and cleaning out the “rubbish” currently inhabiting the new United States.⁵⁴

Another form of imposing containment and control was to create workhouses and poorhouses, punishing those deemed to be vagrants and forcibly hiring out their children as apprentice labor.⁵⁵ As Bob Ellickson has noted, our early history is rich with “efforts to sequester the mentally ill in confined locales: workhouses, poorhouses, and jails in Colonial times; large rural asylums during the nineteenth century.”⁵⁶ Such was the concern over this ever-present lower class that the Articles of Confederation specifically excluded “paupers, vagabonds, and fugitives from justice” from the privileges of citizenship.⁵⁷ Thus, from the very beginning, American society has looked to isolation and segregation to deal with those who were disabled, destitute, or unhealthy.

B. The Rise of the Early Asylum

As Americans in the early Republic adjusted to the massive social transformations created by the Revolution, they began to embrace asylums as a “total institution” to deal with the mentally ill and disabled.⁵⁸ The late eighteenth century and early nineteenth century saw a switch from keeping afflicted relatives at home to a much greater willingness to institutionalize them. This was in large part due to social and cultural changes⁵⁹—changes that would eventually result in the large-scale building of institutions of confinement.⁶⁰ These changes included population growth in the northeastern, border, and western states, which made banishment a more difficult strategy to use for the dangerous and deviant.⁶¹ In addition, the growth and prosperity of

54. *Id.* at 90–91.

55. *See id.* at 91.

56. Robert C. Ellickson, *Controlling Chronic Misconduct in City Spaces: Of Panhandlers, Skid Rows, and Public Space-Zoning*, 105 *YALE L.J.* 1165, 1209 n.235 (1999).

57. ARTICLES OF CONFEDERATION OF 1781, art. IV, para. 1; *see also* ELIGA H. GOULD, *AMONG THE POWERS OF THE EARTH: THE AMERICAN REVOLUTION AND THE MAKING OF A NEW WORLD EMPIRE* 12 (2012).

58. *See* Simon & Rosenbaum, *supra* note 12, at 15.

59. *See* Michael MacDonald, Review, *Madness and Healing in Nineteenth-Century America*, 13 *REVS. AM. HIST.* 211, 214 (1985) (reviewing NANCY TOMES, *A GENEROUS CONFIDENCE: THOMAS STORY KIRKBRIDE AND THE ART OF ASYLUM-KEEPING, 1840-1883* (1984)).

60. *See* Dershowitz, *supra* note 21, at 801.

61. *Id.* at 801–02.

American cities and towns meant that there was a greater need for safe confinement of those individuals who did not fit in to normal society.⁶²

By the early nineteenth century, public asylums were being built to house more obviously disabled individuals, alongside the other unwanted citizens who were incarcerated in almshouses, workhouses, and jails.⁶³ In particular, the mentally ill were deemed so undesirable that small communities often passed them “from town to town, often leaving them in town squares in the middle of the night.”⁶⁴ Thus, the creation of these mental institutions was in large part based on the role they played in warehousing—that is, “confin[ing] and segregat[ing] the mentally ill and disabled from the rest of society.”⁶⁵

This desire to contain and control the disabled combined with a “cult of asylum” that swept across America in the early- to mid-nineteenth century.⁶⁶ Psychiatrists and their supporters insisted that many mental illnesses and cognitive disabilities were curable.⁶⁷ Far from being a last resort, as in the eighteenth century, confinement in the asylum was now “a first resort, the most important and effective weapon in [the] arsenal.”⁶⁸ Moreover, nineteenth century asylums began to admit patients suffering from a wider range of symptoms than had their eighteenth-century predecessors, thus vastly broadening both the type and the number of patients admitted.⁶⁹

The early to middle years of the nineteenth century were the most humane for detention and treatment of those individuals deemed unfit to remain in the public view. Many of the asylums based their approach on a “moral treatment” approach, which stressed small patient sizes (a few hundred), minimal use of restraints and seclusion, and adequate food and exercise.⁷⁰ In terms of approach, the moral treatment movement “combined a system of psychological rewards and punishments with medical therapies” to help ameliorate both the

62. *Id.* at 802.

63. *See* TORREY, *supra* note 39, at 81.

64. *Id.*

65. Polly J. Price, *Infecting the Body Politic: Observations on Health Security and the Undesirable Immigrant*, 63 U. KAN. L. REV. 917, 936 (2015).

66. *See* ROTHMAN, *supra* note 23, at 130.

67. *See id.* at 131.

68. *Id.*

69. *See* MacDonald, *supra* note 59, at 214. Such symptoms included nymphomania, domestic troubles, religious fantasy, overwork, suppressed menses, and childbirth. Katherine Poubia & Ashley Tianon, *Lunacy in the Nineteenth Century: Women’s Admission to Asylums in United States of America*, OSHKOSH SCHOLAR 95, 96 tbl.1 (2006).

70. TORREY, *supra* note 39, at 82.

“mental and somatic causes of insanity,” as they were understood at that time.⁷¹ This new therapy sought to discard the physically coercive treatment, seeking instead to “cure” lunacy and other disabilities via a course of psychological coercion.⁷²

Although ethically focused, the moral treatment was, at heart, a product of its time, culture, and class. As such, a large part of its ultimate focus was to discipline social deviancy into acceptable behavior.⁷³ As historians have argued, the early-nineteenth-century asylum “recapitulated in miniature the larger society and sought to cure deviants by compelling them to accept its dominant ideology.”⁷⁴ The moral treatment approach was dominant, but the time required to properly practice it meant that the number of patients began to overrun the number of beds.⁷⁵

The spirit within which many of these asylums were built stemmed from a moral and ethical concern over the way that the disabled were being treated. Their construction, however, must be placed within a larger context. David Rothman has persuasively written about how, in the decades after the 1820s, Americans built “penitentiaries for the criminal, asylums for the insane, almshouses for the poor, orphan asylums for homeless children, and reformatories for delinquents.”⁷⁶ This desire and motivation to contain, control, and regulate those individuals who fell outside of the boundaries of desirable social behavior was due in large part to the general financial, political, and social instabilities of the first modern Republic.⁷⁷ As Bernard Harcourt observed, the erection of these houses of containment, whether prison, asylum, almshouse, workhouse, or the like, “represented an ordering of spatial exclusion necessary to appease apprehension of the unknown.”⁷⁸ In doing so, they laid the groundwork for our own modern carceral state.⁷⁹

71. MacDonald, *supra* note 59, at 212.

72. *Id.* at 213.

73. *Id.*

74. *Id.*

75. James W. Trent Jr., *Moral Treatment*, DISABILITY HIST. MUSEUM, <https://socialwelfare.library.vcu.edu/eras/moral-treatment-insane> [<https://perma.cc/DB59-FRST>].

76. ROTHMAN, *supra* note 23, at xiii.

77. *Id.* at 133.

78. Harcourt, *supra* note 8, at 1758.

79. *See id.*

C. *Asylums as Carceral Institutions*

Beginning in the mid-nineteenth century, life in the asylum took a drastic turn for the worse. Public psychiatric hospitals became flooded with patients, turning these “moral treatment” centers into “human warehouses.”⁸⁰ This phenomenon first began in the South, when “tens of thousands of indigent immigrants poured into New Orleans” in the 1840s, increasing the number of disabled and indigent wandering the streets.⁸¹ Over 177 new inmates were admitted to Louisiana asylums from 1844 to 1847⁸²—a huge influx, given the population at the time.⁸³ The overflow patients who could not obtain places at the state asylum were detained in such places as “the parish prison, the city workhouse, or the Charity hospital.”⁸⁴ The situation in Louisiana was soon replicated all over the nation.⁸⁵

The number of mentally ill and disabled patients continued to mushroom following the end of the Civil War. A combination of “[i]ndustrialization, rapid growth, and urbanization altered class relations and created a vast corps of chronic, indigent lunatics.”⁸⁶ Private asylums were not able to handle this overflow, and the states lacked both money and interest to build enough public asylums to properly follow the moral treatment regime.⁸⁷

The simplest solution was jettisoning the use of moral treatment altogether. Accordingly, Americans built a two-tier system of hospitals that reflected the realities of mid- to late nineteenth-century society: custodial care for the disabled, criminal, and indigent, and more sophisticated treatment for the wealthier unwell.⁸⁸ For the state

80. TORREY, *supra* note 39, at 82.

81. See Gilles Vandal, *Curing the Insane in New Orleans: The Failure of the “Temporary Insane Asylum,” 1852-1882*, 46 LA. HIST. 155, 157 (2005) (describing New Orleans as an example of a city unable to cope with the influx of psychiatric patients).

82. *Id.*

83. The 1840 census lists the population of Louisiana at 352,411; the 1850 census at 517,762. U.S. CENSUS BUREAU, *Resident Population and the Apportionment of the U.S. House of Representatives: Louisiana*, <https://www.census.gov/dmd/www/resapport/states/louisiana.pdf> [<https://perma.cc/UM9S-CCUH>].

84. Vandal, *supra* note 81, at 159.

85. GERALD GROB, *MENTAL INSTITUTIONS IN AMERICA: SOCIAL POLICY TO 1875* 368–70 (1973).

86. MacDonald, *supra* note 59, at 215.

87. *Id.*

88. *Id.* In other words, while the poor were generally warehoused, with minimal treatment, moral asylums included activities like theater, photography, and writing. See Emily Clark, *Mad Literature: Insane Asylums in Nineteenth Century America*, 4 ARIZ. J. OF

asylums particularly, as the percentage of incurable patients continued to increase, the quality of the doctors began to decrease, presumably due to the less desirable aspects of the work, and the quality of treatment likewise suffered.⁸⁹

The two-tiered model of asylum care was particularly apparent in new states like California, which, after gaining statehood in 1851, began a vigorous building scheme for state-run asylums.⁹⁰ The creation of these California institutions was embraced primarily as a way to isolate and control a dangerous and burdensome segment of the population.⁹¹ California asylums were built not only to incarcerate and treat the mentally ill, but also to provide “detention facilities for ‘imbeciles, dotards, idiots, drunkards, simpletons, fools,’ [and] for ‘the aged, the vagabond, [and] the helpless.’”⁹² In part, this desire to contain and control segments of the population stemmed from the influx of domestic migrants flooding the state from the East, along with high numbers of Mexican and Asian immigrants, making state inhabitants anxious about all forms of “deviance” and difference.⁹³

In addition, a growing “belief in the curability of mental illness by confinement in an appropriate asylum” also helped spur the construction of public institutions.⁹⁴ This newfound support for asylums was “supported by the publication of bogus ‘recovery’ statistics.”⁹⁵ The common conclusion was that confining the mentally ill and disabled to said asylums would benefit both them and society.⁹⁶

These sentiments were disseminated with the help of humanitarian campaigner Dorothea Dix, who publicized the plight of the mentally ill and disabled languishing in prisons.⁹⁷ Her crusade

INTERDISC. STUD. 42, 46 (2015).

89. Dershowitz, *supra* note 21, at 830.

90. See Simon & Rosenbaum, *supra* note 12, at 1718 (discussing California’s construction of state hospitals “on an unprecedented basis” to separate the dangerous and unwanted segment of the population).

91. *Id.* at 18.

92. RICHARD W. FOX, *SO FAR DISORDERED IN MIND: INSANITY IN CALIFORNIA, 1870-1930*, at 17 (1978).

93. Simon & Rosenbaum, *supra* note 12, at 18.

94. Adam Klein & Benjamin Wittes, *Preventative Detention in American Theory and Practice*, 2 HARV. NAT’L SEC. J. 85, 158 (2011).

95. *Id.*

96. See *id.* (outlining the “conclusion that confinement in newly constructed asylums would be a salutary policy benefiting the mentally ill”).

97. Sol Wachtler & Keri Bagala, *From the Asylum to Solitary: Transinstitutionalization*, 77 ALB.L. REV. 915, 915 (2014).

resulted in the creation of at least thirty state asylums.⁹⁸ Dix has been criticized, however, for removing the disabled from their communities and transferring them to detention and isolation in state-run institutions.⁹⁹ Ultimately, Dix's work meant that the disabled were effectively erased from society as communities became accustomed to their distant incarceration.¹⁰⁰

Like many states, New York responded to this new focus on asylum care and treatment with harsh measures. In 1842, its commitment statute *required* detention in the new state asylum at Utica “[i]n every case of lunacy,” for a minimum of six months.¹⁰¹ This drastically increased the number of mentally ill and disabled citizens who were forced to go into asylum confinement.¹⁰² Both dangerous and harmless mentally ill individuals were required to be incarcerated until they were “cure[d],” if ever.¹⁰³ This statute became a model for many other states.¹⁰⁴

Likewise, an 1864 Illinois law allowed men to “commit their wives to state care ‘without the evidence of insanity required in other cases.’”¹⁰⁵ Although this law was challenged in state court,¹⁰⁶ an attempt to require jury trials for every civil commitment failed.¹⁰⁷ Incarceration in public asylums was allowed for a variety of reasons, many only vaguely related to mental illness or disability.

By the late nineteenth century, the pressures on public asylums grew as patient numbers increased and available funds dropped.¹⁰⁸ The

98. See E. FULLER TORREY, JOAN STIEBER, JONATHAN EZEKIEL, SIDNEY M. WOLFE, JOSHUA SHARFSTEIN, JOHN H. NOBLE & LAURIE M. FLYNN, NAT'L ALLIANCE FOR THE MENTALLY ILL & PUB. CITIZEN'S HEALTH RES. GROUP, CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS 11 (1992).

99. Dershowitz, *supra* note 21, at 807.

100. See Dershowitz, *supra* note 21, at 807. As Dershowitz trenchantly comments, “it is beyond dispute that many more insane, some of whom had previously been tolerated in their communities, lost their liberty in the name of an exaggerated therapy.” *Id.*

101. *Id.* at 808.

102. *Id.*

103. *Id.*

104. *Id.*

105. See Klein & Wittes, *supra* note 94, at 159; see also ALBERT DEUTSCH, THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES 423 (1949).

106. See Dershowitz, *supra* note 21, at 834–37 (describing the 1864 Illinois case *Packard v. Packard*).

107. See Klein & Wittes, *supra* note 94, at 160.

108. See Constance M. McGovern, *The Community, the Hospital, and the Working-Class Patient: The Multiple Uses of Asylum in Nineteenth-Century America*, 54 PA. HIST. 17, 18 19

resulting shift in treatment, from intense therapeutic regimes to more workaday caretaking, led to concerns that public asylums were nothing more than convenient but necessary warehouses for the insane, disabled, and feebleminded.¹⁰⁹ The custodial care that these asylums provided was crucial to house those individuals whose families could no longer take care of them, whether due to delusions, epilepsy, violence, severe depression, destructive tendencies, advanced paralysis due to tertiary syphilis, advanced dementia, or gynecological problems, among other issues.¹¹⁰ Some working-class communities also utilized the asylum as a place to house and provide guardianship for their needy and elderly ill.¹¹¹ Thus, by the end of the century, many public asylums were crowded, understaffed, and underfunded, creating difficult and sometimes dangerous living conditions.

Despite criticism of asylum conditions and practices, the detention of the mentally ill, the cognitively and physically disabled, and the chronically ill continued through the rest of the nineteenth and much of the twentieth century.¹¹² Late eighteenth- and nineteenth-century thoughts, attitudes, and behaviors were remarkably stable in their “stance toward disability, dependency, and deviancy.”¹¹³ Most crucially, these attitudes were formalized in state laws, policies, and judicial proceedings, helping crystallize such beliefs, as I discuss below.

Legislative commentary from mid-nineteenth-century Massachusetts is illustrative, nicely elucidating the fear and concern that arose over presence of the disabled, as well as the desire to safely contain it. In a report made to the Massachusetts legislature, Samuel Howe expressed his concern about the teeming mass of undesirables, including “the paupers . . . the drunkards, the vagabonds, the criminals, the insane, the blind, [and] the deaf.”¹¹⁴ Howe then expounded on the necessity of asylum care to the proper ordering of civilization:

(1987) (discussing the financial pressures on asylums as legislators became increasingly concerned about the efficient use of state dollars).

109. *Id.* at 19.

110. *Id.* at 20, 22.

111. *Id.* at 24.

112. *See id.*

113. Kay Schriner & Lisa A. Ochs, *Creating the Disabled Citizen: How Massachusetts Disenfranchised People Under Guardianship*, 62 OHIO ST. L.J. 481, 515 (2001).

114. SAMUEL GRIDLEY HOWE, REPORT MADE TO THE LEGISLATURE OF MASSACHUSETTS, UPON IDIOCY 56 (Boston, Coolidge & Wiley 1848), <https://archive.org/details/66450930R.nlm.nih.gov/page/n63> [<https://perma.cc/Q34A-RJMH>].

[Asylum care was needed to remove] that fearful host which is ever pressing upon society with its suffering, its miseries, and its crimes, and which society is ever trying to hold off at arm's length,—to keep in quarantine, to shut up in jails and almshouses, or, at least, to treat as a pariah caste; but all in vain.¹¹⁵

The nineteenth-century asylum was grounded on a “deep fearfulness of the coherence of the democratic society that . . . [was] developing around” it.¹¹⁶ Although therapeutic aims partially motivated the desire to institutionalize the disabled, deviant, and dependent, this was not the only goal. Equally important was the desire to reorder society.¹¹⁷ The institution of the asylum gave “access to the ambitions and anxieties of the early [R]epublic itself,”¹¹⁸ which relied on confining those who did not fit into the societal order.

D. Asylum Growth and Reform in the Progressive Era

By the end of the nineteenth century, the state of the public mental asylum was a disgrace. Brutality and corruption were widespread and an open embarrassment.¹¹⁹ The asylum patient was alternately ignored or assaulted, “often . . . restrained by camisoles and straightjackets and . . . locked into covered cribs” at night.¹²⁰ The humanitarian efforts of Dorothea Dix had eroded into neglect and squalor.

As asylums expanded in both number and complexity, issues of order, cost, and efficiency conflicted with therapeutic aims.¹²¹ Thus, faced with failure, progressive legislators began to create new policies to deal with three groups of individuals who failed to fit into the community: “the criminal, the delinquent, and the mentally ill.”¹²²

The society of the Progressive Era did not seek to dismantle the

115. *Id.*

116. Michael Zuckerman, *Review of Conscience and Convenience: The Asylum and Its Alternatives in Progressive America*, 73 J. CRIM. LAW & CRIMINOLOGY. 1803, 1804 (1982) (book review).

117. *See id.* (“The founders of the asylums intended to reorder their entire society rather than just redress a few isolated imbalances or resolve a few sequestered social problems.”).

118. *Id.*

119. Gerald N. Grob, *Distorting History*, COMMENT. MAG. (July 1, 1980), <https://www.commentarymagazine.com/articles/conscience-and-convenience-by-david-j-rothman/> [<https://perma.cc/HFP6-SCEZ>] (reviewing ROTHMAN, *supra* note 4).

120. *See* Andrew Scull, *Progressive Dreams, Progressive Nightmares: Social Control in 20th Century America*, 33 STAN. L. REV. 575, 576–77 (1981).

121. *See* GERALD N. GROB, *THE MAD AMONG US: A HISTORY OF THE CARE OF AMERICA'S MENTALLY ILL* 135 (1994).

122. *See* Grob, *supra* note 119.

asylum, however. Instead, it wished to reform the asylum's excesses, its regimentation, and its repressive nature.¹²³ Indeed, the Progressives "rearranged the landscape of deviance and dependence in ways which have survived to our own time."¹²⁴ Ironically, their reforms ended up incarcerating more of the mentally ill and disabled than previously.¹²⁵

Of the three types of institutions fostered by the Progressives—the prison, the reformatory, and the asylum—the asylum grew the fastest. In a forty-year period, from 1880 to 1920, the number of asylum inmates skyrocketed, from around 40,000 in 1880 to over 263,000 in 1923.¹²⁶ By 1923, asylums incarcerated more individuals than did all other types of custodial institutions combined.¹²⁷

Why such explosive growth? In part, the closure of many almshouses in the early part of the twentieth century shifted the poorest and least capable from one institution, the almshouse, to another, the asylum.¹²⁸ In addition, the definition and application of madness as a social construct greatly expanded during this period.¹²⁹ Moreover, family members and other society decision-makers could easily commit people, with very little formal law to constrain admission.¹³⁰

By the turn of the century, a fairly large percentage of all detainees—asylum, correctional facility, or otherwise—were immigrants.¹³¹ Unsurprisingly, the high number of immigrants arriving in America during this period was a topic of great interest to the Progressives. The primary concern was socializing these newcomers

123. See Zuckerman, *supra* note 116, at 1806.

124. *Id.* at 1806–07.

125. See *id.* at 1808.

126. See John R. Sutton, *The Political Economy of Madness: The Expansion of the Asylum in Progressive America*, 56 AM. SOC. REV. 665, 666 (1991).

127. See *id.* In part this was due to funding issues; almshouses were strictly a local affair, and thus were funded by towns, villages, and counties. Asylums, on the other hand, were state affairs, and thus did not require revenue dispersal by local communities. See Jim Boles, *Abandoned History: From Almshouse to Asylum: Early Mental Care in Niagara County*, LOCKPORT UNION-SUN & J. (Aug. 17, 2016), http://www.lockportjournal.com/news/lifestyles/abandoned-history-from-almshouse-to-asylum/article_6be1fe3a-b66a-5710-bd00-341614a2f22c.html [https://perma.cc/W9L4-GKTR].

128. See Sutton, *supra* note 126, at 667.

129. See *id.* at 668.

130. See GERALD N. GROB, *MENTAL ILLNESS AND AMERICAN SOCIETY, 1875-1940*, at 9–11 (1983).

131. See Guyora Binder, *Penal Reform and Progressive Ideology*, 9 REVS. AM. HIST. 224, 226 (1981).

through whatever form necessary, including through institutional confinement.¹³²

As discussed below in Part II, the Progressive Era led to a flowering of eugenic theory in the treatment of the disabled, with deeply disturbing results. This development flowed naturally from the late nineteenth-century idea that social problems, including insanity, dependency, and poverty, were fundamentally individual and moral in nature.¹³³ Individuals suffering from such complaints had two paths: either be cured, or be isolated from society.

From the very beginning, then, American treatment of the disabled was designed to quarantine away those individuals who were seen as “irredeemable members of the polity.”¹³⁴ For those who were mentally ill, cognitively or physically disabled, or outside societal norms, isolation and incarceration seemed to provide the answer. This power to detain, contain, and control the disabled developed “not as an exception to the norms of criminal justice but parallel to it.”¹³⁵ The practices of the early twentieth century built upon these beliefs in disturbing yet deeply familiar ways.

II. EUGENICS AND THE CARCERAL NATION

The history of eugenics is tightly entwined with the broader history of the carceral state.¹³⁶ As the United States expanded and its population increased, the legal and medical professions became increasingly concerned about how to control those citizens with mental illness and physical and cognitive disabilities. With the advent of eugenic philosophy, there appeared a “scientific” approach to formalize this sort of sorting and ordering. A legal and social taxonomy arose, one that was supported by the medical establishment, the law, and the police power of the state. And far from neatly disappearing after the outrages of the Nazi regime and World War II, the scientific “rationales” undergirding eugenics continued to inform law and medicine until very recently. Accordingly, tracing the history of eugenics from its beginning, through its inexorable intertwining with the criminal justice system, is essential to understand how we arrived at our current level of mass incarceration.

132. *See id.*

133. *See* Sutton, *supra* note 126, at 669.

134. *See* Lichtenstein, *supra* note 7, at 124.

135. *See* Klein & Wittes, *supra* note 94, at 164.

136. *See* Hernández, Muhammad & Thompson, *supra* note 18, at 21.

A. *Degeneracy, Class, and Eugenics*

Even before a formal name and discipline were created for eugenics, or the “science of good breeding,” Americans were well familiar with the problems and promise of heredity. A “rich mythology” of concerns and anxiety over heredity had developed since the very beginning of the country’s existence, an offshoot of the theory of “degeneracy” which had been used to explain social degradation since the seventeenth century.¹³⁷

Post-Reconstruction, however, hereditary science gave Americans an easy way to formalize and legalize both class and racial difference.¹³⁸ By the time of the Progressive Era, legal, sociological, and scientific theories abounded that justified societal assumptions about the correct therapies for those citizens categorized as “unfit,” “undesirable,” or “unemployable.”¹³⁹ Mental illness in particular became a concern, as fears that the mentally ill “posed a perilous threat to the future health of American society” began to gain traction.¹⁴⁰ These unfit individuals, whether from disability, congenital illness, or mental illness, were seen as a direct “threat to the vitality of the nation.”¹⁴¹

1. *Early American Eugenics.* One of the earliest manifestations of American eugenics took form in genealogical studies of supposedly “degenerate” groupings of poor individuals, often falsely characterized as consanguineous families.¹⁴² These studies alleged proof of not only the genetic basis of human corruption and social decadence, but also of the overwhelming scale of the problem of degeneracy¹⁴³—now tidily explicated and classified using the scientific method. The solution provided by most of the studies was to sequester and halt the

137. See PAUL A. LOMBARDO, *THREE GENERATIONS, NO IMBECILES: EUGENICS, THE SUPREME COURT, AND BUCK V. BELL* 8 (2008).

138. See ISENBERG, *supra* note 43, at 176.

139. Harry G. Hutchison, *Waging War on the “Unfit”? From Plessy v. Ferguson to New Deal Labor Law*, 7 *STAN. J. C.R. & C.L.*, 1, 4 (2011).

140. ROBERT WHITAKER, *MAD IN AMERICA: BAD SCIENCE, BAD MEDICINE, AND THE ENDURING MISTREATMENT OF THE MENTALLY ILL* 41–42 (2002).

141. See Hutchison, *supra* note 139, at 4.

142. See AMERICAN EUGENICS, <https://library.missouri.edu/exhibits/eugenics/america.htm> [<https://perma.cc/R6QE-3YC7>].

143. See *id.*

reproduction of these “degenerate” lines, usually through a program of sterilization,¹⁴⁴ for the betterment of society.

Such extreme fear-mongering about the decline of the American intellect was popularized with the publication of a variety of books for both the expert and the ordinary reader. One of the most popular was *The Jukes: A Study in Crime, Pauperism, Disease, and Heredity*, originally published by Robert Dugdale in 1877. *The Jukes* was a cautionary tale of a “degenerate” white family¹⁴⁵ who bred wildly and indiscriminately, creating many generations of “inferior” individuals, almost all of whom were a financial burden on the state. Going through many printings, the book increased in popularity as the science of genetics became more mainstream, and it boasted a wide readership by the first two decades of the twentieth century.¹⁴⁶

Similarly, one prominent criminologist of the late nineteenth century and early twentieth century, Cesare Lombroso, provided a seemingly compelling link between degeneracy and criminality. In his best-known work, Lombroso argued that the criminal mind was inherited, and could thus be identified by physical features and defects.¹⁴⁷ Lombroso’s theory of the “hereditary criminal” gave eugenicists a scientific basis for attacking and controlling crime and criminals, primarily through eliminating the criminal class’s ability to procreate.¹⁴⁸ This was to be achieved through a combination of institutionalization, incarceration in penal institutions, and surgical sterilization.¹⁴⁹

144. See CHARLES DAVENPORT AND THE EUGENICS RECORD OFFICE, <https://library.missouri.edu/exhibits/eugenics/davenport.htm> [<https://perma.cc/9VDE-HNLU>].

145. In actuality, the Jukes were not a single family, but a group of over forty families, with only 540 of its 700 members related by blood. See ROBERT DUGDALE’S *THE JUKES*, https://library.missouri.edu/exhibits/eugenics/dugdale_jukes.htm [<https://perma.cc/F5UD-UA77>] (last visited Aug. 1, 2018).

146. Arthur Estabrook, a leading eugenic scientist, updated and revised Dugdale’s original text, arguing that families like the Jukes proved that social improvement schemes were useless and wasteful, and advocating for heredity-controlling legislation, eugenic segregations, and sterilization. See ARTHUR ESTABROOK’S *THE JUKES IN 1915*, https://library.missouri.edu/exhibits/eugenics/estabrook_jukes.htm [<https://perma.cc/A257-VZSY>].

147. See CESARE LOMBROSO, *CRIMINAL MAN ACCORDING TO THE CLASSIFICATION OF CESARE LOMBROSO* 5 (1911), <https://archive.org/details/criminalmanaccor00lomb> [<https://perma.cc/85A6-C5JY>].

148. See JOHN T. WHITEHEAD, KIMBERLY D. DODSON & BRADLEY D. EDWARDS, *CORRECTIONS: EXPLORING CRIME, PUNISHMENT, AND JUSTICE IN AMERICA* 35 (3d ed. 2015).

149. See Joel D. Hunter, *Sterilization of Criminals*, 5 J. AM. INST. CRIM. L. & CRIMINOLOGY 514, 515, 520, 526 (1914).

2. *Creating a Eugenic Taxonomy.* As the twentieth century dawned, a variety of influential reformers agreed that warehousing together people who suffered from different maladies—social, psychological, or medical—was no longer appropriate.¹⁵⁰ This relatively benign realization combined with more social-Darwinian concerns about the “growth of the ‘unfortunate classes’ that resulted from the ‘evils of indiscriminate charity.’”¹⁵¹ The call to segregate and incarcerate “degenerates,” along with the “shiftless poor,” the physically and cognitively disabled, the mentally ill, and the “diseased,” marked a distinct shift to the unsparing viewpoint of the eugenics movement. Eugenic philosophy was bolstered by the work of the Purity Crusade and the social hygiene movement, both of which feared that the sexually immoral could infect the populace with their subnormal mentality.¹⁵²

Part of the work of eugenics was to separate out different types of inferior classes. This was assisted by a “social construction of idiocy distinct from insanity,” which began to evolve by the mid-nineteenth century and enabled reformers to classify and segregate.¹⁵³ In the first decade of the twentieth century, this understanding of mental disability was further refined into three separate classifications¹⁵⁴: idiots (those with intelligence of an infant to a two-year-old), imbeciles (intelligence of a three- to seven-year-old), and morons (intelligence comparable to an eight- to ten-year-old).¹⁵⁵ These more specific classifications would help early twentieth-century doctors and scientists further segregate and treat those citizens they believed were inferior.

The concern over female “morons” was particularly acute, as scientists feared that they would either seduce or be seduced by young men.¹⁵⁶ One or two scientists suggested isolating the women on a farm colony, where they could do simple chores, and performing sterilization on them to prevent reproduction.¹⁵⁷ Similar concerns about promiscuous, impoverished white women, who had the potential

150. See LOMBARDO, *supra* note 137, at 12.

151. See *id.* at 11.

152. See *id.* at 16. Both the nineteenth-century Purity Crusade and the twentieth-century social hygiene movement concentrated on the effects of sexually transmitted diseases to women and their children, tied up with concerns over moral degeneracy. See *id.*

153. See Schriener & Ochs, *supra* note 113, at 513.

154. See ISENBERG, *supra* note 43, at 197.

155. See LOMBARDO, *supra* note 137, at 41.

156. See ISENBERG, *supra* note 43, at 197.

157. See LOMBARDO, *supra* note 137, at 41.

to bear broods of “feeble-minded” children, led eugenics reformers to argue for additional asylums to house them.¹⁵⁸ Locking up “unclean women” in institutions would not only prevent them from spreading their diseases (such as congenital blindness and syphilitic insanity), but would also eliminate the hereditary propensity of bad behavior.¹⁵⁹

The early twentieth century also saw a call from reformers to incarcerate “feebleminded” adults, in hopes of preventing crime, insanity, and prostitution.¹⁶⁰ Laws in several states permitting institutionalization of the cognitively disabled soon followed.¹⁶¹ The charge to incarcerate the feebleminded also led to the movement to “asexualize,” or sterilize them, along with epileptics, three-time felons, rapists, inebriates, those exhibiting “unseemly sexuality,” and the mentally ill, among others.¹⁶² Accordingly, a number of states passed involuntary sterilization laws in the early twentieth century in order to prevent “undesirable” individuals from reproducing.¹⁶³

The advent of World War I also gave public support and power to the arguments of the social eugenicists. Much of the country was shocked to learn that as many as 37 percent of recruits qualified as “feebleminded,”¹⁶⁴ and a high number of recruits were illiterate.¹⁶⁵ These startling conclusions were largely drawn from a study written by one of America’s leading eugenicists, Charles Davenport, subsequently published by the U.S. military.¹⁶⁶ The report determined that a high proportion of U.S. Army draftees were defective in a variety of categories, including physical fitness and psychological or mental readiness.¹⁶⁷

As a result, Davenport and his co-author also claimed that much of the American male population was not equipped for participatory democracy, as they identified “constitutional limitations of the various

158. See ISENBERG, *supra* note 43, at 197.

159. See LOMBARDO, *supra* note 137, at 16–17.

160. See *id.* at 18.

161. See *id.*

162. See *id.* at 20–21.

163. See *id.* at 24–26.

164. See ALBERT G. LOVE & CHARLES B. DAVENPORT, DEFECTS FOUND IN DRAFTED MEN: STATISTICAL INFORMATION COMPILED FROM THE DRAFT RECORDS 100 (1920) (detailing records of “mental deficiencies” on a state-by-state basis); see also LEILA ZENDERLAND, MEASURING MINDS: HENRY HERBERT GODDARD AND THE ORIGINS OF AMERICAN INTELLIGENCE TESTING 289 (1998).

165. See ZENDERLAND, *supra* note 164, at 288.

166. See LOVE & DAVENPORT, *supra* note 164, at 25.

167. See *id.* at 27–48.

aces to meet the conditions imposed by that civilization.”¹⁶⁸ Labeling a segment of the population as too incompetent to participate in public life made it all the easier to proceed to the next step. A new ground for detaining and segregating those deemed to be unfit had been cleared.

By the end of World War I, psychologists and scientists broadened their focus beyond the military in an attempt to better sort the American people into their proper levels.¹⁶⁹ This was combined with the quasi-science of eugenics, which helped transform the familiar discourses of bigotry and nativism into biological “fact.” Eugenics recast mentally ill and disabled citizens from community outsiders into long-term societal dangers by classifying them as hereditarily unfit.¹⁷⁰

Although this sort of classification had been occurring, in one form or another, since the beginning of the American colonies, the Progressive Era took such human cataloging to extremes. In part, this was due to the desire for social control¹⁷¹—the wish to impose order upon the causes of economic and social disorder—as well as a genuine call for social justice.¹⁷² This classification, however, reified a dynamic that enthusiastically promoted the detention and reduction of the disabled and impoverished.

The belief that the poor and disabled were dangerous led society to use hereditary fitness as “a scientific basis for distinguishing workers worthy of uplift from workers who should be regarded as threats to the health and wellbeing of the economy and of society.”¹⁷³ This belief was common not just with eugenicists, but in many areas of progressive thought and study, including economics.¹⁷⁴ For example, Harvard’s Frank Taussig, in his *Principles of Economics*, suggested that “those saturated by alcohol or tainted with hereditary disease . . . [along with] the irretrievable criminals and tramps” should be “segregated, shut up in refuges and asylums, and prevented from propagating their kind,” if

168. *See id.* at 27.

169. *See* ZENDERLAND, *supra* note 164, at 262.

170. *See* David E. Bernstein & Thomas C. Leonard, *Excluding Unfit Workers: Social Control Versus Social Justice in the Age of Economic Reform*, 72 *LAW & CONTEMP. PROBS.* 177, 177 (Summer 2009).

171. *See id.* at 179 (“[Progressives called for] social control, to impose order upon the causes of economic and social disorder. As elitists, the progressives believed that intellectuals should guide social and economic progress . . .”).

172. *See id.* at 179.

173. *See id.* at 180.

174. *See id.* at 185.

they could not be “stamped out.”¹⁷⁵ This desire to segregate and isolate helped set the stage for our modern prison system.

Accordingly, for many scientists and reformers in the early twentieth century, eugenics provided a practical approach to addressing societal problems, particularly the fate of the poor, the mentally ill, and the disabled:

It is a reproach to our intelligence that we as a people, proud in other respects of our control of nature, should have to support about half a million insane, feeble-minded, epileptic, blind and deaf, 80,000 prisoners and 100,000 paupers at a cost of over 100 million dollars per year.¹⁷⁶

Eugenicists wished for state control over the “propagation of the mentally incompetent,” whether through mental illness or disability.¹⁷⁷ Ultimately, these beliefs would lead not only to forced detention and isolation, but also to regular affronts to human life and dignity.

In response to the continuing problem of the “socially unfit,” the Carnegie Institution underwrote the 1911 *Preliminary Report of the Committee of the Eugenic Section of the American Breeders’ Association to Study and to Report on the Best Practical Means for Cutting Off the Defective Germ-Plasm in the Human Population*.¹⁷⁸ This eugenic report developed eighteen potential solutions to deal with those who had disabilities. Point Eight was euthanasia.¹⁷⁹ The report asserted that there were “two-thirds of a million persons so defective that the State must exercise a constant custodial care over them,” and these defectives “should, if possible, be eliminated from the human stock.”¹⁸⁰ Elsewhere, the report claimed that 634,877 individuals were under custodial care in 1900, but that another 7 million citizens were just barely self-sufficient and should be halted from breeding.¹⁸¹

In comparison, in 1904 there were approximately 57,000 people incarcerated in federal and state prisons for various crimes, and in 1910

175. See *id.* (quoting FRANK W. TAUSSIG, PRINCIPLES OF ECONOMICS 300 (1912)).

176. See CHARLES B. DAVENPORT, HEREDITY IN RELATION TO EUGENICS 4 (1911).

177. See *id.*

178. See BLEEKER VAN WAGENEN, EUGENICS EDUCATION SOCIETY, PRELIMINARY REPORT OF THE COMMITTEE OF THE EUGENIC SECTION OF THE AMERICAN BREEDERS’ ASSOCIATION TO STUDY AND TO REPORT ON THE BEST PRACTICAL MEANS FOR CUTTING OFF THE DEFECTIVE GERM-PLASM IN THE HUMAN POPULATION 462 (1912).

179. See *id.* at 464.

180. *Id.* at 462.

181. *Id.* at 464.

there were approximately 68,000 people.¹⁸² In the early twentieth century, the number of people incarcerated for mental, physical, or social disabilities far exceeded the number incarcerated for crime. The first modern mass incarceration was not of criminal offenders, but of the disabled.

The American eugenics movement metastasized through the nation in the 1920s and 30s. The spread was assisted by the extensive funding granted from various corporate foundations, including the Carnegie Institution,¹⁸³ the Rockefeller Foundation,¹⁸⁴ and the Harriman railroad fortune.¹⁸⁵ Eugenic ideology thus became deeply embedded in American popular culture, with pro-eugenic propaganda presented in movies, classrooms, laboratories, state fairs, and religious institutions, among others.¹⁸⁶

Henry H. Goddard and Edward A. Wiggam, two popular authors, proselytized the policy of controlled breeding, warning of a “rising tide of feeble-mindedness”¹⁸⁷ and promoting a “new decalogue of science,”¹⁸⁸ a modern ten commandments based upon eugenic principles.¹⁸⁹ Wiggam in particular attempted to make eugenics comprehensible to the average American through a combination of demagoguery and a simplification of hereditary science,¹⁹⁰ promoting a message of segregation, sterilization, and selection.

The eugenics movement was also an integral part of the great socialization and reorganization of legal and judicial institutions in the

182. See MARGARET WERNER CAHALAN, DEP'T OF JUSTICE, HISTORICAL CORRECTIONS STATISTICS IN THE UNITED STATES 1850-1984, at 29 tbl.3-2 (1986), <https://www.bjs.gov/content/pub/pdf/hcsus5084.pdf> [<https://perma.cc/YF7Y-RV2J>].

183. See *Eugenics Record Office*, COLD SPRING HARBOR LABORATORY, <http://library.cshl.edu/special-collections/eugenics> [<https://perma.cc/SEH4-U8T2>].

184. See Edwin Black, *Eugenics and the Nazis—the California Connection*, S.F. CHRON. (Nov. 9, 2003, 4:00 AM), <https://www.sfgate.com/opinion/article/Eugenics-and-the-Nazis-the-California-2549771.php> [<https://perma.cc/R4BB-92DU>].

185. See *Eugenics Record Office*, *supra* note 183.

186. See Steve Selden, *Eugenics Popularization*, IMAGE ARCHIVE ON THE AMERICAN EUGENICS MOVEMENT, <http://www.eugenicsarchive.org/html/eugenics/essay6text.html> [<https://perma.cc/Z77Y-HA4Y>].

187. *A Rising Tide of Feeble-mindedness*, CHI. TRIB., Feb. 2, 1923, at 8.

188. ALBERT EDWARD WIGGAM, THE NEW DECALOGUE OF SCIENCE 171 (1923) (endorsing a “duty of preferential reproduction” (emphasis omitted)).

189. See CHRISTINE ROSEN, PREACHING EUGENICS: RELIGIOUS LEADERS AND THE AMERICAN EUGENICS MOVEMENT 129 (2004) (explaining that Wiggam argued that these new eugenical scientific discoveries required a new set of moral imperatives, invoking Jesus to justify his revision of the Ten Commandments).

190. See *id.*

early twentieth century.¹⁹¹ As reformers began to centralize court systems, they incorporated more “socialized” disciplinary practices, such as treating offenders individually, which led to changes such as indeterminate sentencing and probation.¹⁹² Simultaneously, judges began to rely upon the professional expertise of social workers and psychiatrists.¹⁹³ As part of this great change, psychological tests, including the tactics of the eugenicists, began to be routinely used in everyday court practice.¹⁹⁴ These changes made it easier and simpler for courts to impose involuntary custodial care upon certain segments of society. Eugenicists played a central role in Progressive criminal justice reform.¹⁹⁵

As crime gradually became more of a national concern in the early parts of the twentieth century, so, too, did the sites of incarceration, whether for crime, or mental illness, or disability. The approach to both crime and disability were inextricably linked during this period, as “the language of eugenic jurisprudence infused American public discourse on crime during the 1910s and 1920s, the years when law and order, historically a local matter, began to be redefined as a national issue.”¹⁹⁶

So what method of incarcerating the mentally, cognitively, and physically inferior did eugenicists prefer? Various theories of best practice abounded. Some argued for special schools to sequester weak-willed women who could be negatively influenced.¹⁹⁷ Others felt lifelong custody was the best approach, since the costs of imprisonment would still be less than a life of crime.¹⁹⁸ For children, best to capture them young, to “moral quarantine” them away from the community.¹⁹⁹ For women of child-bearing years, a regime that included “permanent and watchful guardianship” was particularly necessary.²⁰⁰ Finally, establishing custodial institutions to prevent the birth of “defective children” was simply the most cost-effective, given how much money these practices would save in the future.²⁰¹

191. See Willrich, *supra* note 4, at 67.

192. *Id.*

193. *Id.*

194. *Id.*

195. *Id.* at 70.

196. *Id.*

197. See LOMBARDO, *supra* note 137, at 11.

198. *Id.*

199. *Id.*

200. *Id.*

201. *Id.*

The eugenicist focus on mental disorder was broad, encompassing both mental illness and cognitive disability. “Feeble-mindedness” was one of the most frequent diagnoses, which encompassed abnormal behavior and very low scores on IQ tests.²⁰² In eugenic science, feeble-mindedness was closely linked to promiscuity, criminality, and social dependency.²⁰³ These “feeble-minded” citizens, although not considered to be insane, were determined to be in need of treatment, guidance, and control. As one British eugenics pamphlet advised:

There are at this moment some 150,000 persons in the country, who, while not certifiably insane, are suffering from mental defect—unhappy in themselves, a sorrow and burden to their families, and a growing source of expense and danger to the community Mental defects are hereditary; the feeble-minded are prolific; and thus the relative amount of feeble-mindedness and insanity increases at an ever-growing rate and threatens the race with progressive deterioration.²⁰⁴

The scientists focusing on the “feeble-mindedness” problem were most concerned about how to implement a “system of control” over those who possessed such defects.²⁰⁵

In light of these concerns, various institutions, colonies, and mental hospitals were built to segregate, imprison, and occasionally treat those who were mentally, cognitively, or physically disabled. The category of people so confined included those with seizure disorders, which were believed to lead to “dementia, imbecility, insanity, physical and moral degeneracy.”²⁰⁶ Segregating the cognitively disabled was also a great concern, as they were deemed “a menace to society,”²⁰⁷ and required sequestering in appropriate “colonies.”²⁰⁸ These colonies

202. See, e.g., Walter E. Fernald, Address, *The Burden of Feeble-Mindedness*, 611 BOS. MED. & SURGICAL J. 911, 911–12 (1912) (discussing “widespread prevalence of feeble-mindedness” and “large numbers of feeble-minded persons” in Massachusetts).

203. See *Topic: Mental Illness*, EUGENICS ARCHIVE, [http://www.eugenicsarchive.org/eugenics/topics_fs.pl?theme=9&search=&matches=\[https://perma.cc/74VR-Z37Z\]](http://www.eugenicsarchive.org/eugenics/topics_fs.pl?theme=9&search=&matches=[https://perma.cc/74VR-Z37Z]).

204. *Advertising piece for The Problem of the Feeble-Minded, by the Poor Law Commissioners (preface and order form)*, COLD SPRING HARBOR LABORATORY: EUGENICS ARCHIVE, http://www.eugenicsarchive.org/eugenics/view_image.pl?id=2086 [https://perma.cc/XD7J-4VWM].

205. See *id.*

206. See LOMBARDO, *supra* note 137, at 13.

207. See IND. SOC’Y FOR MENTAL HYGIENE, Bulletin No. 7, at 1–2 (July 1920), http://www.eugenicsarchive.org/eugenics/view_image.pl?id=1420 [https://perma.cc/BS62-APL4].

208. *Id.* at 1.

included training schools, hospitals, mental clinics, post-school supervision, and a “custodial department for the low-grade of idiots and epileptics.”²⁰⁹

There was also concern about housing individuals with one malady alongside those suffering from another, such as mixing the criminally insane with the poor, the mentally unstable, the congenitally defective, or the tubercular.²¹⁰ Preferably, separate institutions needed to be built for all, as this type of isolation and segregation, combined with a careful program of sterilization, would help “annihilate the hideous serpent of hopelessly vicious protoplasm.”²¹¹ Once properly segregated, these “inferior” individuals would no longer trouble society, and eventually die out.

The people categorized as “defectives, dependents, and delinquents”²¹² were thus contained, controlled, and often experimented upon in order to make the world a safer, cleaner, and healthier place. A corresponding change in institutions reflected this focus as well.

B. Asylums, Sterilization, and Medical Experimentation

As concern mounted over the ever-rising numbers of feebleminded and mentally ill, permanent correctives began to be sought. Doctors, lawyers, and state legislators agreed that one of the best solutions to this social problem was the establishment of asylums and farm colonies, to house and segregate the “defective” individuals.²¹³ In addition, wholesale sterilization of patients was also deemed necessary to limit and control the hereditary propensities of both mental illness and developmental disability.²¹⁴

1. *Permanent Isolation for the “Socially Inadequate.”* At the end of the nineteenth century, mental hospitals began to shift their function from places that treated acute mental illnesses for short periods of time to institutions that provided long-term care for chronic mental illness—sometimes for life.²¹⁵ The number of elderly patients (over age sixty)

209. *Id.* at 4.

210. *See* LOMBARDO, *supra* note 137, at 13.

211. CHARLES B. DAVENPORT, *EUGENICS: THE SCIENCE OF HUMAN IMPROVEMENT BY BETTER BREEDING* 34 (1910).

212. *See* LOMBARDO, *supra* note 137, at 78.

213. *See* Fernald, *supra* note 202, at 913–14.

214. *Id.* at 914.

215. *See* GROB, *supra* note 121, at 118–19.

rose, due in part to the decline in the infant/child mortality rate.²¹⁶ The fate of the elderly mentally ill became a new source of concern as almshouses began to be dismantled; abuse increased, costs rose, and living conditions deteriorated.²¹⁷ The decrease in almshouse care corresponded with a rise in the asylum institutionalization of the elderly; in certain states, the rate of institutionalization rose 300 to 400 percent for patients over sixty.²¹⁸

The cost of institutionalizing so many citizens was significant. In 1916, for example, the Eugenical Society tallied up the state expenditures related to caring for the “socially inadequate classes.”²¹⁹ The price was high. The costs of caring for such patients ranged from 5.4 percent (Alabama) to 30.5 percent (Massachusetts) of a state’s total yearly expenditures, with an average of around 17.3 percent.²²⁰ The total, nationwide expenditure on institutionalization for that year was \$73,203,239—a significant sum for 1916.²²¹

Concerns over the amount spent on institutionalizing the disabled and incapacitated became mainstream by the 1930s. The language of eugenics had become so popularized that *People Magazine* ran a feature story discussing the large amounts of money spent on incarcerating the “socially inadequate.”²²² Claiming that institutionalization and treatment of “the defective classes”²²³ cost society \$5 billion a year, the article went on to allude tantalizingly to “effective long range measures”²²⁴ to counteract the “pathologies of our contemporary civilization.”²²⁵

216. *Id.* at 119.

217. *Id.*

218. *Id.* at 120. Grob points out that one reason for this increase in elderly institutionalization was due to financial incentives arising with the creation of state institutions, rather than local almshouses; once local officials realized the burden of caring for indigent elderly could be transferred from their payrolls to the state’s, there was a strong incentive to send older patients to the state mental institution. *See id.* at 121.

219. *See State Expenses for Maintaining State Institutions for the Socially Inadequate Classes. 1916.*, 5 *EUGENICAL NEWS* 79 (1920), http://www.eugenicsarchive.org/eugenics/view_image.pl?id=1881 [<https://perma.cc/93H5-SMKG>].

220. *See id.*

221. *See id.*

222. *See* James H.S. Bossard, *What We Pay*, *PEOPLE*, 1931, at 10.

223. *Id.* at 47.

224. *Id.* at 10 (referencing euthanasia).

225. *Id.* at 47.

2. *Medical Experimentation and Sterilization.* Alongside concerns about the cost of supporting the “defective class” was the fear that the national intelligence of the Anglo-American world was in decline. This fear was compounded by data purportedly showing that families of superior heredity and intelligence were reproducing at a slower rate than less intelligent families.²²⁶ Combined with the belief that rates of insanity were rising significantly,²²⁷ this data provided strong support for continuing to segregate, detain, and experiment on the disabled.

Thirty-two states passed eugenic-sterilization laws in the early decades of the twentieth century.²²⁸ Roughly sixty to seventy thousand people were sterilized after their passage.²²⁹ World War II and the effort to defeat the Nazi regime momentarily stemmed the tide of enthusiasm for eugenics and its rhetoric. Nonetheless, the sterilization rate remained relatively high post-war.²³⁰ Indeed, so many poor female Southerners underwent the procedure that it became known as a “Mississippi appendectomy.”²³¹

The number of patients suffering from mental conditions arising from physical causes also rose significantly in the beginning of the twentieth century. The most prominent of these causes was syphilis, which, if left untreated,²³² often developed into tertiary syphilis, which manifested in paresis or general paralysis. Paresis caused massive damage to the central nervous system and brain and displayed in dramatic behavioral symptoms, neurological deterioration, paralysis,

226. See L.S. Penrose, *Is Our National Intelligence Declining? The Genetic Point of View* 4, London, 1939, http://www.eugenicsarchive.org/eugenics/view_image.pl?id=2236 [<https://perma.cc/UB97-C76M>] (last visited Aug. 31, 2018).

227. See COLD SPRING HARBOR LABORATORY, *Per Cent of Increase in Total Population and in the White and Negro Population of Insane in Hospitals*, SECOND INT. EX. OF EUGENICS 127 (1921) (showing a rising rate of insanity in hospitals for both black and white patients).

228. See Andrea DenHoed, *The Forgotten Lessons of the American Eugenic Movement*, NEW YORKER (Apr. 27, 2016), <https://www.newyorker.com/books/page-turner/the-forgotten-lessons-of-the-american-eugenics-movement> [<https://perma.cc/2LB5-GLQ9>].

229. *Id.*

230. *Id.*

231. See Courtney Hutchison & ABC News Medical Unit, *Sterilizing the Sick, Poor to Cut Welfare Costs: North Carolina's History of Eugenics*, ABC NEWS (Aug. 4, 2011), <http://abcnews.go.com/Health/WomensHealth/sterilizing-sick-poor-cut-welfare-costs-north-carolinas/story?id=14093458> [<https://perma.cc/NV5X-W3SL>]. It is estimated that 100,000 to 150,000 people were sterilized under federally funded programs each year during this period. See Lisa Ko, *Unwanted Sterilization and Eugenics Programs in the United States*, INDEP. LENS (Jan. 29, 2016) <http://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states> [<https://perma.cc/U3AV-ZXV7>].

232. There was no effective treatment for syphilis until the introduction of commercially made penicillin following World War II. See GROB, *supra* note 121, at 124.

and, ultimately, death.²³³ By the beginning of the twentieth century, parietic admissions increased significantly, and by the 1930s, slightly over 9 percent of all first admissions to mental hospitals were due to syphilitic paralysis.²³⁴ Thus, by the beginning of World War II, a significant number of citizens were living full time in asylums, due to physical ailments (epilepsy, syphilis, senility, pellagra), mental disorders, and cognitive disability.

Given the growing number of patients with disabilities, it is unsurprising that their medical treatment would begin to expand beyond sterilization. The 1930s saw the introduction of radical therapeutic innovations for various disabilities, including fever, insulin, metrazol, and electric shock therapies, as well as lobotomization.²³⁵ These therapies were frequently used without patient consent, and the effects could be brutal. Fever therapy, for example, involved infecting the syphilitic inmate with malaria, in hopes that the resulting high fevers would lessen some of the resulting paresis.²³⁶ This method became the most common way to treat syphilitic paresis, despite very weak evidence of efficacy and cure.²³⁷

Likewise, “shock” treatments, which used either insulin to lower mentally ill patients’ blood sugar or metrazol to induce convulsions, were widely used despite dubious efficacy.²³⁸ Both therapies posed substantial risk for patients; insulin had a mortality rate ranging between 1 and 5 percent, and metrazol’s convulsions led to bone fractures and respiratory problems.²³⁹ Eventually, electroshock therapy replaced metrazol, but this only reduced the risk of injury.²⁴⁰ The potential subjects easily accessible in the asylum proved irresistible to doctors and reformers, especially since there was little concern about obtaining proper consent.

By 1940, every mental institution was using some form of shock therapy, in hopes of controlling and regulating the growing numbers of chronically ill patients.²⁴¹ These therapies were joined by the ever-growing popularity of the lobotomy, a relatively simple surgery that

233. *Id.* at 124–25.

234. *Id.* at 125.

235. *Id.* at 178.

236. *Id.* at 179.

237. *Id.* at 180.

238. *Id.* at 181–82.

239. *Id.* at 182.

240. *Id.*

241. *Id.* at 183.

severed the nerve fibers of the brain's frontal lobes.²⁴² The numbers of lobotomies rose rapidly in the years surrounding World War II; between 1936 and 1951, there were 18,608 lobotomies performed.²⁴³ Minimal consent was required from the patient before such psychosurgery was performed.²⁴⁴

Due to the dramatic personality changes that often followed lobotomy, it continued to be a popular treatment. Most critically for overcrowded mental asylums, lobotomized patients who were previously found highly disruptive or intractable became more manageable after the surgery and better-suited to life in an institution.²⁴⁵ The appeal of psychosurgery was tightly related to the influx of mental patients into institutions following World War II. By 1948, the American Psychiatric Association noted that institutions were crowded with 50 percent more patients than the maximum available space could properly hold.²⁴⁶

C. Medication and a Call for Release

The asylum system deteriorated severely due to the financial hit of the Great Depression. Nonetheless, these institutions continued to incarcerate almost half a million chronic inmates.²⁴⁷ World War II did nothing to alleviate these problems; instead, asylums faced acute personnel problems as physicians and staff were inducted into the war effort.²⁴⁸ This led to a disastrous internal environment for patients, including failures in physical health, overcrowding, filth, and general chaos.²⁴⁹ For example, in the 1940s, the Philadelphia State Hospital was forced to house up to eighty male patients in a single dormitory room.²⁵⁰ Institutions became warehouses for the disabled.

242. *Id.* at 182.

243. *Id.* at 183.

244. See MICAL RAZ, *THE LOBOTOMY LETTERS: THE MAKING OF AMERICAN PSYCHOSURGERY* 76 (2013) (describing the minimal amount of consent and approval needed before performing the operation).

245. GROB, *supra* note 121, at 186.

246. See *Cutting of the Mind: The History of Psychosurgery*, DARTMOUTH UNDERGRADUATE J. SCI. (Apr. 8, 2008), <https://sites.dartmouth.edu/dujs/2008/04/08/cutting-of-the-mind-the-history-of-psychosurgery-and-its-application-today> [https://perma.cc/6RM9-4EH9] (citation omitted).

247. GROB, *supra* note 121, at 165–66.

248. *Id.* at 170.

249. *Id.* at 171.

250. *Id.* at 274 illus. 4.

Change began to come for the institutionalized in the mid-1950s. First, chlorpromazine (marketed as Thorazine), a psychotropic, or antipsychotic, medicine created in 1951, first came into use in the United States around 1954.²⁵¹ Chlorpromazine was the first antipsychotic drug approved by the FDA.²⁵² For the first time, an oral medicine was used to treat many of the symptoms of schizophrenia—including delusions, hallucinations, and disordered thoughts and behaviors—for 70 percent of suffering patients.²⁵³ Other antipsychotics soon followed.²⁵⁴ The simultaneous development of these drugs, along with electroshock, psychosurgery, and psychotherapy, convinced many doctors that even high-need institutionalized patients could, with treatment, eventually be released and live in the broader community.²⁵⁵

The 1950s also brought an increased interest in therapeutic communities; the idea that the environment could aid in the treatment of the mentally ill and disabled.²⁵⁶ Combined with psychotropic drugs, the new focus on psychotherapy and the therapeutic community encouraged shrinking the length of time that patients were institutionalized. This ultimately led to a significant decline in asylum populations.²⁵⁷

The post-war years also brought a dawning awareness among the general population that the nationwide system of mental hospitals, institutions, and asylums were overcrowded and in poor shape.²⁵⁸ The Council of State Governments promoted both the rebuilding of state mental hospitals as well as new facilities to house the various constituencies incarcerated therein.²⁵⁹ In 1955, the number of mentally ill patients who were incarcerated in mental institutions hit a peak of 558,992.²⁶⁰ Likewise, the number of developmentally disabled

251. Thomas Ban, *Fifty Years Chlorpromazine: A Historical Perspective*, 3 *NEUROPSYCHIATRIC DISEASE & TREATMENT* 495, 496 (2007).

252. See Deanna Pan, *Deinstitutionalization and Its Consequences*, MOTHER JONES (Apr. 29, 2013), <https://www.motherjones.com/politics/2013/04/timeline-mental-health-america/> [<https://perma.cc/4UUV-MWM5>].

253. Jonathan Meyer & George Simpson, *From Chlorpromazine to Olanzapine: A Short History of Anti-Psychotics*, 48 *PSYCHIATRIC SERVS.* 1137, 1137 (1997).

254. Ban, *supra* note 251, at 497.

255. GROB, *supra* note 121, at 223.

256. *Id.* at 226.

257. Meyer & Simpson, *supra* note 253, at 1137.

258. GROB, *supra* note 121, at 231.

259. *Id.*

260. See BRUCE L. LEVIN, KEVIN D. HENNESSY & JOHN PETRILA, *MENTAL HEALTH SERVICES: A PUBLIC HEALTH PERSPECTIVE* 45 (2010).

individuals held in state-run facilities peaked at approximately 200,000 in 1967.²⁶¹

During roughly the same time period, sociologist Erving Goffman undertook a year-long study of patients in a Washington, D.C. federal mental institution. The study resulted in a seminal work which starkly illustrated the myriad problems with asylums at that time.²⁶² Goffman's work revealed several critical things. First, he emphasized that mental hospitals were very similar to prisons, although the patients had not broken the law.²⁶³ Second, he identified psychiatric institutions as "total institution[s]"²⁶⁴—isolated, closed systems that were segregated from the rest of society. Finally, he painted mental institutions as establishments very similar to prisons, concentration camps, and monasteries, arguing that patients were subjected to an unfair restriction of freedom.²⁶⁵

D. Legislative and Legal Arguments for Deinstitutionalization

Due to a combination of social pressure and advances in medical treatment, a movement grew to release the disabled and mentally ill from asylums. The push for reform used a variety of tactics, including specific health legislation, legal arguments concerning due process rights, and the advent of Medicaid.

In 1963, President John F. Kennedy signed the Community Mental Health Act (CMHA),²⁶⁶ which was designed to help those people with

261. See Samuel Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 7–8 (2012).

262. See ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (Erving Goffman ed., 1961).

263. Winnie Chow & Stefan Priebe, *Understanding Psychiatric Institutionalization: A Conceptual Review*, 13 BIOMED CENT. PSYCHIATRY 169, 169 (2013).

264. See *id.*

265. See *id.* As Chow and Priebe note, Goffman argued that patients and criminal offenders lived very similar lives:

[P]atients received custodial care and typically lived all aspects of their life in a psychiatric hospital with limited access to the outside world. In a total institution, each phase of the patient's daily activities was carried out in the immediate company of a large number of other people. All activities were tightly scheduled and the series of performed activities was enforced from the top. Patients' lives were dictated by institutional routine and isolated from the wider society for an extensive period of time.

Id.

266. The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, 77 Stat. 282. The CMHA's aim was to establish comprehensive community mental health centers throughout the country, approximately 1,500 centers nationwide. See *The Community Mental Health Act of 1963: Still Pursuing the Promise of Reform Fifty Years Later*, YOUNG MINDS ADVOC. (Oct. 31, 2013), <https://www.ymadvocacy.org/>

mental illnesses incarcerated in hospitals and institutions move back into their communities by building local mental health centers to provide care.²⁶⁷ This legislation began a wave of deinstitutionalizing mentally ill patients from state hospitals.²⁶⁸ At the same time, states began to institute large budget cuts, cutting the number of state hospitals and aiming to release many of their currently incarcerated patients.²⁶⁹

The CHMA did not proceed as planned, however.²⁷⁰ Only half of the proposed centers were ever built, none were fully funded, and the Act failed to provide long-term funds.²⁷¹ Some states saw an opportunity to save money by closing expensive state hospitals without spending money on community-based care.²⁷²

Some who desired to abolish asylums also sought the eradication of prisons, as both unfairly caged their inmates at far too high a cost. As David Rothman argues, “[j]ust as asylums and prisons had grown up together in the 1830s and undergone parallel changes in the early 1900s, so it seemed they would both now lose their centrality as institutions of care and correction, to be replaced by community-based programs.”²⁷³

The deinstitutionalization movement accelerated after the 1965 adoption of Medicaid, which incentivized states to move patients out of state hospitals and into communities where the federal government would pick up part of the cost.²⁷⁴ Medicaid specifically excluded

the-community-mental-health-act-of-1963/ [https://perma.cc/TC56-RTPH]. These centers were “designed for the delivery of mental health prevention, diagnosis, and treatment services to individuals residing in the community” and were required to provide “consultation and education on mental health, inpatient services, outpatient services, emergency response, and partial hospitalization.” *Id.*

267. *The Community Special Health Act*, NAT’L COUNCIL FOR BEHAVIORAL HEALTH, <https://www.thenationalcouncil.org/about/national-mental-health-association/overview/community-mental-health-act> [https://perma.cc/EA5G-3GAK].

268. See Stephanie Parker & Rosi Andrade, *Silent Epidemic: The Incarceration of the Seriously Mentally Ill*, HILL (June 18, 2015), <http://thehill.com/blogs/congress-blog/healthcare/245307-silent-epidemic-the-incarceration-of-the-seriously-mentally> [https://perma.cc/AZR3-RZRR].

269. *See id.*

270. See *Kennedy’s Vision for Mental Health Never Realized*, USA TODAY (Oct. 20, 2013), <https://www.usatoday.com/story/news/nation/2013/10/20/kennedys-vision-mental-health/3100001/> [https://perma.cc/RSY5-VKSA].

271. *See id.*

272. *See id.*

273. See David J. Rothman, *The Rehabilitation of the Asylum*, AM. PROSPECT (Sept. 21, 1991), <http://prospect.org/article/rehabilitation-asylum> [https://perma.cc/U2E4-B9PS].

274. *See Kennedy’s Vision, supra* note 270.

coverage for people in “institution[s] for mental diseases.”²⁷⁵ Accordingly, many patients were discharged from asylums and placed in nursing homes and general hospitals.²⁷⁶ Similarly, with the passage of Medicare, the federal government took on between half and three-quarters of the cost of elderly nursing home care, thus giving the states a very strong incentive to discharge aged inpatients (some 30 percent of the total) from asylums to nursing homes.²⁷⁷

By the early 1970s, the mental health bar came to play a large role in the movement to deinstitutionalize the mentally ill and developmentally disabled by framing involuntary incarceration as a civil rights issue.²⁷⁸ The New York chapter of the ACLU (NYCLU) filed a lawsuit challenging the conditions of hospitalization for those with mental illness and developmental disabilities in *Wyatt v. Stickney*.²⁷⁹ In *Stickney*, an Alabama district court held that people involuntarily committed to state institutions due to mental illness or developmental disabilities have a constitutional right to treatment that will afford them a realistic opportunity to return to society.²⁸⁰ The ruling in *Stickney* was viewed as a paradigm for institutional ‘fix-up’ cases nationally,²⁸¹ and led to major reforms in the nation’s mental health systems, creating minimum standards of care for the mentally ill and developmentally disabled and leading to further deinstitutionalization of vast numbers of asylum patients.²⁸²

Changes in federal support also continued to affect asylum inmates. In 1972, for example, Congress passed the Supplemental

275. 42 U.S.C. § 1396d(a)(1) (2012). Called the “IMD Exclusion,” it prevents federal Medicaid funds from being used by states to care for individuals between twenty-one and sixty-five years old who live in institutions that specialize in the treatment of psychiatric disorders (IMDs). See also 42 U.S.C. §§ 1396d(a)(4)(A), (a)(14)–(16), (a)(21) (2012).

276. See Deanna Pan, *Timeline: Deinstitutionalization and Its Consequences*, MOTHER JONES (Apr. 29, 2013, 10:00 AM), <https://www.motherjones.com/politics/2013/04/timeline-mental-health-america> [<https://perma.cc/4UUV-MWM5>].

277. See Rothman, *supra* note 273.

278. See *History of Mental Institutions*, ACLU, <https://www.aclu.org/other/aclu-history-mental-institutions> [<https://perma.cc/9ASM-HJXQ>].

279. *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), *aff’d sub nom.* *Wyatt v. Aderholt*, 503 F.2d 305 (5th Cir. 1974).

280. See *Wyatt*, 325 F. Supp. at 785.

281. See David Ferleger, *The Evolution of Disability Rights Litigation (and Some Stories)*, MINN. COUNCIL ON DEVELOPMENTAL DISABILITIES, <http://mn.gov/mnddc/disability-litigation/right-to-treatment> [<https://perma.cc/B3XV-L7XJ>].

282. See Michael 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, 121 (2011).

Security Income program (SSI), which provided the disabled with a monthly stipend, replacing state programs.²⁸³ Inmates of public institutions, however, including asylums, were not eligible for SSI payments unless they left the institution.²⁸⁴ The impact of SSI on asylums was direct and immediate. In 1974, the first year that SSI was remitted to eligible individuals, the number of inmates housed in state asylums decreased by 13.3 percent, the largest decrease ever recorded.²⁸⁵

Unfortunately, community housing for discharged patients failed to keep pace with the deinstitutionalization brought on by SSI distribution. Quite simply, “[n]o one built residences for them in the community because the regulations did not require anyone to do so.”²⁸⁶ Moreover, the community health clinics established during the Kennedy administration catered more to acute than chronic patients, leaving long-term patients, recently released from institutions, out in the cold.²⁸⁷ Finally, state dollars earmarked for mental hospital or asylum care failed to follow patients into the community.²⁸⁸ A large number of formerly institutionalized individuals simply had nowhere to go.

Soon after, the mental health bar filed a suit attacking the incarceration of the mentally ill and developmentally disabled in *Lessard v. Schmidt*.²⁸⁹ *Lessard*, which struck down Wisconsin’s commitment law as unconstitutional, set aside the traditional *parens patriae* grounds for the basis of commitment.²⁹⁰ Instead, the Eastern District of Wisconsin held that the state needed to prove, beyond a reasonable doubt, all facts necessary to show that an individual is “mentally ill and dangerous.”²⁹¹ The *Lessard* court created a narrow dangerousness standard: involuntary commitment is only permissible

283. See Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329.

284. See John Trout & David R. Mattson, *A 10-Year Review of the Supplemental Security Income Program*, 47 SOC. SEC. BULL. 3, 13 (1984).

285. See ANN BRADEN JOHNSON, *OUT OF BEDLAM* 98 (1990).

286. Rothman, *supra* note 273.

287. See *id.*

288. *Id.*

289. *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded*, 414 U.S. 473 (1974), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976).

290. *Id.* at 1103.

291. *Id.* at 1095.

when “there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others.”²⁹²

In addition, the *Lessard* court required, for the first time, that commitment proceedings provide the mentally ill with all the protections accorded to criminal suspects—among them a right to counsel, a right to remain silent, exclusion of hearsay evidence, and a standard of proof beyond a reasonable doubt.²⁹³ Among other aspects, *Lessard* illustrated how the long-standing detention and segregation of the disabled and dependent bore remarkable similarities to criminal incarceration.

Lessard revolutionized mental health law and involuntary incarceration.²⁹⁴ After *Lessard*, most states jettisoned their broad commitment statutes, essentially abandoning the traditional *parens patriae* grounds for commitment and focusing, instead, on the police power as a primary justification.²⁹⁵ Because of this shift, involuntary civil commitment on the basis of mental illness was no longer seen only as a medical decision, but as a legal decision as well.²⁹⁶

Importantly, the *Lessard* court noted that almost three times as many persons were confined in mental institutions in the United States as were incarcerated, at that time, in all state and federal prisons combined: “In 1963, 679,000 persons were confined in mental institutions in the United States; only 250,000 persons were incarcerated in all prisons administered by states and the federal government.”²⁹⁷ The consequences in the pre-*Lessard* world for being found mentally ill were very harsh; the mentally ill could not vote, serve on a jury, drive a car, practice certain professions, make a contract, or get married.²⁹⁸ The magnitude of the confinement and lack of rights for those determined to “unfit” for society were remarkable.

Following *Lessard*, another case brought by the ACLU, *O’Connor v. Donaldson*,²⁹⁹ led to further change in states’ ability to incarcerate

292. *Id.* at 1093.

293. *Id.* at 1103–04.

294. See LEVIN, HENNESSY & PETRILA, *supra* note 260, at 46.

295. *See id.*

296. *See id.*

297. *Lessard*, 349 F. Supp. at 1090.

298. *Id.* at 1088–89.

299. *O’Connor v. Donaldson*, 422 U.S. 563 (1975). The Court left for later the questions of “whether mentally ill persons dangerous to themselves or to others have a right to treatment upon compulsory confinement by the State, or whether the State may compulsorily confine a nondangerous, mentally ill individual for the purpose of treatment.” *Id.* at 573.

the mentally ill or developmentally disabled. The lead plaintiff, Kenneth Donaldson, had been involuntarily confined in a Florida state hospital for fifteen years, although he was not dangerous and had received no medical treatment.³⁰⁰ A unanimous Supreme Court ruled that states cannot confine a non-dangerous individual who can survive on his own, or with help from family and friends.³⁰¹ As the Supreme Court explained, “Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person’s physical liberty. . . . [A] State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”³⁰²

These cases and the advent of Medicaid changed the course of institutional incarceration of the mentally ill and developmentally disabled. Although there have been various pieces of legislation from Congress in the intervening years, nothing affected institutionalization in asylums as much as the changes in the 1960s and 1970s, since the changes during that era led to the asylum’s demise. During those decades, the entire system devoted to confining and segregating the disabled finally came under scrutiny. What eventually replaced that system, however, was not much of an improvement.

In 1980, President Carter signed the Mental Health Systems Acts,³⁰³ which aimed to revitalize the Community Mental Health Center Program, and improve services for people with chronic mental illness.³⁰⁴ A year later, however, the Omnibus Budget Reconciliation Act³⁰⁵ repealed this legislation and established block grants for the states, eliminating the federal role in providing services to the mentally ill.³⁰⁶ As a result, federal mental health spending decreased by 30 percent.³⁰⁷

The formal process of deinstitutionalization took two main tacks: (1) closing the state mental hospitals, and (2) closing the state facilities

300. *See id.* at 564–65, 568.

301. *See id.* at 575–76.

302. *See id.*

303. Mental Health Systems Act, Pub. L. No. 96-398, 94 Stat. 1564 (1980).

304. *See id.* § 2(1) (noting the dearth of available resources for these vulnerable populations).

305. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 560 (repealing provisions of the Mental Health Systems Act).

306. *See id.*

307. *See Pan, supra* note 252.

housing individuals with mental and physical disabilities.³⁰⁸ Hospital and asylum closures continued to accelerate through the end of the twentieth century. Forty state hospitals completely shut their doors between 1990 and 1997, nearly three times as many as during the entire period from 1970 to 1990.³⁰⁹ The mass closure of asylums and other state institutions meant that one form of mass incarceration on the basis of disability had finally ended.

E. The Uneasy Results of Deinstitutionalization

Whether deinstitutionalization was the right move is still a matter of debate. As Samuel Bagenstos notes, “deinstitutionalization has caused significant positive results for a large number of people who would otherwise have been set apart from their communities and denied the basic interactions of civic life.”³¹⁰ This is particularly true for those individuals who are developmentally or physically disabled.³¹¹

It is equally true, however, that many individuals with psychiatric disabilities have not been well-served by deinstitutionalization,³¹² and a significant number of them have ended up incarcerated in jails and prisons instead. In addition, institutionalization for people with physical, mental, or psychiatric disabilities has not been entirely eradicated. In 1999’s *Olmstead v. L.C. ex rel Zimring*,³¹³ the Supreme Court held that unjustified institutionalization can violate the Americans with Disabilities Act (ADA), acknowledging that involuntary commitment still exists in the modern era. Indeed, lawsuits contesting institutionalization of the disabled continue to this day.³¹⁴ The involuntary commitment and confinement of disabled individuals still persists, despite disappearing from the public eye.

The severely physically disabled have also been left behind by deinstitutionalization. Due to lack of services and funding, people with serious physical disabilities often end up in geriatric nursing homes,

308. See Bagenstos, *supra* note 261, at 7.

309. DJ Jaffe, *Medicaid Discrimination Against People with Severe Mental Illnesses*, MENTAL ILLNESS POL’Y ORG., <http://mentalillnesspolicy.org/imd/imd-medicaid-mentally-ill.html> [<https://perma.cc/4WZN-KVGT>].

310. Bagenstos, *supra* note 261, at 4.

311. See *id.* at 4–5.

312. See *id.*

313. *Olmstead v. L.C. ex rel Zimring*, 527 U.S. 581 (1999).

314. See Bagenstos, *supra* note 261, at 5; *Olmstead Enforcement*, ADA.GOV, https://www.ada.gov/olmstead/olmstead_enforcement.htm [<https://perma.cc/MPE3-L42Z>].

even if they are teenagers or young adults.³¹⁵ According to the Centers for Medicare and Medicaid, one out of seven nursing home residents is under age sixty-five.³¹⁶

Because meeting funding and care requirements for disabled individuals can be very difficult, nursing homes have turned into default caregivers for those who have no other options.³¹⁷ Although large public institutions have closed due to the forces of deinstitutionalization, many individuals with serious mental and physical disabilities have been placed in somewhat smaller private institutions, such as adult care homes, nursing homes, group homes, and intermediate care facilities for the developmentally disabled.³¹⁸ Despite *Olmstead*'s holding that people with mental and physical disabilities cannot be segregated into nursing homes, without enough funding to provide home care, there is little else these individuals can do but enter nursing or group homes.³¹⁹

These “mini-institutions,” although smaller than the large public warehouses of the past, can end up mimicking their structure. Often, those individuals living in group homes are isolated inside the homes due to lack of services or staff. Injuries, serious medical conditions, and even deaths are frequently not investigated, and go unreported.³²⁰ Sometimes, the homes are run like an institution, with locked thermostats and locked cupboards.³²¹ Accordingly, we still sequester

315. See Ashley Cheek, *Young, Disabled, and Stuck in a Nursing Home for the Elderly*, AL JAZEERA AM. (Oct. 2, 2013), <http://america.aljazeera.com/articles/2013/10/2/young-disabled-andstuckinnursinghomes.html> [<https://perma.cc/3N4A-PXDZ>].

316. *Id.*

317. *See id.*

318. *See* Bagenstos, *supra* note 261, at 30.

319. In 2006, the federal government initiated home- and community-care-based programs such as “Money Follows Person” (MFP), which offers states federal money for each Medicaid recipient who transitions out of a nursing home. Not all states have fully implemented MFP, however. *See Money Follows the Person*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html> [<https://perma.cc/GYY7-Z9XU>]. Also, MFP was only funded under the ACA until December 2016; without authorization, the program will expire in 2020. *See Letter in Support of Reauthorizing Money Follows the Person Demonstration*, NAT'L MLTSS HEALTH PLAN ASS'N (Oct. 26, 2017), <http://mltss.org/2017/10/26/letter-support-reauthorizing-money-follows-person-demonstration> [<https://perma.cc/2S84-XDLR>].

320. *See* Michelle Diament, *Government Watchdog Warns of Group Home Danger*, DISABILITY SCOOP (Jan. 18, 2018), <https://www.disabilityscoop.com/2018/01/18/government-group-home-dangers/24603> [<https://perma.cc/NS2U-MBNW>].

321. *See* Abbie J. Thurmes, *How Minnesota's Reliance on Private Group Homes Impacts the Rights of Individuals with Disabilities*, 38 MITCHELL HAMLINE L.J. PUB. POL'Y & PRAC. 4, 7 (2017).

those with physical or developmental disabilities into institutionalized care, often without their desire or consent, if their family cannot support their needs.

Although the deinstitutionalization movement closed the largest public asylums and state hospitals, community-based treatment never really expanded to fill the need for services. By 1984, over half of nursing homes were filled with those suffering from various mental disorders, “thousands of disturbed persons wander[ed] [the] urban landscape without housing,”³²² and equally as many ended up in welfare hotels, board and care homes, and adult residences.³²³

In short, despite the shutting down of state hospitals and asylums, many mentally ill and disabled individuals are still confined. Instead of large state institutions, they have been transferred to nursing or residential homes, which frequently lack the staffing, expertise, and equipment to meet their needs, or correctional facilities, which provide even fewer services. Those who are not confined have had the burden of care shifted to their families, though the families often lack the financial resources and medical knowledge to provide proper care.³²⁴ The results of deinstitutionalization have not been entirely successful.

F. *The Long Tail of Eugenics*

Despite the changes, both good and bad, that resulted from deinstitutionalization, a strong emphasis on an individual’s value in the workforce continues to frame discussions and treatment of those with mental and physical disabilities.³²⁵ The legacy of eugenics remains strong³²⁶ and still undergirds much of our treatment of the disabled.

There is a widespread assumption that the end of asylum care also meant the end of the blatantly eugenic policies and principles that motivated their creation. In addition, many assume that, after the Nazis

322. See John A. Talbott, *Psychiatry’s Agenda for the 80’s*, 251 J. AM. MED. ASS’N 2250, 2250 (1984).

323. See Henry Cisneros, *Searching for Home: Mentally Ill Homeless People in America*, CITYSCAPE, Dec. 1996, at 155, 158.

324. See Enric J. Novella, *Mental Health Care and the Politics of Inclusion: A Social Systems Account of Psychiatric Deinstitutionalization*, 31 THEORETICAL MED. BIOETHICS 411, 415 (2010).

325. See ERIKA DYCK, *FACING EUGENICS: REPRODUCTION, STERILIZATION, AND THE POLITICS OF CHOICE* 222 (2013).

326. See Benjamin J. Ostuguy, Madeline L. Peters & Davey Shlasko, *Ableism*, in *TEACHING FOR DIVERSITY AND SOCIAL JUSTICE* 312 (Maurianne Adams & Lee Anne Bell eds., 2016).

enthusiastically embraced eugenics, its appeal dimmed within the scientific community and popular imagination.

In truth, however, eugenics has never truly disappeared.³²⁷ For example, *Buck v. Bell*,³²⁸ in which the Supreme Court upheld a state statute permitting the compulsory sterilization of the unfit, has never been overruled.³²⁹ Indeed, *Buck v. Bell* was cited as precedent as recently as 2001.³³⁰

Similarly, forced or coercive sterilizations have not entirely vanished.³³¹ Between the 1930s and 1970s, approximately one-third of all Puerto Rican mothers aged twenty to forty-nine were sterilized as part of a U.S. policy that promoted the use of permanent sterilization as a means of birth control.³³² Law 116, initiated in 1937, encouraged government health workers to soft-sell the benefits of “la operación” to minimize the stigma of sterilization.³³³ The doctors performing these sterilizations often did so without consent, claiming that it was reversible or administering it immediately after childbirth.³³⁴

In addition, several states continued to forcibly sterilize citizens well into the 1980s.³³⁵ Even more recently, California sterilized at least 148 female prisoners without their full consent between 2006 and 2010, with potentially more than a hundred others sterilized in the prior decade.³³⁶ Sterilization requirements still pop up in plea negotiations,

327. See James C. Oleson, *The New Eugenics: Black Hyper-Incarceration and Human Abatement*, 5 SOC. SCI. 1, 4 (2016).

328. *Buck v. Bell*, 274 U.S. 200 (1927).

329. See Oleson, *supra* note 327, at 4. Although *Skinner v. Oklahoma*, 316 U.S. 535 (1942), held that compulsory sterilization of habitual criminals was unconstitutional if the sterilization statutes treated similar crimes differently, this did not affect the constitutionality of *Buck v. Bell*. *Id.* at 541–42.

330. See *Vaughn v. Ruoff*, 253 F.3d 1124, 1128–31 (8th Cir. 2001) (upholding the denial of qualified immunity to a social service worker involved in forcible sterilization); DenHoed, *supra* note 228.

331. See DenHoed, *supra* note 228.

332. See Vanessa Bauza, *Puerto Rico: The Covert Campaign to Sterilize Women*, MS, Sept.–Oct. 1994, at 14.

333. See *id.*

334. See *id.*

335. Oleson, *supra* note 327, at 4 (citing ALEXANDRA MINNA STERN, *EUGENIC NATION: FAULTS AND FRONTIERS OF BETTER BREEDING IN MODERN AMERICA* (2005)).

336. See Corey G. Johnson, *Female Inmates Sterilized in California Prisons Without Approval*, NBC BAY AREA NEWS (July 8, 2013, 11:27 AM), <http://www.nbcbayarea.com/news/california/Female-Inmates-Sterilized-in-California-Prisons-Without-Approval-214634341.html> [<https://perma.cc/F89U-WXR6>].

as in a 2015 case in Tennessee where a mentally ill woman was pressured to accept sterilization as part of a lighter plea deal.³³⁷

Women below the poverty line are still often tricked, coerced, or pressured into sterilization. This was the case for a Boston woman in 2006, who was sterilized instead of receiving a long-term IUD after the birth of her ninth child.³³⁸ All of this is deeply redolent of eugenic philosophy—that only “fit” parents should be allowed to procreate.

There is thus a very thin line between the racial and class-based tools of eugenics, particularly as practiced on impoverished women, and our late twentieth-century risk-assessment tools and sentencing guidelines.³³⁹ Our desire to control those individuals who violate our societal norms—whether through crime, disability, mental illness, or poverty—has led us time and time again to tactics of imprisonment, coercive medical procedures, and institutionalization. The ties between institutionalization, eugenics, and social engineering have led to the imprisonment of a significant percentage of our population, for remarkably similar reasons as we did in the nineteenth and twentieth centuries. We simply do so in different types of carceral institutions.

III. TRANSINSTITUTIONALIZATION, MENTAL ILLNESS, AND DISABILITY IN THE TWENTY-FIRST CENTURY

“[D]einstitutionalization has made visible degradations that were once invisible.”³⁴⁰ Ending the institutionalization of the mentally ill and developmentally and physically disabled did not result in full liberation. Deinstitutionalization has led to the imprisonment of many disabled people in correctional facilities.³⁴¹ Indeed, as other scholars have noted, our new standard for care, the least restrictive setting, “often turns out to be a cardboard box, a jail cell, or a terror-filled

337. See Sam P.K. Collins, *Tennessee Prosecutor Insisted Woman Undergo Sterilization as Part of Plea Deal*, THINKPROGRESS (Mar. 30, 2015, 4:41 PM), <https://thinkprogress.org/tennessee-prosecutor-insisted-woman-undergo-sterilization-as-part-of-plea-deal-a1ad95a5e045/> [<https://perma.cc/7BSX-Z7S4>].

338. See Sarah Netter, *Mother of Nine Sues Massachusetts Hospital After Unauthorized Sterilization*, ABC NEWS (Jan. 5, 2010), <http://abcnews.go.com/Health/mother-sterilized-lawsuit-claims/story?id=9474471> [<https://perma.cc/7LNW-H7XJ>].

339. Hernández, Muhammad & Thompson, *supra* note 18, at 22 (arguing that eugenics underlie risk assessment tools used to determine dangerousness or incarceration of detainees, because risk factors tend to parallel “racial types,” with high risks associated with minority offenders).

340. Rothman, *supra* note 273.

341. ELIZABETH F. EMENS & MICHAEL ASHLEY STEIN, *DISABILITY AND EQUALITY LAW* 203 (2002).

existence plagued by both real and imaginary enemies.”³⁴² In large part, this is because society has not been willing to devote enough resources to ensuring that deinstitutionalization works.³⁴³ In addition, our discomfort with those who are differently abled—whether through physical ability, intellectual ability, or mental illness—has led us to fall into our familiar default for treating the disabled: incarceration.

A. *The Persistence of Mental Illness*

Approximately 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates suffer from mental health issues, as defined in our modern medical system.³⁴⁴ These individuals often receive inadequate care, with only one in three state prisoners and one in six jail inmates receiving proper mental health treatment during incarceration.³⁴⁵

Roughly 20 percent of jail inmates and 15 percent of state prison inmates are estimated to have a serious mental illness.³⁴⁶ Accordingly, if one uses the total number of inmates for calculation, “approximately 356,000 with serious mental illness are in jails and state prisons - 10 times more than the nearly 35,000 individuals with serious mental illness remaining in state hospitals.”³⁴⁷ This level of severe mental illness in our prisons and jails should raise great concern about the safety, well-being, and levels of treatment for the inmates who are incarcerated.³⁴⁸

What disorders do these inmates suffer? Serious depressive disorder ranks the highest, with 21 percent of all inmates diagnosed, followed by bipolar disorder at 12 percent, post-traumatic stress disorder (PTSD) at 7 percent, and schizophrenia at 5 percent.³⁴⁹ These

342. See TORREY, *supra* note 39, at 11.

343. See EMENS & STEIN, *supra* note 341, at 203.

344. See KIDEUK KIM, MIRIAM BECKER-COHEN & MARIA SERAKOS, URBAN INST., *THE PROCESSING AND TREATMENT OF MENTALLY ILL PERSONS IN THE CRIMINAL JUSTICE SYSTEM: A SCAN OF PRACTICE AND BACKGROUND ANALYSIS V* (2015), <http://webarchive.urban.org/UploadedPDF/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf> [<https://perma.cc/PJP9-5X4S>].

345. See *id.* (citing DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, *MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES* (2006), <https://www.bjs.gov/content/pub/pdf/mhppji.pdf> [<https://perma.cc/BN69-J9RF>]).

346. Parker & Andrade, *supra* note 268.

347. *Id.*

348. See KIM, BECKER-COHEN & SERAKOS, *supra* note 344, at 1.

349. See *id.* at 9 (citing U.S. BUREAU OF JUSTICE STATISTICS, *SURVEY OF INMATES IN STATE AND FEDERAL CORRECTIONAL FACILITIES*, 2004 (2007)).

illnesses are often diagnosed at various times during a prisoner's sentence,³⁵⁰ meaning some could possibly be ascribed to the effects of incarceration. It is likely, however, that many of these diseases were present in the afflicted before their interaction with the criminal justice system.³⁵¹

There is no true consensus for why there are so many mentally ill people in prisons and jails. Some scholars argue that deinstitutionalization of state and county mental hospitals caused the number of mentally ill inmates in state prison to increase substantially.³⁵² Other scholars argue that most deinstitutionalized patients rejoined their communities, and that the formerly hospitalized and the mentally ill individuals who are incarcerated are neither demographically nor clinically similar.³⁵³ Further attempts to explain the high rate of incarceration include: selective enforcement of laws applied more harshly to the mentally ill, the concentration of mentally ill individuals in high-crime settings, repeated arrests for low-level crimes such as public nuisance offenses and homelessness, and inadequate community mental health treatment.³⁵⁴ It is likely that all of these causes, including deinstitutionalization, have collectively contributed to the problem.

The mentally ill are greatly overrepresented in our prisons and jails, even when differences in background characteristics between the general population and the incarcerated are taken into account.³⁵⁵ The level of serious mental health disorders in state prisons has been rising steadily in recent years, up from 17 percent in 2004 to 28 percent in

350. *See id.* at 8.

351. *See Jailing People With Mental Health*, NAT'L ALLIANCE OF MENTAL ILLNESS, <https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness> [https://perma.cc/3X7Z-ZJ7T] (noting that more individuals suffering from a mental health crisis "encounter police than get medical help").

352. *See* EMENS & STEIN, *supra* note 341, at 203.

353. *See* Edward P. Mulvey & Carol A. Schubert, *Mentally Ill Individuals in Jails and Prisons*, 46 CRIME & JUST. 231, 235 (2016) (citing Emil R. Pinta, *Psychiatric Disorders and Repeat Incarcerations: Is There an Epidemic?*, 166 AM. J. PSYCHIATRY 489 (2009); Robert L. Trestman, Julian Ford, Wanli Zhang & Valerie Wiesbrock, *Current and Lifetime Psychiatric Illness Among Inmates Not Identified as Acutely Mentally Ill at Intake in Connecticut's Jails*, 35 J. AM. ACAD. PSYCHIATRY & L. 490 (2007)).

354. *See id.* at 236.

355. *See id.* at 232 (citing Linda A. Teplin, *The Prevalence of Severe Mental Disorders Among Male Urban Jail Detainees*, 80 AM. J. PUB. HEALTH 663 (1990); Linda A. Teplin, Karen M. Abram & Gary M. McClelland, *Prevalence of Psychiatric Disorders Among Incarcerated Women Jail Detainees*, 53 ARCHIVES GEN. PSYCHIATRY 505 (1996)).

2011.³⁵⁶ In the early years of the twenty-first century, the nation's jails and prisons have become de facto hospitals for people with mental illnesses, many of whom grapple with substance use problems, prior homelessness, and repeated incarceration.³⁵⁷

Unsurprisingly, the majority of prisons and jails are not prepared to properly diagnose and treat such serious mental illness.³⁵⁸ Only 12.7 percent of incarcerated citizens report getting any treatment during their sentences.³⁵⁹

Forty-four states and the District of Columbia have at least one jail that houses more people with mental illnesses than the largest state psychiatric hospital.³⁶⁰ Many of these people are funneled into the prison system because they have nowhere else to go.³⁶¹ The community mental health system that followed deinstitutionalization lacks enough resources to ensure that the mentally ill who have been released continue to “take prescribed medication or to use other interventions such as psycho-social rehabilitation and assertive case management in a timely and effective way to prevent relapses.”³⁶² In addition, the current system lacks enough beds and is unable to determine when an

356. *Id.* (citing Cece Hill, *Survey Summary: Inmate Mental Health Care*, 33 CORRECTIONS COMPENDIUM 12 (Sept.–Oct. 2008); Cece Hill, *Inmate Mental Health Care*, 29 CORRECTIONS COMPENDIUM 12 (Sept.–Oct. 2004)).

357. *See* KIM, BECKER-COHEN & SERAKOS, *supra* note 344, at 9–10 (citing Kristin G. Cloyes, Bob Wong, Seth Latimer & Jose Abarca, *Time to Prison Return for Offenders with Serious Mental Illness Released from Prison: A Survival Analysis*, 27 CRIM. JUST. & BEHAVIOR 175 (2010)); Riki Hokama & Rene Binder, *A Crisis in Our Jails: People With Mental Illnesses Need Proper Treatment, Not Jail Sentences*, U.S. NEWS & WORLD REP. (May 14, 2015, 1:15 PM), <https://www.usnews.com/opinion/blogs/policy-dose/2015/05/14/stepping-up-aims-to-keep-the-mentally-ill-out-of-jail> [<https://perma.cc/M39L-URQE>].

358. *See* KIM, BECKER-COHEN & SERAKOS, *supra* note 344, at 10.

359. *See id.* (citing JAMES & GLAZE, *supra* note 345). Approximately 64 percent of local jail inmates, 56 percent of state prisoners, and 45 percent of federal prisoners have symptoms of serious mental illness. *See Department of Justice Study: Mental Illness of Prison Inmates Worse Than Past Estimates*, NAT'L ALLIANCE ON MENTAL ILLNESS (Sept. 6, 2006), <https://www.nami.org/Press-Media/Press-Releases/2006/Department-of-Justice-Study-Mental-Illness-of-Pris> [<https://perma.cc/P7AD-7CVZ>].

360. *See* 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/7GQR-PNBR>].

361. *See TAC Reports*, TREATMENT ADVOCACY CTR., <http://www.treatmentadvocacycenter.org/evidence-and-research/studies> [<https://perma.cc/9DBS-WTQQ>].

362. *See* Mark J. Heyrman, *Mental Illness in Prisons and Jails*, 7 U. CHI. L. SCH. ROUNDTABLE 113, 115 (2000).

individual should be referred to a hospital or other in-patient services.³⁶³

The standard practices of the criminal justice system contribute to overrepresentation of the mentally ill in correctional institutions.³⁶⁴ People with serious mental illness, compared with others similarly charged, tend to have longer jail stays, and are less likely to qualify for non-jail sentences such as probation or other forms of community-based supervision.³⁶⁵ Sometimes these kind of prisoners are housed in a special psychiatric unit, which can lack even the most minimal types of programming.³⁶⁶ In addition, mentally ill prison inmates are less likely to obtain parole, more likely to violate parole when granted, and are more likely to serve out their full sentences.³⁶⁷ Thus the long-term incarceration of mentally ill individuals continues, simply in a different type of institution.

Like any epidemic, the growing problem of mass incarceration must be tackled at many different levels.³⁶⁸ Mass incarceration of people with mental disabilities is unjust, unethical, and cruel. But it is also penny-wise and pound-foolish, as community-based treatment and prevention services cost far less than housing an individual behind bars.³⁶⁹

363. *See id.*

364. *See* Mulvey & Schubert, *supra* note 353, at 236.

365. *Id.* (citing FRED C. OSHER, DAVID A. D'AMORA, MARTHA PLOTKIN, NICOLE JARRETT & ALEXA EGGLESTON, *ADULTS WITH BEHAVIORAL HEALTH NEEDS UNDER CORRECTIONAL SUPERVISION: A SHARED FRAMEWORK FOR REDUCING RECIDIVISM AND PROMOTING RECOVERY* (2012); PAULA M. DITTON, BUREAU OF JUSTICE STATISTICS, *MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS* (1999), https://www.prisonlegalnews.org/media/publications/bojs_mental_health_and_treatment_of_inmates_and_probationers_1999.pdf [<https://perma.cc/PUF4-WAC3>]).

366. *See* Toshio Meronek, *The Invisible Punishment of Prisoners with Disabilities*, *NATION* (July 23, 2013), <https://www.thenation.com/article/invisible-punishment-prisoners-disabilities/> [<https://perma.cc/Z9MS-995Z>].

367. *See* Mulvey & Schubert, *supra* note 353, at 237 (citing JAMES & GLAZE, *supra* note 345; Christine M. Sarteschi, *Mentally Ill Offenders Involved with the US Criminal Justice System: A Synthesis*, SAGE, July–Sept. 2013, at 1; MARISSA J. SCHNELL & MAUREEN L. O'KEEFE, *OFFENDERS WITH MENTAL ILLNESS IN COLORADO* (2006); Steven R. Wood, *Co-occurring Psychiatric and Substance Dependence Disorders as Predictors of Parolee Time to Rearrest*, 50 *J. OFFENDER REHABILITATION* 175 (2011)). This is in large part due to the mentally ill inmate's inability to follow rules and keep to the letter of their parole or probation. *See id.*

368. Editorial, *Mass Imprisonment and Public Health*, *N.Y. TIMES* (Nov. 26, 2014), <https://www.nytimes.com/2014/11/27/opinion/mass-imprisonment-and-public-health.html> [<https://perma.cc/S4MC-AUMX>].

369. Rebecca Vallas, *Disabled Behind Bars: The Mass Incarceration of People with Disabilities in America's Jails and Prisons*, *CTR. FOR AM. PROGRESS* (July 18, 2016, 12:01

It is possible that the ADA, which has significant requirements for public services provided by state, county, and local entities, can be used to help minimize the number of mentally ill individuals in correctional facilities. Title II of the ADA bans unnecessary institutionalization, and in particular provides the “Integration Mandate,”³⁷⁰ which requires public entities to “administer services, programs, and activities”³⁷¹ in non-institutional settings that “enable individuals with disabilities to interact with nondisabled persons to the fullest extent possible.”³⁷² Interpreted broadly, jails and prisons can definitely be a type of unnecessary institutionalization that affects many thousands of individuals with mental illness,³⁷³ depriving them of services, programs, and activities that are necessary for them. People with disabilities, whether mental, physical, or developmental, are often deprived of necessary medical care while imprisoned and frequently lack necessary supports, services, and accommodations.³⁷⁴

Due to lack of treatment, sometimes the mentally ill have ended up in jails even without an accusation of criminal behavior. In a 1992 Public Citizen survey, investigators found that 29 percent of jails sometimes incarcerated persons *who had no charges against them*, but were merely waiting for psychiatric evaluation, the availability of a psychiatric hospital bed, or transportation to a psychiatric hospital. Such incarceration was done under state laws permitting emergency detentions of individuals suspected of being mentally ill. These detentions were especially common in more rural states such as Kentucky, Mississippi, Alaska, Montana, Wyoming, and New Mexico.³⁷⁵ This type of emergency detention still occurs in five states—

AM), <https://www.americanprogress.org/issues/criminal-justice/reports/2016/07/18/141447/disabled-behind-bars/> [<https://perma.cc/T9US-67HR>].

370. 28 C.F.R. § 35.130(d) (2010) (the “integration mandate”); *see also* U.S. DEPT OF JUSTICE, STATEMENT OF THE DEPARTMENT OF JUSTICE ON ENFORCEMENT OF THE INTEGRATION MANDATE OF TITLE II OF THE AMERICANS WITH DISABILITIES ACT AND *OLMSTEAD V. L.C.* (2011) (providing guidance to assist state and local governments in complying with the integration mandate).

371. 28 C.F.R. § 35.130(d).

372. 28 C.F.R. § 35 app.B (addressing § 35.130).

373. *See* Ira A. Burnim, *Using the Americans with Disabilities Act to Reduce the Incarceration of People with Mental Illness*, SAFETY AND JUSTICE CHALLENGE (Jan. 12, 2017), <http://www.safetyandjusticechallenge.org/2017/01/using-americans-disabilities-act-reduce-incarceration-people-mental-illness/> [<https://perma.cc/C9BQ-EY8T>].

374. *See* Vallas, *supra* note 369.

375. *See* E. Fuller Torrey, *Deinstitutionalization: A Psychiatric “Titanic,”* PBS (May 10, 2005), <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html> [<https://perma.cc/EV9C-FXAG>].

New Mexico, North and South Dakota, Texas, and Wyoming³⁷⁶—despite the dubious legality, due to the simple lack of other treatment options.³⁷⁷

Most severely mentally ill people in jail, however, are there because they have been charged with a misdemeanor. A 1983 study by Edwin Valdiserri reported that mentally ill jail inmates were four times more likely to have been incarcerated for less serious charges such as disorderly conduct and threats compared to non-mentally ill inmates.³⁷⁸ Mentally ill inmates were three times more likely to have been charged with disorderly conduct, five times more likely to have been charged with trespassing, and ten times more likely to have been charged with harassment.³⁷⁹ This still proves true; in Dade County, Florida, for example, the vast majority of mentally ill offenders are there due to misdemeanors or low-level felonies.³⁸⁰

Correctional officials are in a difficult position when it comes to the mentally ill. Although they have minimal training or equipment, corrections officers are required to house thousands of seriously mentally ill inmates, even when they are not able to provide these inmates with their necessary psychiatric medications.³⁸¹ This challenge

376. Taylor Eldridge, *When a Mental Health Emergency Lands You in Jail*, MARSHALL PROJECT (Sept. 20, 2017, 10:00 PM), <https://www.themarshallproject.org/2017/09/20/when-a-mental-health-emergency-lands-you-in-jail> [<https://perma.cc/E5EX-EVWU>].

377. See *Mental Health Holds in Jails: Incarcerating Those with Mental Emergencies*, NAT'L PARALEGAL C.: LAW SHELF, <https://lawshelf.com/blog/post/mental-health-holds-in-jails-the-bizarre-phenomenon-of-incarcerating-those-with-mental-emergencies> [<https://perma.cc/2PLL-RC88>] (discussing mental health holds in Vermont, New Mexico, and South Dakota). Wyoming also follows this practice. See WYO. DEP'T OF HEALTH BEHAVIORAL HEALTH DIV., *EMERGENCY DETENTION PROCESS 1–2* (Feb. 2017), https://health.wyo.gov/wp-content/uploads/2016/06/Emergency-Detention-Process_RHW.pdf [<https://perma.cc/52V3-NFQB>].

378. See TORREY ET AL., *supra* note 98, at 49.

379. See Torrey, *supra* note 375.

380. See NAT'L ASS'N OF COUNTIES, *MENTAL HEALTH AND CRIMINAL JUSTICE CASE STUDY: MIAMI-DADE COUNTY, FLA.* 1 (2015), <http://www.naco.org/sites/default/files/documents/Miami-Dade%20County%20-%20Mental%20Health%20and%20Jails%20Case%20Study.pdf> [<https://perma.cc/AX8E-N57J>]. See generally Rebecca Vallas, *Disabled Behind Bars: The Mass Incarceration of People with Disabilities in America's Jails and Prisons*, AM. PROGRESS (July 18, 2016, 12:01 AM), <https://www.americanprogress.org/issues/criminal-justice/reports/2016/07/18/141447/disabled-behind-bars/> [<https://perma.cc/TF3S-M97R>] (pointing out that many mentally ill offenders land in jail or prison due to minor offenses).

381. See E. FULLER TORREY, MARY T. ZDANOWICZ, AARON D. KENNARD, H. RICHARD LAMB, DONALD F. ESLINGER, MICHAEL C. BIASOTTI & DORIS A. FULLER, *TREATMENT ADVOCACY CTR., THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 8* (Apr. 8, 2014), <http://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf> [<https://perma.cc/K35N-LNSR>].

is particularly acute for jails, which function essentially as substitutes for mental health facilities. Jails lack the resources and training to handle medical and mental health emergencies.³⁸² When the mentally disabled are detained in jails, whether they are waiting for transfer to a health facility or for determination of criminal justice issues, they very frequently lack access to medical care.³⁸³ The lack of medical care can worsen existing health problems—particularly mental health crises and suicide threats.³⁸⁴ In addition, jail detainees are often not properly diagnosed and fail to receive proper healthcare.³⁸⁵

Once convicted, mentally ill inmates more frequently fail to follow rules, and are thus sanctioned for disciplinary infractions at higher rates than other prisoners.³⁸⁶ For example, a 2012 Human Rights Watch study found that 58 percent of state prisoners with mental disabilities had been charged with rule violations, compared to 43 percent of non-disabled state prisoners—a 12 percent difference.³⁸⁷ Mentally ill inmates are also more likely to be victimized by other prisoners, and two to three times more likely to get into a fight with another inmate.³⁸⁸

Finally, mentally ill prisoners endure a high level of abusive force from prison or jail staff.³⁸⁹ The use of force against inmates with mental illness is widespread, purposeful, and sometimes even malicious.³⁹⁰ As a Human Rights Watch report has documented, “[c]orrections officials at times needlessly and punitively deluge [prisoners] with chemical sprays; shock them with electric stun devices; strap them to chairs and beds for days on end; break their jaws, noses, ribs; or leave them with lacerations, second degree burns, deep bruises, and damaged internal organs.”³⁹¹ Reasons for such excessive force include minimal mental health treatment available for prisoners, weak policies protecting

382. See Elliot Oberholtzer, *Police, Courts, Jails, and Prisons All Fail Disabled People*, PRISON POL’Y INITIATIVE (Aug. 23, 2017), <https://www.prisonpolicy.org/blog/2017/08/23/disability/> [https://perma.cc/62DH-4JZT].

383. See Swanson, *supra* note 360.

384. See Oberholtzer, *supra* note 382.

385. See Jamie Fellner, *Callous and Cruel: Use of Force against Inmates with Mental Disabilities in US Jails and Prisons*, HUMAN RIGHTS WATCH (May 12, 2015), <https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and> [https://perma.cc/M65Z-SDUD].

386. See *id.*

387. See *id.*

388. See JAMES & GLAZE, *supra* note 345, at 10.

389. See Oberholtzer, *supra* note 382.

390. See Fellner, *supra* note 385.

391. See *id.*

prisoners from unnecessary force, insufficient staff training and supervision, and a lack of accountability for the abuse of force.³⁹²

As a society, we have not been successful in caring for those individuals with mental disabilities, and have left them to languish in prisons, jails, halfway houses, and the streets. The suffering and degradations these citizens have endured do not differ that significantly from the shameful and squalid conditions of the state mental asylums of old.

B. Cognitively Challenged Prisoners

People with cognitive and developmental disabilities tend to interact with the criminal justice system at a disproportionately higher rate.³⁹³ Overall, between 4 and 10 percent of all prisoners have an intellectual or cognitive disability, depending on the facility and the definition.³⁹⁴ Breaking it down by facility type, approximately 19.5 percent of state and federal prison inmates, and 30.9 percent of jail inmates, suffer from a cognitive disability.³⁹⁵ Examples of cognitive disabilities include Down syndrome, autism, dementia, attention deficit disorder, learning disorders, intellectual disabilities, and traumatic brain injury.³⁹⁶ Prison inmates are four times as likely and jail inmates are more than six times as likely to have a cognitive disability than the general population.³⁹⁷ Some scholars contend that the closure of asylums simply paved the way for the use of jails and prisons, as both types of institutions provide a convenient way to segregate and control the lives of people with disabilities.³⁹⁸ Less controversially, studies show

392. *See id.*

393. *See* THE ARC'S NATIONAL CENTER ON CRIMINAL JUSTICE AND DISABILITY, COMPETENCY OF INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES IN THE CRIMINAL JUSTICE SYSTEM: A CALL TO ACTION FOR THE CRIMINAL JUSTICE COMMUNITY 1 (2017), <http://www.chhs.ca.gov/IST%20Workgroup/Competency%20White%20Paper%202017.pdf> [<https://perma.cc/4ZBE-VK89>].

394. *See* Margo Schlanger, *Prisoners with Disabilities: Individualization and Integration* 1 (U. Mich. Pub. Law Research Paper No. 544), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2932940 [<https://perma.cc/D92Y-R3ZA>].

395. *See* JENNIFER BRONSON, LAURA M. MARUSCHAK & MARCUS BERZOFKY, BUREAU OF JUSTICE STATISTICS, DISABILITIES AMONG PRISON AND JAIL INMATES, 2011-12, 3 (2015), <https://www.bjs.gov/content/pub/pdf/dpji1112.pdf> [<https://perma.cc/45MF-464Y>].

396. *See id.*

397. *See* Vallas, *supra* note 374.

398. *See* Jean Stewart & Marta Russell, *Disablement, Prison, and Historical Segregation*, MONTHLY REV. (July 1, 2001), <https://monthlyreview.org/2001/07/01/disablement-prison-and-historical-segregation/> [<https://perma.cc/4UL6-6NBN>].

that cognitively impaired offenders are more likely to be convicted, receive a prison sentence, and serve a greater portion of their prison term than non-cognitively disabled offenders.³⁹⁹

There are myriad reasons for these discrepancies. First, people with intellectual or developmental disabilities are sometimes manipulated into partaking in criminal behavior, but lack the criminal intent to commit the crime.⁴⁰⁰ Many offenders with cognitive disabilities are not so much criminals as unwitting participants who go along with criminal schemes to make friends.⁴⁰¹ As one police officer put it, “they are the last to leave the scene, the first to get arrested, and the first to confess.”⁴⁰²

After arrest, a disabled individual often cannot understand the charges or explain what happened from their point of view.⁴⁰³ Their understanding of their *Miranda* rights, for example, is often minimal.⁴⁰⁴ Complicating matters, criminal justice officials frequently process a developmentally disabled individual without knowledge of their disability; 75 percent of developmentally disabled offenders were not identified as having a disability at the time of arrest.⁴⁰⁵

In addition, many defense lawyers do not know the legal defenses applicable to the developmentally disabled, or may not even be aware of the disability in the first place.⁴⁰⁶ Bail is frequently denied to cognitively challenged arrestees, since they are often unemployed and do not have families or friends to vouch for them, two primary

399. See Joan Petersilia, *Justice for All? Offenders with Mental Retardation and the California Corrections System*, 77 PRISON J. 358, 361–62 (1997). Petersilia defined cognitively disabled individuals as those possessing an IQ of 70 or below, which is a common marker for such classifications. *Id.*

400. See *Keeping the Developmentally Disabled Out of Prison*, FLA. B. FOUND. (Jan. 1, 2010), <https://thefloridabarfoundation.org/keeping-the-developmentally-disabled-out-of-prison/> [<https://perma.cc/3ENQ-2H8D>].

401. See JOAN PETERSILIA, CALIFORNIA POLICY RESEARCH CENTER, *DOING JUSTICE? CRIMINAL OFFENDERS WITH DEVELOPMENTAL DISABILITIES* 5 (2000), <https://eric.ed.gov/?id=ED465905> [<https://perma.cc/E83L-TREF>].

402. See *id.*

403. See *Keeping the Developmentally Disabled Out of Prison*, *supra* note 400.

404. See William Edwards & Leigh A. Reynolds, *Defending and Advocating on Behalf of Individuals with “Mild” Mental Retardation in the Criminal Justice System*, 10 IMPACT 2, 12 (1997), <https://files.eric.ed.gov/fulltext/ED411627.pdf> [<https://perma.cc/DY5V-68UE>].

405. See PETERSILIA, *supra* note 401, at 6.

406. See *Keeping the Developmentally Disabled Out of Prison*, *supra* note 400.

requirements for granting pre-trial freedom.⁴⁰⁷ Individuals who are not released on bail before trial are more likely to be convicted.⁴⁰⁸

At adjudication, cognitively disabled offenders are more likely to get convicted or receive less favorable plea bargains than regular offenders. This is largely because they concede guilt more quickly than their non-disabled peers, and provide more self-incriminating material than other defendants.⁴⁰⁹ Likewise, at sentencing hearings, offenders with cognitive disabilities are often rejected as good prospects for probation, a condition that is more routinely granted to those individuals with higher intelligence and greater educational and work abilities.⁴¹⁰ In addition, when less punitive sanctions (such as boot camps) or diversion programs (such as work release) are available, eligibility requirements often specifically exclude those who are physically or cognitively disabled.⁴¹¹

Similarly to inmates with physical disabilities or mental illness, cognitively disabled inmates receive few to no services once incarcerated, whether in prison or jail.⁴¹² Cognitively disabled prisoners often are mistreated or manipulated by other inmates, and are easy targets for victimization and theft of personal property.⁴¹³

Inmates who have cognitive disabilities also find it more difficult to stay out of trouble and avoid misconduct violations once incarcerated in correctional institutions.⁴¹⁴ This is because they either cannot comprehend or cannot conform to jail and prison rules.⁴¹⁵ Likewise, prisoners with below-normal cognitive functioning may refuse to work or go to school within the prison setting, for example, because they fear engaging in tasks that would reveal their disabilities,⁴¹⁶ making them more vulnerable in a harsh environment.

407. See PETERSILIA, *supra* note 401, at 6.

408. See Laura I Appleman, *Justice in the Shadowlands: Pretrial Detention, Punishment, & the Sixth Amendment*, 69 WASH. & LEE L. REV. 1297, 1297 (2012).

409. See Tammy Smith, Edward Polloway, James Patton, & Julia Beyer, *Individuals with Intellectual and Developmental Disabilities in the Criminal Justice System and Implications for Transition Planning*, 43 EDUC. & TRAINING IN DEVELOPMENTAL DISABILITIES 421, 427 (2008).

410. See Petersilia, *supra* note 399, at 361.

411. See *id.*

412. See *id.* at 362.

413. See *id.*

414. See Jeanice Dagher-Margosian, *Representing the Cognitively Disabled Client in a Criminal Case*, STATE BAR OF MICH. 1 (Mar. 2006), <http://www.michbar.org/programs/EAI/pdfs/disabledclient0905.pdf> [<https://perma.cc/YY4T-K4P3>].

415. See PETERSILIA, *supra* note 401, at 6.

416. See William J. Edwards & Denis W. Keyes, *Competence Assessment: Questions and*

Simply put, the criminal justice system is not designed to address the competency of cognitively disabled individuals, as illustrated repeatedly by the lack of appropriate evaluations, restoration programs, resources, and expertise for these suspects, arrestees, defendants, and prisoners.⁴¹⁷ The mistreatment and neglect that such prisoners suffer show how the fate of the incarcerated and disabled can easily slide back to the type of cruel and inhumane treatment that led to deinstitutionalization in the first place.

IV. BREAKING THE CYCLE

What alternatives exist to either incarcerating or institutionalizing the mentally ill and disabled? One unique method of housing and treating the disabled comes from Geel, Belgium. For over seven hundred years, Geel residents have settled people with mental disorders, including very severe mental disorders, into their homes on a permanent basis.⁴¹⁸ These patients, called boarders, are paired with Geel townspeople for long-term living arrangements.⁴¹⁹ The townspeople receive a government stipend for their boarders, along with training and support from psychiatric experts.⁴²⁰ At the heart of the program is a deep and profound acceptance of mental difference within the community, which integrates those with severe mental illness or cognitive disabilities into part of everyday life.⁴²¹

In the United States, however, this type of radical community integration is a long way off, as we have reverted to the incarceration of disabled and dependent citizens. We have simply moved the site of imprisonment from the asylum to the nursing home and the correctional facility. This latest movement to isolate and segregate those with mental, physical, and cognitive disabilities is just another chapter in our carceral state, no matter whether we have conceptualized it as treatment, rehabilitation, sequestration, crime-prevention, or the like.

[Some] Answers 11–12, CHAMPION (May 1996).

417. See NAT'L CTR. ON CRIMINAL JUSTICE AND DISABILITY, *supra* note 393, at 2.

418. See Angus Chen, *For Centuries, A Small Town Has Embraced Strangers With Mental Illness*, NPR (July 1, 2016), <https://www.npr.org/sections/health-shots/2016/07/01/484083305/for-centuries-a-small-town-has-embraced-strangers-with-mental-illness> [https://perma.cc/SV52-MQXM].

419. See *id.*

420. See *id.*

421. See *id.*

To truly understand how our jails and prisons have gotten and remained so full despite record low crime rates, we must fully recognize the largely ignored population of disabled inmates who still reside in institutional detention. Three hundred years into the American experiment, our society still has not determined an appropriate way to treat, serve, and grant full citizenship rights to the disabled. Historically, we have run the gamut: from detaining the disabled in basements and attics, to sequestering them on the town green, to locking them up in local and state-run asylums, to practicing nonconsensual experiments on them in state hospitals, to deinstitutionalizing them and leaving them to their own wherewithal, to imprisoning them back in correctional facilities and nursing homes. None of these strategies have led to proper treatment and care of disabled citizens who need it.

The first step, then, should be recognizing that citizens with disabilities—physical, mental, or cognitive—often seem to end up in an institution, and that their history forms an important part of our current carceral practices. When we are stymied by the challenges brought by such disabled citizens, we are far too quick to fall back on our old habits of isolation and containment, whether through institutionalized care, nursing homes, or correctional facilities. As Justice Marshall contended in 1985, our treatment of the disabled is based on a “regime of state mandated segregation . . . that in its virulence and bigotry rivaled, and indeed paralleled, the worst excesses of Jim Crow.”⁴²²

And yet it seems that segregating and imprisoning the most vulnerable among us is a reflexive and deeply ingrained habit. Budgetary cuts and repeated failings in state and local community-based services for the mentally, physically, and cognitively disabled have led some advocates to call for the return of the asylum. Recently, a trio of ethicists argued that, because the deinstitutionalization of mentally ill has been a failure, we should reconsider a return to psychiatric asylums.⁴²³ Likewise, a practicing psychiatrist has contended not only that we should bring back the psychiatric asylum, but that we should also create similar institutions for the severely

422. *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 462 (1985) (Marshall, J., dissenting).

423. See Dominic A. Sisti, Andrea G. Segal, & Ezekiel J. Emanuel, *Improving Long Term Psychiatric Care: Bring Back the Asylum*, 313 J. AM. MED. ASS'N 243, 244 (2015).

cognitively disabled.⁴²⁴ As all of these professionals point out, severely mentally ill or cognitively disabled patients are often already institutionalized—in psychiatric hospitals, nursing homes, or correctional facilities.⁴²⁵

As detailed in Parts II and III, we have continued to detain and segregate the physically, cognitively, and mentally disabled. This unfortunate reality, however, hardly calls for re-establishing the carceral instinct. At minimum, both history and current practice should teach us that warehousing the disabled is rarely a solution, even if done with the very best of intentions. Even when treatment and care are adequate, long-term institutionalization imposes real harms by taking away independence and autonomy.⁴²⁶

Our current system of services for the disabled is certainly not perfect. In 2013, for example, almost two hundred thousand disabled citizens waited for residential state services, often for years.⁴²⁷ Over eight hundred thousand disabled individuals now reside with caregivers older than age sixty, obviously a long-term problem.⁴²⁸ But many of our recent problems could be fixed by properly funding the community-based services that provide the necessary care and group-based housing for the disabled.⁴²⁹ Moreover, current costs for housing and treating individuals in institutional care are approximately \$150,000 per patient, per year; community care, where individuals are treated at home or in small group settings, costs approximately \$30,000 per year.⁴³⁰ Thus for a variety of reasons, there is no good reason to resurrect the specter of the asylum.

424. See Christine Montross, *The Modern Asylum*, N.Y. TIMES (Feb. 18, 2015), https://www.nytimes.com/2015/02/18/opinion/the-modern-asylum.html?_r=0 [https://perma.cc/FB4M-UFNG].

425. See *id.*

426. See Renee Binder, *Return to Asylums? Never!*, AM. PSYCHIATRIC ASS'N (Aug. 13, 2015), <https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2015.8b16> [https://perma.cc/6YJ2-SUMX].

427. 427: Jen Fifield, *What Happens to Developmentally Disabled as Parents Age, Die?*, PBS NEWS HOUR (Aug. 10, 2016, 9:37 AM), <https://www.pbs.org/newshour/health/happens-developmentally-disabled-parents-age-die> [https://perma.cc/2ZJG-M2X5].

428. See Harold Pollack & Samuel Bagenstos, *We Don't Need "Modern Asylums,"* PROSPECT (June 12, 2015), <http://prospect.org/article/we-dont-need-modern-asylums> [https://perma.cc/T466-TDSJ].

429. See *id.*

430. See Benedict Carey, *Bring Back Asylums?*, N.Y. TIMES (Mar. 5, 2018) <https://www.nytimes.com/2018/03/05/health/mental-illness-asylums.html> [https://perma.cc/EZE9-5EQE].

In particular, our large-scale imprisonment of the mentally ill demands new approaches—ones that convert a person’s initial contact with the justice system into his or her first step toward long-term mental health. One possibility is implementing a new integrated framework that encourages mental health and criminal justice to collaborate on early intervention programs. This would require an understanding of the social determinants that underlie the interaction between ill health and criminal justice involvement. In other words, we must bolster efforts to prevent those with mental illness from criminal incarceration in the first instance.⁴³¹ This is only possible if mental health and justice systems work in tandem to identify people in crisis and to provide access to appropriate services in the community, thus reducing the chance of engagement with the criminal justice system.⁴³²

One way to begin breaking the cycle of institutionalizing the disabled would be to create local panels to screen arrested offenders for mental illness and cognitive disability before they attend their bail hearings. By diverting the seriously disabled before they are placed in jail (since many of them will not be able to afford the bond, and thus will be incarcerated), not only would the state or county save significant amounts of money,⁴³³ but much needed services could also be provided. Although this type of screening usually takes place after an offender is sentenced, and is done by their assigned correctional facility,⁴³⁴ having the screening take place before any criminal adjudication would protect the seriously mentally ill or cognitively disabled from rote processing through the criminal justice system. A disability panel consisting of an assigned prosecutor, a mental health specialist, and a social worker could help screen the seriously disabled before they have their bail hearing, determining the best ways to address cognitive or mental challenges before they either plead guilty or stand trial.

For those disabled individuals who need assistance in their daily lives, the expansion of group homes, subsidized by state, local, and

431. See Nicholas Turner, *Stop Placing the Mentally Ill in Jails*, N.Y. TIMES (Feb. 26, 2015), <https://www.nytimes.com/roomfordebate/2015/02/26/would-we-be-safer-if-fewer-were-jailed/stop-placing-the-mentally-ill-in-jails> [https://perma.cc/H5YL-DGWH].

432. See *id.*

433. In Miami-Dade County, for example, taxpayers pay more than \$178,000 per day for 1200 individuals receiving psychotropic medications in jail. See Mary T. Zdanowicz, *Keeping the Mentally Ill Out of Jail: Sheriffs as Litigants*, 8 ALBANY GOV'T L. REV. 536, 542 (2015).

434. See E. Lea Johnston, *Conditions of Confinement at Sentencing: The Case of Seriously Disordered Offenders*, 63 CATH. U. L. REV. 625, 631 (2014).

federal governments, has strong support among social workers, doctors, and health officials. Supervised group homes, which are licensed facilities with round-the-clock staffing and therapeutic services, are often the least restrictive and most supportive living environments for those who have cognitive or mental health issues.⁴³⁵ Although creating and staffing these group homes requires both money and oversight, some of the funding can come from Social Security income payments, and the rest could be covered by the state.⁴³⁶

Similarly, there are nonprofit programs for the disabled that either find them appropriate housing or support them in housing they already have, allowing them to receive services while continuing to live and participate in the community. These types of programs range from supported housing, where individuals receive services and counseling once or twice a week, to semi-independent living, where individuals live with a few others and receive multiple support services, to intensive in-home support, where individuals receive up to sixteen hours of support a day, to full assisted living.⁴³⁷

People with disabilities have the same right as every other citizen to live, participate in, and be fully integrated into the wider community.⁴³⁸ Moreover, it is important for the disabled to maintain their “decisional independence”—using personal assistance services for disabled persons in group-based and home-based settings grants them the most control over their lives.⁴³⁹ Cordoning off the disabled in institutions undercuts this goal and denies the disabled their basic dignity.

Our past practice of warehousing the disabled, motivated by fear, eugenics, and class prejudice, presents us with an all-too-easy path back to incarceration. Whether intentional or not, we have already fallen back into its easy, familiar embrace. It is critical to fight the patterns of the past, however, if we are to preserve the rights and human dignity of our fellow citizens.

435. See Lisa Esposito, *Community Living Options for People with Serious Mental Illness*, U.S. NEWS & WORLD REP. (Oct. 26, 2016), <https://health.usnews.com/wellness/mind/articles/2016-10-26/community-living-options-for-people-with-serious-mental-illness> [<https://perma.cc/ZCL5-LWYP>].

436. See *id.*

437. See *Housing Programs*, PATHWAY HOMES, <http://www.pathwayhomes.org/programs/housing-programs/> [<https://perma.cc/LKZ4-62U9>].

438. See Samuel R. Bagenstos, *Disability Rights and Labor: Is This Conflict Really Necessary?*, 92 IND. L.J. 277, 278 (2016).

439. See *id.* at 281.

CONCLUSION

The origins of our current carceral crisis are difficult to fully unearth. Although recent attention has been given to several root causes, including slavery, racism, the war on drugs, and prosecutorial overreach, there has been minimal scholarship concerning another source of our mass incarceration: the historical and continuing segregation and detention of the disabled.

Our practice of locking up and isolating the physically, cognitively, and psychologically disabled has been a constant since the nation's founding. While the incentives over time might have differed, we have constantly removed disabled citizens from the mainstream of society. Our incarceration of the disabled has gone from almshouses to workhouses to asylums to correctional institutions and nursing homes, ever spurred by fear, discomfort, class bias, and a continual undercurrent of eugenic philosophy. The careful, coded ways we have framed our carceral desires have evolved from generation to generation, each time fitting the institutionalized setting of choice.

As with all discussions concerning modern mass incarceration, there are no easy answers. In an ideal world, no one with cognitive disabilities or mental illness would end up in a correctional facility due to their disability; no one with moderate to severe physical disabilities would be involuntarily exiled to a nursing home or care facility, or be placed in solitary confinement for lack of services. Although increased funds to support community and group homes, better psychiatric care, and nursing services would unquestionably help, this would still not change society's seemingly deep-seated discomfort with the disabled and our reflexive desire to set these individuals apart from the mainstream.

As we continue to debate how best to solve the problems of modern mass incarceration, we must confront and incorporate the largely forgotten story of the imprisonment of the disabled. No understanding of the punitive carceral state can be complete without this neglected history.