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Why prisons are not "The New Asylums"

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Abstract
This paper will offer an antidote to the axiom that jails and prisons are becoming "the new asylums" in the U.S. Without disregarding the reality of having disproportioned numbers of people with disabilities (psychiatric, cognitive, learning disabilities in particular) in jails and prisons, I will caution against declarations that prisons are becoming "the new asylums" in the U.S. and offer a more nuanced explanation that incorporates perspectives from those critiquing incarceration, institutionalization and psychiatry to shed new light on the connections between incarceration and deinstitutionalization at present and in the past. The claims that post-deinstitutionalization people with psychiatric disabilities were "abandoned to their fate" and re-incarcerated in jails and prisons via being homeless will be critically examined. While doing so, I will also discuss the processes of disablement inherent in prisons and in being housing insecure.

Keywords
deinstitutionalization, disability, homeless, mental illness, prison

In a recent editorial of the Journal of the American Medical Association (Sisti, Segal and Emanuel, 2015), three renowned bioethicists called for "a return to the asylum" following what has become familiar logic: citing statistics of the number of mentally ill in prison; claiming that jails and prisons are becoming the new asylums; that they are largest mental health facilities in the U.S. in the absence of psychiatric hospitals; stating that deinstitutionalization failed and led to people being homeless and funneled into the criminal justice system, and therefore the only way to correct it is to reinstate psychiatric hospitals. The first author of the article (Sisti) then re-appears in a New York Times forum in 2016 about "the mentally ill

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in prison", reinstating these same claims (Sisti, 2016). I will refer to these set of claims as "the new asylums" thesis.

Why are we still discussing deinstitutionalization of psychiatric hospitals in 2016, decades after its heyday? Why is it taken for granted that deinstitutionalization is relevant to an analysis of the current phenomenon of mass incarceration? And why are there so many people with mental health differences behind bars currently, if not for deinstitutionalization? I will set to answer these questions by returning to the era in which "the new asylum" thesis first arose, the end of the 1970s and into the 1980s. My aim is to interrogate and destabilize the seemingly neat connections that are being drawn between deinstitutionalization, homelessness and imprisonment. The second analytical aim is to reveal why these counter-hegemonic readings, which I offer here, did not gain traction – because of the erasure of the socio-political benefits of maintaining the "new asylum" thesis.

I will offer a three-part analysis of the hegemonic narrative equation "deinstitutionalization → homelessness → imprisonment," which I shorthand as the "new asylums" thesis. The construction of the "homeless mentally ill" in social science literature and the medicalization of the phenomenon of homelessness will provide the core of interrogating the "deinstitutionalization → homelessness" nexus. I will then briefly discuss the criminalization of housing insecurity to further explain the nexus of "homelessness → imprisonment." Lastly, I will provide alternative explanations to the phenomenon of the "mentally ill" in prison, which will address the deinstitutionalization → imprisonment trajectory. Here, I will offer a counter hegemonic argument showcasing the disabling effects of imprisonment as well as the lack of mental health treatment while incarcerated. I will end the paper with a discussion of why this analysis matters in our current moment.

"The New Asylums"

To untie the Gordian knot between imprisonment, deinstitutionalization of psychiatric hospitals and homelessness, I will bookend this paper with scenes from the 2005 PBS Frontline documentary appropriately titled "The New Asylums," produced and directed by Miri Navasky and Karen O'Connor. The documentary showcases life behind bars for those with severe mental health difference in a supermax prison in Ohio. I will begin with a discussion of the first scenes in the film and end the paper with a discussion the disabling effects of incarceration and mental health treatment behind bars as exemplified in the film.

The film opens with a collage of forthcoming vignettes with a grim voice-over inquiring: "Why have American prisons become the new asylums?" Posing the question already makes the case in the first few minutes of the film that indeed prisons are the "new asylums" and the only question is how it came to be this way. The first scene in the documentary introduces us to an African American man in an ambulance being questioned by paramedics and police. Then the

narrator informs us: ''Scenes like this have become all too familiar throughout America. As the nation's psychiatric hospitals shut down, police departments everywhere were left to handle the growing number of mentally ill on the streets.'' How did it come to this? Fred Cohen, prison mental health consultant says:

> Once you had hundreds of thousands of people leaving the mental hospitals, they suddenly, obviously, didn't become mentally healthy. They went to the streets, they became homeless, and then they eventually began to cycle into the system that cannot say no.

If you are watching this documentary online or reading the transcript, at this point you are prompted to click on [What happened to mental hospitals?]. This link[1] takes you to the aptly named page ''Deinstitutionalization: A psychiatric ''titanic.'' It is an excerpt from *Out of the Shadows: Confronting America's Mental Illness Crisis* by psychiatrist E. Fuller Torrey. Torrey is the founder of the Treatment Advocacy Center.[2] The center supports the psychiatrization of those with mental health differences and their hospitalization.

One does not even have to read the excerpt to understand the implications embedded in the title of the piece (''Deinstitutionalization: A psychiatric ''titanic'') offered by PBS to its viewers as an answer to the question ''What happened to mental hospitals?'' The juxtaposition of deinstitutionalization (as a disaster-like event) and the scene of taking a person experiencing mental distress to jail solidify for the viewer the main thesis – that the irresponsible closure of psychiatric hospitals nationally led to massive homelessness and to a revolving door leading those same populations to now be scooped up by criminal justice apparatuses. Precisely because this narrative seems so common sense, it requires further scholarly examination as to how ''the new asylums'' became the prevailing discourse around deinstitutionalization and imprisonment.

Throughout this paper, I complicate the answer many people give in relation to the question of how did prisons become spaces of confinement for the so called ''mentally ill.[3]'' I suggest that deinstitutionalization could be characterized not only as a process or an exodus of oppressed people outside the walls of institutions but as a radical anti-segregationist philosophy (Ben-Moshe, 2011; 2013). It is not something that ''happened'' but an ideological shift in the way we react to difference among us. The resistance to institutionalization and psychiatric hospitalization arose from a broader social critique of medicalization and medical authority (Conrad, 1992; Scheff, 1970; Smith, 1978), institutionalization (Goffman, 1968) and the anti-psychiatry and consumer/survivor/ex-patients movements (Chamberlin, 1978; Chesler, 1972; Morrison, 2013; Szasz, 1961). Although these ideological shifts did not solely bring about deinstitutionalization and the closure of psychiatric hospitals, any significant decrease in institutionalized populations would have been impossible without them.

Untangling housing insecurity from deinstitutionalization

Although there are variations to this idea, the hegemonic story is that deinstitutionalization led to "dumping people in the streets," or to "mentally ill" people living in the streets or in jail via being homeless. Deinstitutionalization of people who were labeled as mentally ill began in 1950s onwards and resulted in massive closures of psychiatric hospitals across the U.S. In 1955, the state mental health population was 559,000, nearly as large on a per capita basis as the prison population today. By 2000, it had fallen to below 100,000 (Gottschalk, 2010; Harcourt, 2011).

Although the heyday of deinstitutionalization is far behind us, I will focus in the next few sections on the hegemonic discourse regarding the failure of deinstitutionalization, which gained prominence in the early 1980s. I will therefore attend to literature and studies that are written in or focus on this era. There were several influential scholarly books decrying the failure of deinstitutionalization written at that time or chronicling these times such as Dear and Wolch's *Landscapes of Despair: From Deinstitutionalization to Homelessness*, Issac and Armat's *Madness in the Streets* and E. Fuller Torrey's *Out of the Shadows*. If we add to these the plethora of popular news stories from the era (such as Morganthau et al., 1986; Weissmann, 1982), it would appear that the connection between deinstitutionalization and homelessness is indisputable.

In what follows, I destabilize the category of "the homeless mentally ill" and complicate the connection between deinstitutionalization as a culprit for homelessness. I then argue that "The new Asylums" discourse psychiatrizes what is a deeply political and socio-economic issue.

Counting and accounting for "The homeless mentally ill"

What is at odds, then, with the narrative of deinstitutionalization leading to incarceration via homelessness, or more simply the narrative equation "deinstitutionalization → homelessness → imprisonment"? To begin with, there is vast variance[4] in accounts of "the homeless mentally ill." The heart of the matter is that "the homeless mentally ill" is not a neutral group of people but a constructed category of analysis. As discussed by mad/psych survivors/ex-patients and activists in the recovery and anti-psychiatry movements, mental illness is not a biological diagnosis but a social construction based on normative assumptions that are already gendered/raced/classed, etc. (LeFrancois et al., 2013; Metzl, 2009; Szasz, 1961).

If diagnosing "mental illness" seems intangible and subjective, add to that the very act of living unhoused. As Stewart and I suggest (2016), homelessness by itself disables. The streets (or shelters or living day to day without housing security) are disabling psychologically as well as physically. The constant noise, diesel fumes, cold/heat, lack of privacy, the anxiety of not knowing where the next meal will come from, fear of attack, fear of being removed or arrested by police are part and parcel of the everyday reality of living without permanent shelter. In addition, one

cannot prove a causal relation between mental illness, deinstitutionalization and homelessness, because the very definition of homelessness conflates with that of mental illness, such as the inability to care and provide for oneself (Wright, 1988). Thus, many of the behaviors and responses exhibited by people who are homeless can be attributed to that fact alone, such as being depressed, agitated, mistrusting authority, having eating difficulties and being unresponsive, but these are all taken as signs of the prevalence of ''mental illness'' (Snow et al., 1986).

In addition, the timing of closure of psychiatric hospitals and the growth of housing insecurity as a national phenomenon do not add up neatly. Deinstitutionalization in mental health began in the 1950s and continued in earnest in the 1960s and although in some US states it continues to this day, nationally the major waves had waned by the 1970s. Therefore, from the mid-1980s, many of those classified as ''homeless mentally ill'' were not previously institutionalized, especially for those under 30 (Wright, 1988). In terms of home loss, increasing rates of people seeking public shelter did not appear en-masse until the early 1980s with an increase in percentage throughout that decade (Mathieu, 1993). In the public's eye, it seems that deinstitutionalization is a major cause of homelessness even though during deinstitutionalization the major population affected by home loss were families with small children, which are not the same populations affected by deinstitutionalization (Johnson, 1990; Mathieu, 1993).

If deinstitutionalization occurred decades before the mass waves of housing insecurity and affected a slightly different population, why does this narrative (presented in the film ''The New Asylums'' decades later) seem so clear cut, common sense and irrefutable? As de Santos (2009) aptly demonstrates, social statistics often transform quanta of information into powerful collective representations. In that sense, it does not matter if they were ''biased'' or ''exaggerated'' but what matters is how they get embedded in social meaning and become a part of what de Santos characterizes as ''statistical imagination.'' For our purposes, then, the notion of exactly how many people are or are not ''homeless'' and ''mentally ill'' is almost inconsequential to the larger question of how statistics became powerful cultural agents in the fight for and against deinstitutionalization. Since such statistics have been circulating in the media quite frequently during the 1980s, they have become symbolic objects, or ''fact totems'' (de Santos, 2009).

Medicalization of ''homelessness''

I want to offer an alternative explanation, other than deinstitutionalization, for the phenomenon of ''the homeless mentally ill'' – economics, or more specifically Raeganomics and decline of the welfare state. Among sociological and public health literature, it seems that one of the most commonly researched aspects of the phenomenon of housing insecurity, especially during the 1980s, was not lack of shelter or the political and economic causes leading to home loss but measuring the pervasiveness, or lack thereof, of mental illness (and secondarily, drug usage) among the homeless (see Bassuk et al., 1984; Piliavin et al., 1989;

Snow et al. 1986, 1988; Wright, 1988, among others). As Willse (2015) suggests, instead of focusing on housing and poverty alleviation, most studies of the last 20 years had focused on ''the homeless,'' especially through a lens of pathology and medicalization in relation to psychiatric disability and drug use. As Willse puts it: ''what to do with the homeless, rather than what to do about housing, has become the obsession of government policy, social service practice and signal scientific inquiry'' (2015: 54).

The U.S. discussion on homelessness in the 1980s became a way to psychiatrize or medicalize (Conrad, 1992) what is a deeply political and socio-economic issue. In their survey of the field at the time, Morrisey and Gounis (1988) suggest that ''The perception that mental illness is rampant among the homeless becomes, for some, an indication that mental health policies are the cause of homelessness and a reason to press for mental health solutions to the problem'' (p. 286). When the source of housing insecurity is psychiatrized/medicalized (whether it is due to mental illness or addiction), the solution is also perceived to reside within the individual and become service oriented with therapeutic interventions, most extreme of which are calling for reinstitutionalization and a ''return to the asylum,'' as we shall see below. Morrissey and Gounis (1988) refer to this process of transforming structural social problems into individual pathologies as *alchemy*. Instead, they present an alternative view of homelessness as ''a structural embodiment of current political and economic policies,'' with a particular focus on survival economies as emerged in the ecology of the 1980s.

If we understand the ''homeless mentally ill'' to be a constructed category and complex social-economic phenomenon, why have the discourse that medicalizes housing insecurity, via blaming deinstitutionalization for its spread, become so common sense? In ''Madness IS Civilization,'' historian Michael Staub demonstrates how deinstitutionalization and anti-psychiatry became a perfect scapegoat on which to pin the housing crisis of the 1980s. Despite evidence to the contrary, Staub suggests, ''There developed nonetheless and almost all at once other ways to tell the story of deinstitutionalization that effectively erased any perception that people living on the streets had suffered from the callous disregard of the Reagan administration'' (2011: 185). In other words, the alchemy of individualizing structural inequalities and using the fact totems of the figures of ''the homeless mentally ill'' (and the ''mentally ill in prison'' discussed later) gave credence to deinstitutionalization as an explanatory value for a whole host of socio-political-economic problems.

The ''New asylum'' thesis puts the blame on an easy target, deinstitutionalization, and away from discussions of neoliberal policies that led simultaneously to the growth of the prison system and to lack of accessible and affordable housing. Populations in psychiatric hospitals began to shrink in the mid-1950s and were already low when Reagan became the Governor and was the first to close down all the state hospitals in California, referring to them as ''the biggest hotel chain in the state''(Ahmed and Plog, 1976). The money that was saved from closing down these facilities was supposed to be used towards supporting community mental health

centers, which never materialized as part of austerity measures to cut publically funded services. It is also important to remember that the Reagan administration introduced a fundamental change in public housing in the early 1980s that included a 30 billion cut in housing assistance (Johnson, 1990; Hopper, 1985). At a time when workers' wages were eroding, Reagan tightened eligibility requirements for federal assistance programs, including unemployment benefits (Mathieu, 1993).

To add to these economic shifts, local changes in housing markets work to displace many populations. Such changes include gentrification of urban neighborhoods, inflated rents (coupled with decreasing welfare benefits), and "urban renewal" projects or evictions (Johnson, 1990; Hopper, 1985). In addition, at its root, both housing security and deprivation are distributed not simply in terms of economic resources, but along racialized and gendered lines (Harris, 1993; Passaro, 2014). Therefore, the issue of housing insecurity and deprivation is a phenomenon much larger and more complex than can be gleaned from the discourse of "the new asylums."

Housing deprivation and incarceration

I now turn to the second part of the equation of "deinstitutionalization → homelessness → imprisonment," which is the relation between being housing insecure and incarceration. It is imperative to understand the connection between housing deprivation and incarceration through the lens of racial criminal pathology. As Wacquant (2009) demonstrates in the aptly titled "Punishing the Poor," there are three main ways societies react to those who they deem as dangerous, undesirable or deviant. The first is by socialization, via education for example. The second mechanism is medicalization, defining the problem as an individual pathology which needs to be treated by health care professionals. The third strategy is to penalize the individual. Although these are listed as separate strategies by Wacquant, it is clear that they are interrelated and feed off each other. The psychiatrization and criminalization of homelessness allowed city and state officials to remove unsheltered individuals out of public spaces by using a discourse which emphasizes the connections between danger and mental illness, a process I refer to as "racial criminal pathologization" in short.

While it's true that disabled street "beggars" have been criminalized in the U.S. as far back as the mid-19th century (Schweik, 2009), everyday acts such as sleeping in public spaces, asking for money or even food from a passerby are now a punishable offense. This is part of what Beckett and Murakawa (2012) refer to as the "shadow carceral state" – the conflation of criminal punishment with civil codes and administrative pathways to incarceration. More specifically, in *Banished*, Beckett and Herbert (2011) show that many U.S. cities are increasingly deploying social control tools that involve spatial exclusion, such as "off limit" orders, trespassing, Stay Out of Drug Areas (SODA) and Stay Out of Areas of Prostitution (SOAP) orders and gang injunctions, which meld in essence civil codes with criminal laws. They therefore signal the genealogy of banishment as a form of

punishment, even though many propose these ordinances as *alternatives* to punishment (because they are meant to compel people to leave a locale and thus supposedly avoid imprisonment or connection with ''criminal'' activity such as drugs, sex work, etc.). But in actuality, such ordinances only increase the scope of the carceral state.

Because of the criminalization of housing insecurity, it is no wonder that being housing insecure is such a strong conduit to imprisonment, regardless of mental health diagnosis or deinstitutionalization. And yet deinstitutionalization became a scapegoat on which to pin the plight of the so called homeless mentally ill, and by affiliation homelessness itself (Mathieu, 1993; Morrissey and Gounis, 1988). In short, the discourse that pits confinement in institutions and prisons against living on the streets or being unhoused creates a false equation since there are, and should be, much more alternatives beyond either the medico-punitive discourse of social control (institutionalization/psychiatrization and criminalization) or biopolitical discourse of social abandonment (housing insecurity).

From asylums to prisons?

I want to move us now to the last part of the equation ''deinstitutionalization → homelessness → imprisonment,'' mainly the nexus of deinstitutionalization leading to imprisonment. This part is the bulk of the thesis, also presented in the documentary ''The New Asylums.'' The move from one carceral space to another had been termed trans-incarceration and is much debated in the sociological literature (Liska et al., 1999; Raphael and Stoll, 2013). It is certainly true that from the 1960s the mental inmates' population decreased while the prison population increased. Furthermore, as discussed earlier in regards to housing insecurity, while public services (such as affordable housing and healthcare) shrank due to neoliberal austerity measures, the carceral arm of the government exploded (Wacquant, 2009). This, however, leads various social scientists (Dear and Wolch, 1987; Isaac and Armat, 1990; Wacquant, 2009) to argue that these changes (transitioning from medicalization into criminalization) can be best viewed when examining the treatment of people with psychiatric disabilities via deinstitutionalization.

The ''new asylum'' thesis therefore purports that unsheltered people with mental health issues as well as those in mental distress more generally, end up incarcerated because psychiatric hospitals closed and are no longer an option for them. I would like to complicate this critique of deinstitutionalization by offering an alternative critique of psychiatrization and institutionalization. In other words, institutionalization is the problem and not the solution to dealing with mental difference. As those involved in mad/consumer/survivor/ex patients/anti psychiatry tell us, just because psychiatric hospitals were full, does not mean that they were places of quality care and treatment (Grob, 1994; Rothman, 1971; Reaume, 2002). We need to contend with the reality that during the heyday of institutionalization – extreme variance in behavior, thought or mind was not seen or accommodated in public since many people were institutionalized ''out of sight, out of mind''

(referencing Wright's (1947) exposé by that name) and made invisible. But it does not neutrally and ethically follow that people who were psychiatrized were better off in such locales in the "good old days" of the "asylum era" (Rothman, 1971).

Connecting, not to mention blaming, deinstitutionalization on the rise of imprisonment also leads one to believe that psychiatric hospitals closed and led the *same people* to be incarcerated in prisons. But this claim cannot be corroborated in terms of demographics, as Harcourt (2006) masterfully shows. Over the years, the gender distribution of those in mental hospitals tended to be either equal or tended towards over-representation of women (Harcourt, 2006; Metzl, 2009). However, in terms of imprisonment, the majority of those newly imprisoned are male. There are differences in terms of age and race as well (see Harcourt, 2006, Steadman et al., 1984). It should now be clear to anyone familiar with the prison system in the U.S., non-whites are highly over-represented, reaching over 50% in the early 1990s. Put differently, generally speaking, the inmate population in mental hospitals tended to be white, older and more equally distributed by gender then those incarcerated in prisons (Harcourt, 2006). Therefore, we are not speaking about the same populations that were deinstitutionalized and sent to prison, but of ways in which the technique and discourse of incarceration (whether in asylums or prisons) retained its importance, but for differing populations (Ben-Moshe et al., 2014).

Prison is maddening

There is another part of the equation "deinstitutionalization → homelessness → imprisonment" that should trouble us and it becomes painfully obvious throughout the film "The New Asylums." The movie painstakingly follows several incarcerated men who experience altered states and often a complete break with reality, and their situation is not unique. I suggest that we do not need to go to deinstitutionalization to explain the presence of those imprisoned with mental health differences in jails and prisons in the U.S., as the first scene described at the beginning of the paper purports to do. Instead, I examine literature on conditions of confinement from a disability and mad studies lens to suggest that poor mental health (and other disabling conditions) is intrinsic to the prison and that should warrant an indictment of the system of incarceration and institutionalization and not of deinstitutionalization.

Rates of suicide can be examined as an example. As Stewart and I discuss elsewhere (2016), suicide remains the leading cause of jail inmates' deaths and the picture is not much different in state prisons. According to Bureau of Justice Statistics (BJS, 2012), between 2001 and 2010, suicide was among the five leading causes of death in prison[5] in all but two years. Why is the suicide rate so high in carceral spaces? Much of the research on suicide rates in prison had focused on the individuals incarcerated and their characteristics as explanatory variables, particularly indicators of mental health. As Huey and McNulty (2005) rightfully state, this focus is related to the medicalization of suicide more broadly, in which the causes for suicide (even in a repressive setting such as a prison or other total institutions)

are seen as reflective of personal pathology. As Liebling (1999) adds, this narrow focus on the individual had led to limited and ineffective analysis and prevention policy for suicide in prisons. Huey and McNulty (2005) show that it is *prison conditions* that should be examined if we want to have a holistic understanding of the high rates of suicide behind bars.

The nature of incarceration itself, therefore, distresses those incarcerated and worsens their mental and physical well-being. Conditions of confinement may cause further mental deterioration in those entering the system with diagnoses of mental or intellectual disabilities (American Association of Mental Retardation, 2005). To make matters worse, those incarcerated who are identified as mentally ill or exhibit "disruptive behaviors" are often sanctioned to "administrative segregation" in separate units (often referred to as the SHU – security housing units – or facility wide as supermax). These are isolation units resembling a closet, in which one lives for 23 hours a day. People who are "mentally ill," queer/gay, gender non-conforming and others are often placed in solitary as a form of "protective custody," often "for their own good."

These segregated forms of incarceration are likely to cause or exacerbate mental and physical ill-health of those incarcerated, regardless of their mental state prior to incarceration. Haney (2003) lists rage, loss of control, hallucinations, and self-mutilations as some of the adverse effects prisoners secluded in supermax and solitary confinement have experienced. Shalev (2008) details the detrimental health effects of solitary confinement, including trauma, nightmares, headaches, hallucinations, and overall emotional and physical breakdown. Legal scholar DeMarco (2011) goes a step further to argue that since confinement in supermax facilities almost guarantees the creation of a mental disability, such confinement violates the Convention on the Rights of People with Disabilities (which was approved by the UN in 2006). In a tragic cyclical way, as Reiter and Blair (2015a) point out, the very presence of seriously mentally ill people in jail or prison has become a primary justification for the use of solitary confinement, which, in turn, creates or exacerbates mental distress.

There is also a racial and gender bias in the *interpretation* and diagnosis of mental health differences in prisons. Prisoners of color who experience an emotional breakdown are more likely than their White counterparts to be sent to segregation, to be thought of as malingering/stubborn/violent and to be denied treatment. This is part of the discourse of racial criminal pathologization, which interlinks anti-black racism with pathologization. Although the film "The New Asylums" was shot only in men's correctional facilities, people in women's correctional facilities (including transgender inmates) also experience bias in diagnosis and treatment of mental health difference while incarcerated. Women and gender variant folks who are incarcerated report high levels of trauma, both before and during their incarceration (Kupers, 1999, 2008). This previous experience with trauma is hardly taken into account both in sentencing and during their incarceration. This trauma is then triggered and re-triggered by the further violence within prison, such as the common practice of bodily cavity search, leading feminist

abolitionists (see Davis, 2003) to refer to incarceration itself as State sponsored violence against women.

In the documentary ''The New Asylums,'' those incarcerated understand this reality all too well. Towards the end of the film, Carl M.,[6] one of the men incarcerated in Lucasville, the supermax prison in Ohio, says that ''Before discussing or taking a miracle drug that supposed to be a cure all,'' he says, ''let's find out what's going on, and being in prison,'' he continues, ''that is one problem.'' Carl puts the crux of the issue within the prison itself. The narrator tells us Carl's story as an example of other prisoners' circumstances that landed them in the supermax, as a result of what I called earlier racial criminal pathologization or the racialized entanglement of incarceration and disablement. Carl was convicted of burglary initially and then returned to prison for violating his parole by taking someone's bicycle. He then began disobeying officers, which a decade later landed him at Lucasville, the maximum security prison.

Indeed, many so-called mentally ill prisoners came to Lucaseville from minimum security prisons but because they were seen as disruptive in their original placements they were sent to a supermax, which the film narrator describes as ''the basement for the very mentally ill in Ohio.'' Because people with differing behaviors and altered state of mind often disregard or disobey orders, the likelihood of them entering a supermax or segregation is higher (Kupers, 1999). Because of these disciplinary actions, Carl M. has been in prison over 13 years beyond his sentence. By the end of the film, we learn that he had finally been granted parole, but because he came from Jamaica as a child, he was detained by immigration after his parole and deported to Jamaica, a country he never really resided in. Here too, we see the entanglement of racial criminal pathologization, which leads people like Carl not to freedom post incarceration but to other forms of abjection.

In summary, as those incarcerated tell us in this film, one of the reasons why there are many people with mental health issues in prisons is not because of deinstitutionalization or because such people belong in psychiatric hospitals (which ultimately closed down). It is because of the nature of confinement and incarceration itself, which is disabling and leads to mental and physical deterioration. This leads some to advocate for increased treatment options within the prison as a way to address at least some of the distress experienced by prisoners with mental health differences. But if the problem is endemic to incarceration itself, and we take seriously the perspective of those incarcerated and psychiatrized, creating more psychiatric units in prison is not a solution but part of the problem. If incarceration disables and exacerbates mental health conditions as I have suggested, then ''treatment behind bars'' is an oxymoron, as I demonstrate in the next section.

Treatment while incarcerated

A common claim made by those who conflate prisons as ''the new asylums'' is that prisons and jails had become de facto the biggest mental health treatment facilities in the U.S. In order to be regarded as a mental health facility though, carceral

spaces need to actually provide mental health treatment. As we shall see, this claim is highly suspect. A related claim is that people who are destitute and in crisis are often so lacking in choices that they seek criminalization and incarceration in order to get proper treatment (at times this is also said regarding nourishment, physical health or shelter). In the documentary ''The New Asylums,'' for example, an officer points out that it is remarkable that many of the prisoners get much better care inside prison than they would on the outside. Wilkinson, the then director of the Ohio department of rehabilitation and corrections, further states in the film that he knows a judge that sent people to prison because this is where they thought they would finally get the help they need. But I would like to scrutinize these two claims (that those incarcerated get treatment in prisons and jails) on ethical and factual grounds.

So what does treatment behind bars looks like? At the very beginning of the film ''The New Asylums'' we are brought into Lucasville and shown a group therapy session. Most of the participants in this group therapy scene are black, all are men and each of them is sitting in a cage. This is not a hyperbole description but mere fact. Each of the participants in this therapy session is in a small cage with bars and locks, including chains around their ankles (where would they escape to in their tiny cage, we are not told). The presumed therapist (who looks phenotypically white) is sitting outside the cages, asking the men who are lined up in a row of cages how they are doing, how they progressed this week, inquiring about new body injuries he can observe, and so on. A guard is constantly circling the cages. This is treatment we are told. A level of treatment some of them never experienced before on the outside (and one indeed hopes these men were not treated like this prior to incarceration). This scene is a representation of a talk therapy session, the *best case* scenario in Lucaseville and many prisons like it.

Other forms of treatment inside are just as problematic. Behind bars, even though psychiatric medication is discussed as voluntary, refusal to take it can often result in punitive measures (Davis, 2014; Kupers, 1999). Psychopharmaceuticals as a mandate in ''treating'' psychic difference or distress has been heavily critiqued by consumer/survivors/x-patients/mad identified people, in relation to a broader critique of the conceptualization of psychic difference as ''mental illness'' by bio-psychiatry (Fabris, 2011; Whitaker, 2010). The point is not to criticize people who take psychiatric medication, but to alert to the fact that it is a first and often *only* course of action when dealing with psychic harm, inside and outside prisons. This form of therapy (in a cage) is not unique to Lacasville, as detailed by Reiter and Blair (2015).

In addition, security regimes trump so-called treatment in almost every way, since the prison is governed by top-down hierarchies in which medical staff are much lower than correctional personnel (Kupers, 1999). Here again, criminalization is entangled with and ultimately triumphs over pathologization in ways that are often deadly. When someone incarcerated is in crisis or is acting out, the response comes from security guards and not mental health professionals. If someone seeks mental health aid, correctional staff are often reluctant (because they think the person is faking it or is manipulative), unwilling (because of what they

deem as security risks), unable (because even if they see those imprisoned as human beings, they, like the rest of us, have been de-skilled in dealing with human variation and put it on so called experts, which are only available for a few hours a month in any given prison) or tentative (refuse to let a prisoner see a professional until they disclose some information, such as who started a fight) in their decision to "allow" an inmate to be given access to even request treatment.

This reliance on individualistic discourse (don't commit crimes, behave and be rewarded) to address structural oppression (including the very nature of and rationale for incarceration) is at the heart of "treatment" behind bars. This alchemy, again, psychiatrizes and obscures larger political and social inequities and violence. When enshrined in medical discourse, as opposed to and in addition to security discourse, such treatment is discussed as if it occurs in a vacuum, and not in the most inhumane and repressive setting possible. At its core then, under the "new asylums" thesis, prisons and jails can be thought of as places of treatment ("the largest mental health centers," etc.). But as I have tried to show they are, more often than not, places of disablement which create and exacerbate mental ill health. Discussing them as places in which people can (and do) get treatment is not only factually improper but also ethically and ideologically problematic as it legitimizes incarceration and makes it appear needed and normalized. The plight of those experiencing mental health issues while incarcerated should concern us, but I want to suggest that the reason is because of the detrimental effects of incarceration and not because they need to be in psychiatric hospitals instead.

Rediscovering the Asylum: The consequences of prisons as "the new asylums"

"The new asylums" thesis posits that "deinstitutionalization → homelessness → imprisonment." I hope this paper has demonstrated that people did not become homeless because of deinstitutionalization, or because they needed to be in institutions. People are unsheltered because of economic inequalities that left them unhoused, including the shrinkage of the safety net, cuts in public services, erosion in living wages, and policies that made affordable and accessible housing out of reach, especially for those already marginalized. Blaming deinstitutionalization diverts attention from these structural violence. In addition, it makes it appear as if hospitalization and institutionalization were a panacea but disability based institutions and psychiatric hospitals should not be residential placements or alternatives to housing (Ben-Moshe et al., 2014).

One reason blaming deinstitutionalization for socio-economic conditions is dangerous, is that the romanticized notion of psychiatrization in the "good old days" could become a reality once again. In 1984, the special task force of the American Psychological Association was calling deinstitutionalization in mental health "a major societal tragedy." The chair of the committee who wrote that report will then become a major proponent of the reinstitutionalization[7] of mental patients including authoring a recent editorial (in 2016) urging practitioners to

''rediscover the concept of the asylum.'' And almost every document written about this axiom of prisons as ''the new asylums'' and ''the mentally ill in prison/jail'' since the 1970s has referenced, was authored, co-authored or otherwise involved Dr. Torrey or the Treatment Advocacy Center.

The danger is that such public appeals are often followed by specific policy changes, which taken together could become a reality of reinstitutionalization of those who are labeled as mentally ill. Wolch et al. (1988) characterize these calls as a ''new asylum movement,'' especially within psychiatry. Such policies include the construction of new homeless shelters (which have many restrictions and house unsheltered people only temporarily); the upgrading and reform of state mental hospitals; and the segregation of those labeled as mentally ill in the criminal justice system, especially by the creation of new facilities or beds in existing prisons and jail (Wolch et al., 1988). This increase in state capacity towards reinstitutionalization and away from community living and adequate services in the community is joined by various measures that increase social control over those who are regarded as mentally disabled offenders.

Further, critiques from experts on (and often family members of) those psychiatrized and incarcerated often lead to claims that ''the mentally ill'' do not belong in prison or jail. But I want to suggest that such calls leave the carceral logic intact and even gives it more credence. In other words, if ''the mentally ill'' do not belong in prison, surely others do. By painting deinstitutionalization as the culprit for the plight of people with mental health differences inside and outside of prisons, the disabling effects and legitimacy of the prison remain intact. This is why I contend that it is important to conceptualize deinstitutionalization as a logic, a mindset, a movement and not just a social and historical process. And although the movie's main protagonist, deinstitutionalization, is never really discussed in the film – its shadow looms large on all the other players in the sad, dangerous and simplistic saga of prisons as ''the new asylums.''

Notes

1. http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html
2. http://www.treatmentadvocacycenter.org/about-us
3. I am using the term 'the mentally ill' to allude to the way people are described in this discourse of ''the new asylums.'' This terminology is not neutral though and as a discourse, reifies experiences as pathologies in need of medical (and sometimes punitive) intervention. As this is the hegemonic discourse, I will refer to it by using its own language, often in quotations.
4. In social science literature in the 1980s estimates of the percentage of mental illness among the so called homeless vary extensively, from almost 90% to less than 30% (see Wright, 1988 for a discussion of these debates).
5. In the general, non-incarcerated, population suicide is the 10th leading cause of death, according to the CDC, National Center of Health Statistics (http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm)

6. Even though the documentary mentions the imprisoned people interviewed by name, I will not mention their last name here because of privacy concerns.
7. See Lamb and Weinberger (2016).

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