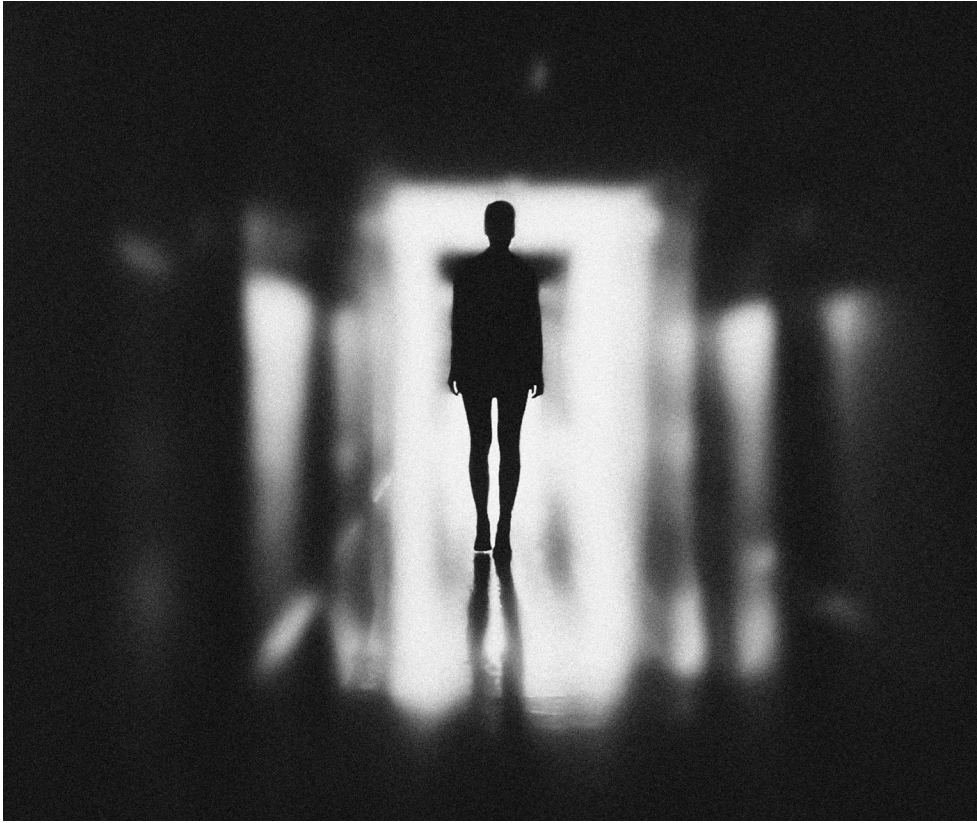


INCARCERATION AND MENTAL WELLNESS ARE INCOMMENSURABLE - A CALL TO DECARCERATE

BY BOKÉ SAISI



Photograph by Elina Krima. Source: www.Pexels.com.

Legal and academic discourses about incarceration and mental unwellness, particularly in women's prisons, often highlight the high rates of people that experience mental distress—medicalized as mental “illness”—in both prisons and jails.¹ Social scientific findings show that upwards of 70 percent of all incarcerated people, and 73 percent of incarcerated women, have a “mental illness.”² These discourses and research findings fail to take into account two interrelated factors. Firstly, the findings are premised on the taken-for-granted idea of “mental illness” as an inherent individual biological and neurological pathology that can only be treated through pharmaceutical intervention—forced or otherwise. Secondly, the research findings presume that incarceration itself does not contribute to mental unwellness, again implying a biologically unhealthy mind as the sole source of unwellness.

CURRENT APPROACHES to mental unwellness fail to mark incarceration as a contributing factor of distress. Without such recognition, incarcerated people will continue to stay and get increasingly unwell. I recommend decarcerating incarcerated people experiencing mental distress,

that is, using legislative means to reduce prison populations. This can be accomplished by extending the definition and practice of “compassionate release” to include mental unwellness, allocating funding for community-based mental-health care *outside* of carceral settings (i.e., jails, prisons, and state psychiatric hospitals), averting new admissions, decreasing recidivism, and providing social support systems upon release. These recommendations need to be actualized in collaboration with formerly incarcerated people at every step.

PROBLEM DESCRIPTION

Incarceration is a detriment to mental health. The idea that normative practices in prisons and jails have little bearing on incarcerated people's mental health is false. For instance, both current and previous research illustrate the direct correlation between solitary confinement and experiences of distress (e.g., auditory or visual hallucinations).³ Solitary confinement is used both as punishment for the subjective violation of institutional rules and as a means of “protection from self,” despite evidence that shows this practice is injurious to mental health.⁴ Moreover, social isolation from community (e.g., incarceration and psychiatric commitment), and from other individuals (e.g., solitary confinement—both punitive and “protective”), are detrimental to mental health—the latter producing conditions ripe for suicidal ideation and completion.⁵ The imperative to confine those experiencing

mental health distress, then, can be lethal.

Social movements to end the involuntary confinement of people in state psychiatric hospitals in the mid-twentieth century illustrate why the contemporary practice of incarcerating people experiencing mental distress is severely misguided. Deinstitutionalization in the 1950s and 1960s—the closure of many state psychiatric hospitals and subsequent implementation of the Community Health Act of 1963—illustrates why psychiatric confinement is detrimental to adequate mental healthcare.⁶ The subsequent disinvestment in community care and other social welfare policies, for example, resulted in houselessness and a lack of healthcare for many ex-patients, which culminated in the mass criminalization and incarceration of people experiencing mental distress as seen in the present. The current overrepresentation of mentally unwell people in prisons and jails is a consequence of policy failures, as well as ethical and fiscal failures to invest in community care, following mid-twentieth century deinstitutionalization. Funding allocated primarily to community mental health care will prevent this documented cycle from repeating itself.

The incongruence of adequate mental healthcare with incarceration cannot be divorced from institutional structures of discrimination inherent to the criminal justice system. The past and current overrepresentation of Black, Indigenous, and other people of color; queer identified, low or no-income, and mentally unwell people in prisons and jails, is a direct result of histories of criminalization and pathologization of these marginalized groups.⁷ For example, prior to the 1865 Emancipation Proclamation, Black people were seen to be psychologically unfit for freedom,

which led to the creation of the diagnosis of ‘drapetomania’ (desiring freedom from enslavement), which was criminalized and violently punished. Contemporary practices of overdiagnosing and/or wrongfully diagnosing Black people with more severe psychiatric labels—resulting in penal and psychiatric incarceration, and often forced medication—replicate such racialized pathological diagnoses.⁸ Similarly, much of the volumes of the Diagnostic and Statistical Manual (DSM) labelled same-gender relationships, non-normative gender expressions, and the “hypersexuality” of women as mental disorders—all practices which carried corresponding *de jure* and *de facto* punishments throughout the legal system. These fallacious pathologies have been, and continue to be, criminalized and punished both within and outside of prisons and jails.

While the aforementioned DSM labels have been rescinded from recent volumes, the criminalization of non-normative gender and sexual expressions, as well as the criminalization of mental distress, still occur through the policing of these expressions by arrest, incarceration, and punishable “infractions” within prisons.⁹ The use of solitary confinement as punishment for not adhering to gender-based rules, such as “compliant” physical attire and appearance, speech patterns, or self-assertion, illustrates that the system is structured to violently regulate normative gender categories.¹⁰

The criminalization of mental distress can be seen through the disproportionate lethal police violence towards Black and Indigenous people and other people of color experiencing mental distress, whereby up to 50 percent of police killings involve a victim in a mental health crisis.¹¹ Health concerns are also made punishable in prisons

where people experiencing mental distress, such as engaging in self-injury, are criminalized as “committing” internal “infractions” and punished by solitary confinement.¹² Current policies that uphold and encourage these practices illustrate the inherent contradiction between incarceration and effective mental health care given the context of pathologization and criminalization of marginalized groups of people. Policy changes, then, must: (a) pinpoint factors that produce and exacerbate mental unwellness within prisons, jails, and psychiatric hospitals; (b) recognize how structural racism, sexism, homophobia, and transphobia are replicated by current incarceration practices and psychiatric labelling; and (c) allocate funding to community care initiatives independent of state institutions.

CRITIQUE

Adequate mental health care within prisons, jails, and other carceral settings, such as state forensic hospitals, is impossible to deliver. The purpose and effect of incarceration is always punitive. While there are rights implemented by the Constitution’s Eighth Amendment to avoid cruel and unusual punishment (often applied as the right of incarcerated people to receive adequate physical and mental health care), reported conditions in prisons and jails illustrate that these rights are far from upheld.¹³ A 2018 federally ordered independent investigation of the California Department of Corrections and Rehabilitation’s (CDCR) lack of compliance with psychiatric care legislation, highlighted that the CDCR had falsified information in a federal court to produce the illusion that facilities complied with mental health care regulations.¹⁴ One example was the irregular monitoring of people placed in solitary confinement under “suicide

watch”—referred to as protective isolation—and resultant attempted and completed suicides at multiple facilities.¹⁵ Since solitary confinement and isolation are proven to produce mental distress, both the regulations and the lack of adherence to them create the conditions for attempted and completed suicide. Given such recent state falsifications, testimonies from currently and formerly incarcerated people about their experiences are essential to any comprehensive recommendations about policy change. Such accounts reveal just some of the ways practices of incarceration are harmful, and at times lethal, with regard to people's mental health.¹⁶

Recommendations that attempt to make current structures more gender, culturally, or medically sensitive or inclusive do not work. Much legal and academic discourse about incarceration and mental health provides analytically flattened accounts of incarcerated peoples needs, thus not attending to issues of racism, sexism, homophobia, gender-based discrimination, ableism, and sanism—the social stigma and oppression against mental unwellness—in prisons and jails. Any policy devoid of such an analysis is inherently faulty. For example, psychiatric discourses about women's sexuality, same-gender relationships, non-normative gender expression, and the autonomy of racialized groups, have produced pathological and criminalized diagnoses since the inception of psychiatry as a medical field.¹⁷ Prison officials' insistence on regulating normative gender roles, gender expression, and sexuality, results in punishment for those who deviate from those norms in ways that bolster their pathologization through psychiatric means.¹⁸ Likewise, people of color, primarily Black and Indigenous peoples, who experience mental distress are met with disproportionate

amounts of violence—largely lethal—in prisons and jails, and by law enforcement outside.¹⁹ Experiences of physical and sexual violence from prison employees and other incarcerated people, the involuntary consumption of psychiatric medication, and social isolation from family and community, also produce deleterious effects on mental health.^{20,21,22} Additionally, incarcerated people of color experience a racialized and discriminatory criminalization of mental distress, mental distress as a result of institutional oppression, and medical racism, when seeking mental health care. All three of these non-biological elements contribute to mental unwellness among incarcerated people.

Accessing mental health care, particularly in women's facilities, comes with many barriers. Many people incarcerated in women's prisons are survivors of gender-based sexual violence.²³ Incarceration itself often reproduces the traumas of sexual violation. The prevalence of male guards in women's facilities creates an atmosphere of risk of sexual violence from guards in positions of power, as do the mandated cavity searches at intake, which include “gender searches” to identify genitalia, and moves between facilities (including, and especially so, moves to mental health facilities).²⁴ In this way, these commonplace practices for the incarcerated produce and exacerbate mental unwellness, and function as a barrier to receiving even *inadequate* mental health care. This is done by reproducing experiences of sexual violence and abuse in ways that deter incarcerated people from seeking care. State psychiatric forensic hospitals replicate these gendered and violent practices. In California, its five forensic hospitals house only those classified as men. While some feminist legal and policy scholars have suggested the creation of psychiatric prisons for women to fill such an

institutional void, death rates in the five men's institutions are notoriously high and thus show that the construction of penal hospitals for incarcerated women is clearly not the solution.²⁵ This point is also evident in the successful public pressure to stop the construction of a men's mental health treatment prison in Los Angeles County.²⁶

Mental health care, both inside and outside of prisons and jails, does not operate in a societal vacuum. Current manifestations of institutional and structural racism, sexism, and gender and sexuality-based discrimination, inform mental health care. Just as the legalized criminalization and pathologization of marginalized groups inform who is incarcerated, so does the construction and application of psychiatric labelling. For example, as shown in an ever-growing scholarship about medical and clinical racism, traditional mental health care is an illustration of structural racism itself.²⁷ Likewise, the growing body of research that shows how structural racism produces mental distress indicates the need for alternative modes of mental health care. Clinical practitioners often lean towards ideas of cultural competency training for mental health care workers as a remedy.²⁸ However, cultural competency training—the practice of studying cross-cultural interactions in occupational settings—reinscribes notions that racism is simply individual prejudice and not structured into the medical system itself. Structural medical racism can determine who receives consistent care (i.e., how pain and discomfort are measured and perceived); which diagnostic labels are ascribed and, thus, which medications are prescribed (i.e., the overdiagnosis of schizophrenia and prescription of atypical antipsychotics for Black men); and which behaviors by which people are read as criminal versus clinical (i.e.,

how behaviors are unequally interpreted based on the presumed race of a patient).²⁹ Such problems are magnified during incarceration. The overrepresentation of Black, Indigenous, and people of color in prisons and jails, and the evident need for mental health care, implicates prisons and jails as inherently unable to provide adequate mental health care.

Concerns about the release of incarcerated people with mental-health struggles often focus on the potential acts of violence that may be perpetrated by those released. However, the presumption that mental unwellness inherently equates to violence is a well-documented myth and part of the stigma produced by mental health “diagnoses.”³⁰ For example, the rampant mass shootings perpetrated by white men in the US are fallaciously construed as a result of a pathology, rather than the legacy of racialized and gendered violence that has been upheld by the courts for the majority of this country’s existence. People experiencing mental distress are actually more likely to be *victims* of violence, whether by vigilantes or by police, than perpetrators.³¹ This victimization is largely due to the lack of social support systems, which creates the conditions for vulnerability to violence, such as homelessness and a lack of mental health care. Given that incarceration produces even more violence for these vulnerable populations, decarceration through compassionate release is an apt response to the crisis of incarcerating people experiencing mental distress.

RECOMMENDATIONS

Policy recommendations that aim to provide mental health care must focus on decarceration and center the experiences of formerly incarcerated people.

First, this means ending solitary confinement as a practice, whether punitive or “protective,” indefinitely. Solitary confinement constitutes cruel and unusual punishment and has been ruled so in California. The ruling resulted in the limited use of solitary confinement on incarcerated minors and those with pre-existing mental health diagnosis.^{32,33} The emphasis on a pre-existing diagnosis as a determination of which incarcerated person is exempt from or receives limited solitary confinement fails to account for and address how incarceration and solitary confinement produce distress. Legislators need to extend the limited use of solitary confinement to *all* incarcerated people to address this conceptual failure. For example, if an incarcerated person requires self-protection, such as in the context of suicide, they should be released from prison.

Decarceration can be accomplished through the extension of compassionate release. Compassionate release is granted for severe medical or humanitarian reasons, both of which apply to those in “protective” isolation.³⁴ Organizations that work with incarcerated and formerly incarcerated people need to be consistently consulted by legislators. Many organizations already participate in policy initiatives that recognize the harm of incarceration itself, including the California Coalition for Women Prisoners and Survived & Punished.^{35,36}

Future mental health care for incarcerated people should center community-based mental health care, as opposed to state psychiatric holding, which is both isolating and often punitive.³⁷ Again, isolation as it pertains to mental health care is inherently counterproductive. Since Black, Indigenous, and other people of color are overrepresented in prisons and jails, any mental

health care needs to address the structure of racism in the medical system and acknowledge the detrimental effect that racism and other interrelated structures of discrimination have on mental health. This means that funding needs to be allocated *away* from the criminal system (such as the California Department of Corrections and Rehabilitation and law enforcement bodies), *to* independent community care initiatives.

Community mental health care initiatives have been successfully implemented in other states and geographical contexts. For instance, the White Bird Clinic in Eugene, Oregon is a 24/7 community-run mental health facility that prioritizes care for low- or no-income and houseless people experiencing mental distress.³⁸ Instead of focusing primarily on psychiatric medication and clinical institutionalization, the organization provides outpatient treatment; resources for housing, legal representation, and counseling; and broader healthcare. These interventions address many of the causes for the incarceration of people experiencing mental distress in the first place. Additionally, the clinic has a mobile crisis-intervention team that functions as an alternative to police intervention—an often fatal interaction for Black people and other people of color in distress. This preventative initiative can function as a model for alternative community-centered modes of mental health care that legislators will allocate funds to construct and support. This will require consultation with organizations and critical mental health care providers that center the experiences of incarcerated and formerly incarcerated people working through a racial, gender, and queer justice framework, to effectively address and counter medical racism and institutional discrimination in mental health care.



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