Disablement, Prison, and Historical Segregation
(excerpt)

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The Neoliberal Shift, Deinstitutionalization, and Incarceration

To better understand the relationship between disability and prison, it is instructive to focus on the treatment of those who are mentally ill.[13] In the second half of the twentieth century, the dominance of the mental health institution began to decline as the capitalist economy underwent restructuring. Economic stagnation and low profits, the fiscal crisis of the seventies, were met with Reaganomics, i.e., tax cuts for corporations and the wealthy, an attack on labor, deregulation of health and safety regulations and cuts in state spending on education, welfare, and social programs, including those institutions housing people with mental illnesses.

Deinstitutionalization, as it related to those who had been labeled mentally ill, was a government policy change driven by cost-cutting motives. Spending by the fifty states on treatment for people with mental illness, for instance, was lower by a third in the nineties than it was in the fifties; fewer than half of Americans diagnosed with schizophrenia receive adequate services today. When the awful snake pits of neglect and abuse we called “mental institutions” were closed, necessary new structures and solutions, including community housing, employment services (a vital component for populations experiencing severe labor market discrimination), and other appropriate programs designed and run by disabled individuals themselves, were never put in place.

Instead, GOP revolutionaries of the 104th Congress, falsely blaming the deficit on the welfare state and entitlements, attacked the social safety net. The 1990’s crackdown on federal disability and welfare benefits and state reductions to General Relief and Medicaid further expanded the scope of damage to deinstitutionalized people who had been diagnosed with mental illness, many of whom found themselves destitute the moment they were discharged from the hospitals.

Because the states had abandoned their social contract with deinstitutionalized people labeled mentally ill, many were left stranded on the streets, caught up in the revolving door between homelessness and prison. At present, an overwhelming number of jail inmates with mental illness were homeless. For instance, of the approximately 2,850 mentally ill people in New York City jails on any given day in 1996, 43 percent were homeless. The vast majority were not violent or dangerous; they have been jailed for petty theft, disturbing the peace, and other "crimes" directly related to their illness. Increasingly, the judicial system punishes such people for their "quality of life" misdemeanors by slapping them with jail sentences—670,000 of them in 1996. At any given moment, 40 percent of all Americans with serious mental illness are estimated to be in jail or prison, comprising from 10 to 30 percent of all inmates. The Center on Crime, Communities & Culture concludes that in many jurisdictions, jails have become the primary "treatment" provider for poor people with mental illnesses.[14]

This "criminalization of mental illness" has its roots in the U.S. capitalist health care system and the growth of the prison industry. The great majority of "mentally ill" people in New York jails and prisons, for instance, are Medicaid recipients or have no insurance at all. To qualify for Medicaid, low-income individuals must be extremely debilitated and indigent (which many achieve by spending down savings), and they must stay indigent.

Adding insult to injury, mental health parity does not exist in the private U.S. insurance system. For instance, private long-term disability plans, most of them employer-sponsored, provide benefits to eligible recipients with "physical disorders" through age sixty-five, while they impose duration limits of twenty-four months or less on benefits to eligible recipients with "mental disorders." In defending its refusal to provide mental health parity, the insurance industry claims the extra coverage would place a demand on the for-profit system which would cause everyone's premiums to skyrocket. In order to protect its profit margin, the corporate health care industry denies this segment of the population treatment and services.

The rise of managed care, now the dominant paradigm among hospitals and physicians, has also had a debilitating effect. In the name of cost containment, payment mechanisms have shifted; hospitals and doctors are now paid a flat fee, instead of receiving payment for individual services rendered. Because of financial incentives for physicians and hospitals to keep costs low, people who have been hospitalized for "mental illness" are often discharged in three weeks, ready or not, without a discharge plan that would provide them with crucial community support.

People with so-called mental illnesses are generally deemed to have little or no production value. Their unemployment rate is the highest among the disabled population at 80 percent, and disproportionately high within the incarcerated population. Perhaps the term "social junk," as coined by criminologist Steven

Spitzer, best describes how society views this cast-off segment of the population. People labeled “mentally ill” experience harsh discrimination in many arenas, among them housing, employment, and health insurance. Increasingly they have become a part of what Christian Parenti calls “a growing stratum of ?surplus people’ [who, because they are not] being efficiently used by the economy must instead be controlled and contained and, in a very limited way, rendered economically useful as raw material for a growing corrections complex.” Thus the old “snake pit” mental institution is being replaced with yet another institution, the prison, where incarcerated “social wreckage” contributes to the GDP by supporting thousands of persons associated with expanding and maintaining the prison industry.

Mental health advocacy groups rightly point out that people with mental illness rarely belong in prison. Jail diversion and discharge planning, they say, are key to stopping the “revolving door” of repeated hospitalizations and incarcerations. They recommend ongoing community treatment and support services, all grossly underfunded now, to mend the broken system.

The psychiatric social change movement, comprised of survivors of the mental health industry, is wary of solutions that may lead to forced hospitalization, involuntary psychiatric drugging (psychiatric medicine is not a science and damage is often done by inappropriate drugs), and forced electroshock, all of which have been a part of the corporate psychiatric model. The World Bank now has a “mental health division” to promote corporate psychiatry globally! In thirty-seven states, people living in their own homes can be court-ordered to take psychiatric drugs even though many experience toxic reactions to such treatment. Six states have “at- home” drug deliveries. The shattered mental-health system has largely depended upon one or another form of incarceration and forced treatment, whether in hospitals or prisons. In their efforts to end the involuntary imprisonment of so-called mentally ill persons, grassroots social change groups are concerned that one destructive institution not be replaced with another. The focus must be on human rights (including the right to refuse treatment), empowerment, and alternatives such as community and peer support.

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Notes

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13. The authors wish to credit the psychiatric survivors’ movement for a large body of literature examining America’s social policies with regard to people who have been labeled “mentally ill.” Among its sharpest commentary has been the movement’s critique of language; analysts point out that such terms as “the mentally ill” are highly charged, pejorative

cultural constructs. They observe that such labels have been assigned to them by an entrenched power structure, relying for its authority on the DSM—the *Diagnostic & Statistical Manual of Mental Disorders*—a reference book that has repeatedly and justly been challenged for the subjectivity and bigotry underlying many of its socially constructed "diagnoses." Psychiatric survivors point out that throughout history, individuals who have been identified by the dominant class as "mentally ill" have in many cases been iconoclasts and mavericks whose behavior has been provoked by social injustice. In a paper which examines the situation of people who have been incarcerated—whether in prisons, nursing homes, or mental institutions—we particularly want to avoid the assumption that those labels which have been used to justify incarceration are appropriate or just. Readers are referred to Support Coalition International of Eugene, OR: www.MindFreedom.org and to its newsletter, *Dendron News*.

14. Heather Barr, "Prisons and Jails" *Hospitals of Last Resort*: The Need for Diversion and Discharge Planning for Incarcerated People with Mental Illnesses in New York," A research brief from the Center on Crime, Communities & Culture, 1999.