

Prisons as the “New Asylums” Liat Ben-Moshe

In 2008, for the first time in history, more than 1% of all adult Americans were behind bars. By 2011, the number of adults incarcerated in prisons and jails in the USA had reached 2,266,800. Another whopping 4,710,900 people were under “community corrections”, which includes parole and probation (BJS, 2012). Race, gender and disability play a significant role in incarceration rates. By 2006, one-in-fifteen black men over the age of eighteen and one-in-nine black men aged between twenty and thirty-four were incarcerated. From 1997 to 2007 the overall incarceration rate for women increased 832% (Human Rights Index, 2009-10). To put these numbers in perspective, consider the fact that today more African-Americans find themselves in penal institutions than in institutions of higher learning (Thompson, 2010).

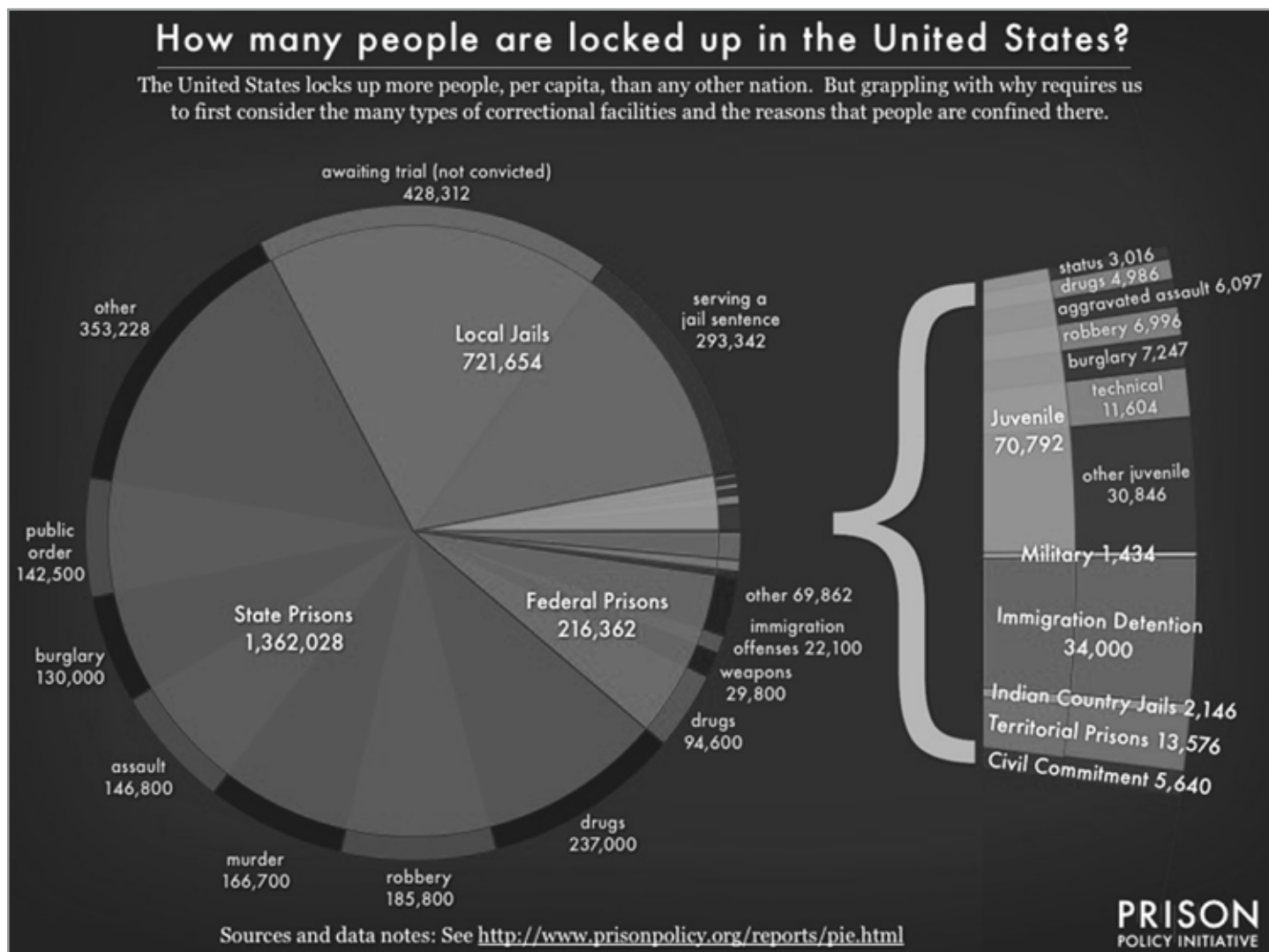
Although several attempts have been made to estimate the number of prisoners who have a psychiatric diagnosis, it is impossible to estimate the numbers with any precision, even if ‘mental illness’ is presumed a viable construct. In 2000 The American Psychiatric Association reported that as many as 20% of all prisoners were “seriously mentally

ill”, while up to 5% were “actively psychotic” (APA, 2000). Other estimates appear to use a substantially more expansive definition of mental illness. Bureau of Justice

Statistics show that in 2005 **more than half of all prison and jail inmates were reported as “having a mental health problem”.**

The reported prevalence of mental health problems amongst the imprisoned also seems to vary by race and gender. White inmates are reported with higher rates than African-Americans or Hispanics (Erickson & Erickson, 2008). However, African-Americans, especially men, appear to be labeled “seriously mentally ill” more often than their white counterparts. It is also reported that, in general, women inmates have higher rates of mental health problems than men (Human Rights Watch, 2006).

Prisoners are not randomly selected and do not represent all strata of society. Most prisoners are poor and people of color. Poverty is known to cause a variety of impairments and disabling conditions. In addition, the prison environment itself is disabling: from hard labor in harsh



conditions with toxic materials, to closed wards with poor air quality, the circulation of drugs and unsanitary needles, and a lack of medical equipment and medication (Russell & Stewart, 2001). In addition, conditions of confinement may cause further mental deterioration in prisoners entering the system already with a diagnosis of “mental” or “intellectual disability”. The nature of incarceration further distresses those incarcerated, and worsens their overall mental and physical health. Prisoners identified as “mentally ill” or who exhibit “disruptive behaviors” are often sanctioned to “administrative segregation” in separate (often isolation) units. Those segregated forms of incarceration, such as “supermax” or SHU (security housing units), are likely to cause or exacerbate the mental and physical ill-health of those incarcerated, regardless of their prior mental state.

As I suggested elsewhere (Ben-Moshe, 2013), these statistics are not used merely for heuristic purposes: there is much at stake in counting the percentage of “disabled” and so-called “mentally ill” prisoners. For activists, using statistics that demonstrate the high prevalence of disabled prisoners can take several directions. For instance, an activist in NAMI (National Alliance of Mental Illness) might use the statistics to show that deinstitutionalization failed and that, with a lack of other alternatives, prisons and jails have become a dumping ground for those labeled mentally ill. In essence, a campaign might call for the (re)hospitalization of those with psychiatric diagnosis (e.g., see Torrey, 1996). Also, critiques from activists and scholars about inappropriately placing disabled people in nursing homes or prisons (as argued, respectively, by some ADAPT and NAMI activists) reaffirm the sentiment that it is somehow appropriate to place some people in nursing homes and prisons. In other words, they seem to suggest that some people really do need to be segregated in places of confinement, while the young and the disabled do not.

A similar approach is taken by those who find the living conditions of disabled prisoners and the institutionalized so deplorable that they call for more hospital beds in prisons, the reform of psychiatric hospitals and institutions for those labeled “intellectually disable”, and the creation of more accessible prisons. Others call not for reform, but for abolishing those institutions altogether.

Perhaps most relevant to the prison abolitionist and anti-institutional stance is the analysis of imprisonment and institutional segregation as a core structure which shapes social relations throughout society, not just for those immediately affected (Davis, 2003). It is not just about closing down prisons or such institutions. This kind of analysis offers a revolutionary framework which transforms the way we understand the forces that shape our histories and everyday lives. It questions notions such as “crime” and “innocence” (what gets defined as crime, and who gets defined as criminal); “disability” (not just a medical diagnosis but also an identity) and “rehabilitation” (a benign process or a force of assimilation and

normalization); ideas of punishment (justice vs. revenge or retribution); notions of community (as in “living in the community” or “community re-entry”); “institution” (Who defines what is called an institution?); notions of freedom and equality (Can we feel free and safe without locking others away?); and concepts of danger and protection (Who do we protect by segregating people behind bars in psychiatric hospitals and prisons? Is it really for “their own good?”) (Ben-Moshe, 2013).

“Can we
feel free and safe
without locking
others away?”

When we discuss the connection between disability or madness/mental illness and imprisonment, it is important to recognise what is meant by the terms carceral and incarceration. There are various spaces and technologies to remove or make people disappear from the community for being problematic, unproductive, lgbtq/gender non-conforming, of color, disabled etc. These methods include segregating people in specific spaces such as nursing homes and institutions, psychiatric hospitals, boot camps, prisons, detention centers, and more. But there are also processes such as psychiatric labeling or forced medication, which could be equally characterized as forms of confinement. For instance, Erick Fabris (2011) discusses “chemical incarceration” by psychopharmaceuticals, not as a metaphor but as an actual way to control people’s bodies and minds that is akin to imprisonment.

There are various connections that can be made between all these carceral mechanisms, which is not to say that all those forms of confinement are the same, but only to say that we need to examine critically their similarities and differences. (For more on these connections, see Ben-Moshe, Chapman and Carey, 2014.) Some connections between spaces of confinement of disability/madness are also made uncritically. For example – something becoming an axiom heard from activists, policy makers and the media – it is said that in the US jails are becoming “the new asylums”. A documentary was even made with that name. Without disregarding the reality of having disproportionate numbers of people with disabilities (in particular, psychiatric, cognitive and learning disabilities)

in jails and prisons, **I want to caution against uncritical declarations that jails are becoming the largest mental health facilities in the US, for these reasons:**

1 It implies that people in prison or jail actually get treatment. This is highly suspect, both in the lived experience of those imprisoned and in terms of the resources available in such places, as several submissions in this special issue of Asylum magazine demonstrate.

2 It builds on arguments heard by various activists, including those in the mental health arena, such as NAMI, that people with mental health issues should not be placed in jail or prison in the first place. We would like to see more advocacy from such activists in terms

of critiquing the SHU and solitary confinement, and I think that this could be a great case for coalition building between prison abolitionists and disability/madness activism. However, calling for certain kinds of people to be released from jails and prisons might simply consign them to re-incarceration in other institutions, or by other means. For instance, they might then be subjected to forced drugging and/or indefinite detention in psychiatric hospitals or psych-forensic units.

3 Such ideas often imply that the main reason for people with psychiatric disabilities ending up in prisons and jails is due to deinstitutionalization – from the early 1960s, the progressive closure of psychiatric hospitals in the US. They might seem to support those who condemn the movement for deinstitutionalization as “irresponsible” and “leaving people in the streets”. But it wasn’t deinstitutionalization that led to homelessness and increased incarceration. It was racism and neo-liberalism that did that – by means of privatization, budget cuts in all the service or welfare sectors, and little or no funding for affordable and accessible housing. Meanwhile, budgets for corrections, policing and punishment ballooned (for example, through “The War on Drugs”).

4 In addition, the assumption that these are the same people - i.e. that the people who were deinstitutionalized ended up in prison – should also be deconstructed since the demographics of the two populations are quite distinct. Over the years, the gender distribution of inmates in mental hospitals tended to be either equal or slightly over-represented by women. Although there is some evidence to suggest that during deinstitutionalization the proportion of those admitted to mental hospitals identified as non-whites increased, they were still at about one-third of all in-patients, at most (Harcourt, 2006). Anyone familiar with the US prison system knows that non-whites are highly over-represented. In other words, the inmate population in mental hospitals tended to be white, older and more equally distributed by gender than those incarcerated in prisons. So we are not speaking about the same population or group of people (who exited hospitals and institutions and entered prisons), but of ways in which the social control function of incarceration retained its importance. It is also important to keep in mind that prisons damage people’s bodies and psyches, and that due to practices like mandatory minimum sentencing and solitary confinement, even those who did not enter the prison with any diagnosable psychiatric disability will very likely experience one during their incarceration.

5 Often what we hear about people with various disabilities or addiction issues who are caught in the criminal injustice system is that they need medical help and treatment, not incarceration and punishment. But often what is touted as treatment and medical help is no less coercive and normalizing than other forms of incarceration. For instance, touting drugs as a treatment

and alternative to incarceration is highly problematic – there is a lot of questioning and downright resistance to psychopharmaceuticals from the psychiatric survivor or ex-patient movement. Holding people in psych wards for unspecified periods of time, as an alternative to prison and as a form of treatment supposedly for their own good, is also highly questionable.

What I want to question is not only putting people with various societal disadvantages (including madness) in prison, but also what are generally considered the alternatives to incarceration. Isn’t “rehabilitation” or “treatment” another apparatus of the carceral state, attempting to make people over into its own image – white, hetero, masculine, able-bodied, sane/rational, etc? In the context of the prison-industrial-complex, as well as in the disability context, it is important to ask: What is the person being “habilitated” to? To a society fraught with violence, racism and lack of economic opportunities?

In the context of looking at prisons as “the new asylums”, these are some questions that prison abolition movements and madness activism need to confront.



“The Two of Us” by **Alan Scally**, an artist living in Portland Oregon. For more of Scally’s work, visit: www.scallysmashmouthart.weebly.com

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Anticipatory Allyship Adelle Menees

I am certain that “ally” is not an identity. Much like being anti-racist, being an ally is not an achievement; it is continuous work. Allyship is a stance. Rather than try to resolve the question of what qualities I want in an ally, I have instead wondered: what does my mad identity offer to my allied stance?

Years after my time in a Seroquel experiment, years after becoming a psychiatric survivor of the at-risk teen industry in the US, I slowly came to a mad identification. These experiences place me in a minority. I started politicizing my madness simply because I grew tired of being misunderstood.

In his brilliant 2009 book, *Cruising Utopia: The Then and There of Queer Futurity*, the late scholar Dr José Esteban Muñoz identifies the (queer) utopianism of the “not-yet-here,” the possibility in the anticipatory. Inspired by his theoretical imagination, I think that allyship is “not-yet-here,” and that is okay. Anticipatory allyship is a practice of friendship and hope.

If we are insensitive, maybe we are not anticipating what there is to be sensitive about. We need a stance in which awareness of struggles, histories, and experiences translates into an informed social sensitivity about peers’ lived realities, even those which may not be stated or obvious. Anticipatory allyship would not require someone to “out” oneself in every single interaction to gain respect.

Identifying as a feminist doesn’t mean that my ways of being are inherently feminist. If my girlfriend is a trans woman, I can anticipate that maybe I should stop incessantly trying to borrow tampons from her. If my friend has a body that menstruates, I can anticipate the possibility that she or he has had an embodied experience with pregnancy that I do not know about.

How can I be anti-racist if I am not anticipating the realities of racism? In the United States, we have about 5% of the world’s population, and 25% of the world’s prison population. Is my allyship a stance which forefronts awareness of people grieving? We know that at any given time, about 10% of black men are excluded from our communities, locked up. As a white person, am I anticipating the impacts of this anti-black racist exclusion? It is a structural fact that my friends of color have experienced racism including hurtful micro-aggressions. People of color should not have to explain this me.

There is healing in anticipation. Friends returning from war with PTSD may not want a surprise “Welcome Home” party. Friends living with physical disabilities could have issues with the word “special”. Most friends of Bill smoke cigarettes. I know that many people in my life experienced sexual assault before they turned 18, whether they told me that or not. No-one should have to “out” their marginalization, life-story, or trauma to me for me to behave in a new, enlightened, and respectful way. Solidarity isn’t an exclusive club.

Anticipations are not assumptions; they are something like gentle knowing or wondering. I care about happy, healing, collaborative friendships in which diverse realities are respected. My mad identity is rooted in a desire for political community that informs the ways in which I affirm and support the people in my life. We all make mistakes. Allyship is “not-yet-here,” but there is something liberating about anticipating it.

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