Beyond the “New Asylum”: Mental Health Care as Carceral Expansion in DC’s Jails

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Introduction

“Across the country, correctional facilities are struggling with the reality that they have become the nation’s de facto mental health care providers, although they are hopelessly ill-equipped for the job. They are now contending with tens of thousands of people with mental illness who, by some counts, make up as much as half of their populations.”

— Alisa Roth, *Insane: America’s Criminal Treatment of Mental Illness* (Roth)

"The District's detention system, like other correctional systems nationally, has now become a major provider of basic human services. As such, we not only play a critical role in ensuring public safety but also in promoting public health."

— DC Department of Corrections Director Devon Brown (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”)

Portrayals of jails and prisons as mental health care providers in the United States have come to dominate criminal legal and psychiatric discourses in the 21st century. Carceral actors and mental health and prisoners’ rights advocates have increasingly defined these institutions as the “new asylums,” as 20% of individuals in jails and 15% of individuals in state prisons hold diagnoses of “serious mental illness” (Ben-Moshe, *Decarcerating* 136; “Serious Mental Illness”). Experts largely attribute this phenomenon to deinstitutionalization, or the US’ mass closure of psychiatric facilities in the 1960s and 1970s. Establishing what Liat Ben-Moshe refers to as the “‘new asylum’ thesis,” they argue that insufficient community-based mental health services following this phenomenon left individuals with psychiatric disabilities houseless, uncared for, and, thus, increasingly vulnerable to incarceration (Ben-Moshe, *Decarcerating* 136-138).

A new image of the incarcerated individual and their place of confinement has thus emerged: that of the formerly-houseless, mentally ill, incarcerated individual held in a makeshift
place of “care”: the “new asylum” (Jonathan Simon qtd. in Ben-Moshe, Decarcerating 249; Ben-Moshe, Decarcerating 136). Operating within this framework, prisoners’ rights and mental health advocates and, following, carceral actors, have worked to implement further screening, treatment, and mental-health-focused re-entry services in US jails and prisons. Resulting programs include the “Adults with Behavioral Health Needs under Correctional Supervision” screening framework, corrections-specific behavioral treatment programs such as “Thinking for a Change,” and specialized mental health units (Osher et al.; “Thinking for a Change”; Mental Health Step-Down Unit).

The District of Columbia’s Department of Corrections (DC DOC) and its two jails, the Central Detention Facility (CDF) and Central Treatment Facility (CTF), reflect these efforts. Following a tumultuous, three-decade history of lawsuits, violated court mandates, and court supervision surrounding the facilities’ health care services, DC DOC made mental health care provision a central point of its stated mission, becoming DC’s “largest single-location mental health care provider” (Smith; “Department of Corrections Institutes Community-Oriented Healthcare for Inmates”; District of Columbia, Council, Committee on the Judiciary & Public Safety [2018] 1:34:29-1:34:31). In 2006, in an effort to address DC-based activists’ increasing concerns over the overrepresentation of formerly-houseless, mentally ill, incarcerated individuals in the criminal legal system, the Department entered a contract with Unity Health Care, a prominent DC-based community health center network (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”; Gordon). DC DOC has since worked with Unity to implement extensive mental health screening and treatment at the jails, including a specialized Men’s Mental Health Step-Down Unit (MHSUD), a Women’s Wellness Unit, and a therapeutic housing unit for men with substance use issues (“Department of Corrections Institutes...
Community-Oriented Healthcare for Inmates”; “Unity Health Care”; *Performance Oversight Responses* [2022] “59. Please Provide an Update on the Specialized Step-Down Unit at CDF”).

DC DOC’s mental health initiatives thus suggest that, taking the “new asylum” thesis as fact, carceral actors and prisoners’ rights advocates have focused on reframing and, albeit less successfully, repurposing jails and prisons as psychiatric facilities.

**Problematizing the “New Asylum” Thesis**

Despite its reliance on a seemingly-logical, chronological progression between deinstitutionalization, housing insecurity, and incarceration, the “new asylum” thesis operates on factual inaccuracies and reductive conceptions of pathology and criminality that offer a limited perspective on the overcriminalization of individuals with mental health diagnoses (Ben-Moshe, *Decarcerating* 136). In her extensive critique of this framework, Ben-Moshe shows that deinstitutionalization and the rise of housing insecurity that characterized the late 20th century did not perfectly overlap and impacted different populations (Ben-Moshe, *Decarcerating* 138; Mathieu 174). Further, she challenges this framework’s understanding of pathology as an innate quality, framing it, instead, as a social construction that holds important political functions. She shows that constructions of the “homeless mentally ill” attribute rising rates of housing insecurity to houseless individuals’ supposed pathologies as opposed to neoliberal policies that weakened the social safety net and abandoned large groups of people to housing insecurity (Ben-Moshe, *Decarcerating* 142). Ben-Moshe thus destabilizes the simplistic, seemingly-causal relationship between deinstitutionalization and housing insecurity that defines the “new asylum” thesis.
Ben-Moshe also examines the criminalization of housing insecurity and psychiatric pathology that coincided with this neoliberal abandonment and pathologization of houseless individuals. She argues that the simultaneous criminalization and pathologization of houselessness and behaviors associated with it led to the mass criminalization and, thus, incarceration of housing-insecure individuals (Ben-Moshe, Decarcerating 144-145). Ben-Moshe thus paints pathology as a political and social tool for targeting and controlling individuals rather than a natural condition that state actors are left to deal with. By this framework, then, criminal legal actors are no longer helpless agencies tasked with addressing an issue that is beyond their scope, as Alisa Roth’s quote at the beginning of this introduction would suggest (Roth), but active agents in a scheme of pathologization, criminalization, and confinement that allows for the continued mass imprisonment of so-called mentally ill, incarcerated individuals.

Ben-Moshe contextualizes the “new asylum” thesis and its resulting policies in a disability rights framework to problematize its legitimization of pathologized individuals’ confinement. Causal associations between deinstitutionalization, housing insecurity, and mass incarceration imply that individuals with mental health diagnoses require confinement and treatment – albeit not in a traditional carceral setting – in the form of, for example, psychiatric hospitals, specialized homeless shelters, and, even, mental health units in jails and prisons (Ben-Moshe, Decarcerating 158). Therefore, Ben-Moshe’s analysis largely focuses on the impact that the “new asylum” thesis and its resulting policies have on disability rights movements and conceptions of disability that affect pathologized individuals inside and outside of prison. In this thesis, I focus on this framework’s application in the carceral setting. I do so to shed light on the ways in which the “new asylum” thesis has shaped carceral practices and, thus, impacted not only incarcerated individuals but also carceral systems.
I add to Ben-Moshe’s work through an analysis of jail-and-prison-based mental health initiatives in DC as manifestations of prisoners’ rights advocates’ and carceral actors’ adoption of the “new asylum” thesis. By adopting this thesis, which individualizes the structural issues of housing insecurity and incarceration, activist initiatives work within a framework of pathology in advocating for mental health services to meet incarcerated individuals’ perceived needs. I argue that, due to their reliance on processes of pathologization, these services construct their recipients into a unique subject identity that I term the “mentally ill, incarcerated individual.” This construction, in turn, strengthens and expands carceral control and violence in two principal ways. First, through a framework of carceral humanism, I argue that this subject identity legitimizes carceral expansion in the form of psychiatric treatment. More specifically, I show that mentally ill, incarcerated individuals’ constructed need for “care” and incapacitation depicts carceral actors as benevolent service providers and, thus, allows for their growth in the face of an increasingly-abolitionist political context (Kilgore). Second, I posit that mentally ill, incarcerated individuals’ unique position at the intersection of psychiatric and carceral violence grants carceral actors extended control over this group in comparison to that exercised over non-mentally-ill, incarcerated individuals. I thus show that the psychiatric and criminal legal knowledge that emerged from the “new asylum” thesis, as well as their resulting policies, had a profound impact on systems of carceral control and incarcerated individuals.

Tracing the Origins of the “New Asylum” Thesis

This introduction examines the political and economic context that gave way to the “new asylum” thesis and its resulting policies. I examine the central role that processes of pathologization play in neoliberal and carceral systems of power in an effort to trace this
framework’s reliance on constructions of criminal, houseless, and mentally ill subjects. I thus contextualize this framework’s individualization of the structural issues of housing insecurity and incarceration in the emerging subject identity of the “homeless mentally ill,” which, this thesis will suggest, is reflected in rising jail-and-prison-based mental health initiatives.

*Foucault and “Life Administering Power”*

In order to understand the role of pathologization in the current political and economic system, one must consider Foucault’s analysis of productive power. Foucault argues that the 19th century witnessed a transition in political power from the sovereign right to “take life or let live” to a current power that, instead, *makes live* and *lets die* (Foucault, “March” 241-242). He thus distinguishes between a strictly repressive power and a productive, “life-administering” one that takes life as its object and works to “administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations” (Foucault, *History* 136-137). One end of this form of power, disciplinary power, centers on the individual (Foucault, *History* 139). Through techniques of hierarchization, surveillance, and organization, disciplinary power makes individuals into productive and, yet, docile subjects that reproduce existing social, economic, and political structures (Foucault, *History* 139). The other end holds “man-as-species,” as opposed to “man-as-body,” as its primary object (Foucault, *History* 136; Foucault, “March” 242). Biopower focuses on and regulates the life of the population as a whole through the study of its rates of birth, death, illness, production, fertility, etc., differentially distributing life chances and vulnerability to death among various sectors of the population (Foucault, “March” 243, 254-256).
According to Foucault, disciplinary power and biopower operate through the construction of distinct subjects within various fields of knowledge, including the psychiatric, medical, and criminal legal fields (Foucault, “March” 252-253; Foucault, “Afterword” 208). These fields of knowledge produce norms – such as definitions of who is and is not a criminal in the criminal legal system – that assign meaning to individuals and, in doing so, restrict their actions and define their position in society (Foucault, “Afterword” 212). For example, consider the construction of the “disabled” or “mentally ill” subject in present medical and psychiatric discourses. According to Shelley Tremain, disciplinary power and biopower gave rise to an apparatus of institutions – including asylums, special education programs, and quality of life assessments – that “created, classified, managed, and controlled social anomalies through which some people have been divided from others and objectivizes as (for instance) physically impaired, insane, handicapped, mentally ill, [...]” (Tremain 5-6). In other words, medical knowledge operating through these institutions has constructed the categories of “disabled,” “able-bodied,” “sane,” and “insane” to classify and regulate individuals (Tremain 6).

This subject formation wields power in two important ways. First, it limits an individual’s possible actions on the basis of their subject identity, imposing a “law of truth on him which he must recognize and which others have to recognize in him (Foucault, “Afterword” 212). For example, in their treatment of pathologized individuals, medical and psychiatric facilities impose narrow definitions of disability and illness on the former that significantly restrict their behavior (Yates; Sullivan). Scott Yates specifically examines this phenomenon in community care facilities for individuals with learning difficulties. He shows that these facilities construct pathologized individuals, by virtue of their pathology and, thus, of their medical construction as “disabled,” “as punishable beings” upon their admission, situating them as inferior to the
facility’s staff in a power dynamic that both parties respect (Yates 73). For instance, the residents who Yates interviews recognize that they cannot perform certain tasks, such as throwing away their garbage, without asking for staff permission (Yates 73). This dynamic clearly points to the productive nature of this form of power, which, rather than restrict individuals’ actions through verbal or physical punishment, relies on medical processes of hierarchization to construct them as pathological, docile subjects with limited sets of actions.

Second, subject formation constructs individuals as deserving or undeserving of the life chances that this “life-administering” power promises (Foucault, History 138; Foucault “March” 255). As suggested by disciplinary power’s and biopower’s ability to let die, despite their stated life-administering function, these forms of power do not relinquish their “power of death” (Foucault, “March” 254; Foucault, History 137). Governments continue to fight wars, institute the death penalty, and, as the next section will explore in detail, abandon large sectors of their populations to housing and food insecurity and incarceration (Foucault, History 137). Foucault explains that disciplinary power and biopower justify these practices in life-affirming terms, constructing the death of some individuals or sectors of the population as necessary for the well-being of the whole (Foucault, History 137). For example, justifications for the death penalty now require depictions of individuals as posing “a biological danger to others,” which, as this introduction will show, often rely on criminal legal, medical, and psychiatric knowledge that categorizes individuals as pathologically criminal and, thus, dangerous (Foucault, History 138; Ben-Moshe, Decarcerating 25). On a larger scale, racism – a form of subject formation that depends on biological discourses to differentially construct individuals – justifies the death and abandonment of racialized individuals. According to Foucault, this ideology constructs a sense of
competition between two groups that leads one group to think of its survival as dependent on the death of the other (Foucault “March” 255).

I have thus established that present systems of power wield control through the differential construction of individuals within fields of knowledge. The next sections will contextualize these processes in the present political and economic system, neoliberalism, to shed light on a number of subject identities that have established and sustained it.

*Neoliberalism and the Making of Abandoned-Pathologized Subjects*

Disciplinary and biopolitical processes of pathologization play a fundamental role in legitimizing and sustaining the neoliberal state. Neoliberalism calls for the government’s disinvolvement from the market, operating on the logic that the market will appropriately distribute income based on individuals’ worth (Povinelli 17). This system allows little to no room for a strong social safety net, leaving low-income and unhoused individuals with no protections in the face of calamity (Gilmore and Gilmore 188). Importantly, despite its anti-state rhetoric, neoliberalism relies on the state “to facilitate upward transfer of wealth, income, and political power from the relatively poor and powerless to the already rich and powerful” (Gilmore and Gilmore 174). A key aspect of this system, then, is its “organized abandonment” of large sectors of its population, which manifests, for example, in global disparities between colonized and non-colonized nations and steep wealth inequalities between socioeconomic groups in the US (Povinelli 19; Gilmore and Gilmore 188).

As Foucault notes, however, the state’s intentional abandonment of its population is largely incongruent with its newly-gained, life-affirming function, which is clearly reflected in the underlying logics of neoliberalism as a political system that gains legitimacy through its
population’s supposed access to an equal-opportunity market (Foucault, “March” 253; Povinelli 17). Therefore, in order to justify its purposeful exclusion of sectors of the population from its life-affirming functions, the neoliberal state needs to construct abandoned individuals as deserving of their abandonment through, for example, the construction of racialized subjects, as outlined above (Foucault “March” 255). This section will consider three subject identities – that of the “criminal,” the “homeless,” and the “disabled” – that justify organized abandonment and, importantly, sustain the “new asylum” thesis.

Ruth Wilson Gilmore examines the value of the criminal in the capitalist state. She considers “prisons as catchall solutions to social problems” that manage and hide neoliberal political and economic crises, framing the late-20th-century expansion of the prison system as an attempt to address the social and economic unrest that characterized the late 1970s and early 1980s (Gilmore, Golden 5; Gilmore, “Globalisation”). Economically, this period witnessed a recession, which limited consumers’ spending power, inflated rates of unemployment, and displaced wealth and labor, idling entire regions of the US (Gilmore, “Globalisation”). As profits waned, capitalists transitioned their capital from productive investments – such as investments in expanding manufacturing corporations – to nonproductive investments – namely, interest brokering and other “means to make money make more of itself” (Gilmore, Golden 58; Gilmore, “Globalisation”). These phenomena led to a “surplus crisis,” where surplus signifies the accumulation of profit in the form of, for example, excess land, unemployed workers, and uninvested capital. If capitalist systems require a degree of unemployment and the production of more capital than they can expend, excessive surplus can lead to crises in the capitalist state, calling into question its ability to manage its capacities (Marx qtd. in Willse 12; Gilmore, Golden 26-28, 58; Gilmore, “Globalisation”).
Gilmore argues that, through what she refers to as the “prison fix,” jails and prisons addressed the aforementioned political and economic crises (Gilmore, “Globalisation”). Using California as a case study, she shows that the mass construction of prisons allowed the state to put its surpluses to use, thereby abating its surplus crisis. For example, jails and prisons provided a new venue for productive capital investments and locations in which to confine and hide members of the surplus population (Gilmore, Golden 111). To this latter point, Gilmore shows that the practices of criminalization that emerged with the “prison fix” in California largely targeted members of the state’s surplus labor population – namely, low-income Black and Latinx Americans (Gilmore, Golden 111-113). Importantly, in addition to warehousing surplus populations in an effort to address surplus crises, jails and prisons simultaneously produce a new, abandoned surplus population: that of the perpetually criminalized. This group sustains the “prison fix” and, thus, serves clear economic and political purposes in the capitalist state. Gilmore thus outlines the role of jails and prisons in masking the state’s organized abandonment of its surplus population, a process that, in turn, depends on the abandonment of large sectors of the population to incarceration.

Justifications for jails and prisons’ warehousing of surplus populations depend on the construction of the criminal as a subject deserving of abandonment. Gilmore explains this phenomenon, showing that, in the 1980s and 1990s, a rollout of policies targeting drug use and gang membership in California constructed the criminal as a distinct social category, as “[p]oliticians of all races and ethnicities merged gang membership, drug use, and habitual criminal activity into a single social scourge, which was then used to explain everything from unruly youth to inner-city homicides to the need for more prisons to isolate wrongdoers” (Gilmore, Golden 109). Importantly, processes of criminalization hold clear racial dimensions, as
mass incarceration largely targets Black Americans (Gilmore, Golden 111). This latter point suggests that constructions of abandoned subjects intersect, as Black Americans, as devalued, racialized subjects, are more vulnerable to various forms of organized abandonment – such as incarceration and, as I suggest below, housing insecurity.

Through a similar framework, Craig Willse examines the economic and political value of “the homeless” (Willse 2). According to Willse, “[h]ousing deprivation is produced to make literal room for the speculative urban consumer,” or, in other words, allow for the redistribution of resources from low-income to wealthy people in urban spaces that safeguards the latter’s “security and protection afforded within a neoliberal economy” (Willse 11). Therefore, neoliberalism depends on the justified abandonment of a large sector of its population to housing insecurity and, thus, on the construction of houselessness as an individual pathology possessed by “the homeless” (Willse 11). As a surplus population, houseless individuals also require management, which manifests in the work of “social welfare industries” (Lisa Gray-Garcia qtd. in Willse 46). These refer to nonprofit organizations that leave the structural causes of housing insecurity unchallenged and, instead, manage and profit off of houseless individuals through the delivery of social services. Willse considers the example of a New-York-City based organization that connects incarcerated individuals to low-wage jobs in an effort to enable “them to advance towards better futures as independent, contributing members of society.” Along the way, the organization earned hundreds of thousands of dollars from the management of houseless people every year (Willse 13). Thus, just as the neoliberal state depends on the abandonment and (profitable) management of the “criminal,” it depends on the pathologization and management of “the homeless.”
Medical and psychiatric discourses also occupy a central role in the neoliberal state and its differential treatment of sectors of the population. Capitalist systems of labor, which have become increasingly-individualized in structure and require “greater speed, stamina and rigid production norms,” have established distinctions between able-bodied and disabled individuals on the basis of their labor capacities (Ben-Moshe, “Disabling” 390-391; Oliver 47). Permanently excluded from the workforce, individuals constructed as disabled have become a surplus population that requires management (Charlton 24; Ben-Moshe “Disabling” 390-391). Medical definitions of disability pin this exclusion on this group’s individual pathology, while rendering its members manageable and profitable (Stone; Ben-Moshe, “Disabling” 391). Similarly to how constructions of the “criminal” and the “homeless” justify these surplus populations’ management, constructions of individuals with disabilities allow for their surveillance, management, and economic exploitation in nursing homes, psychiatric hospitals, and other institutions (Charlton 47; Ben-Moshe, Decarcerating 11-12). Importantly, as the next section will discuss, constructions of disability, or medical abnormality, are tied to constructions of racial abnormality, making racialized individuals especially vulnerable to processes of pathologization (Ben-Moshe, Decarcerating 26). This latter point suggests that abandoned identities intersect, rendering individuals who face abandonment on the basis of their racialization, for example, especially vulnerable to other forms of abandonment.

This section has thus shed light on the productive role that the subject identities of the “criminal,” the “homeless,” and the “disabled” or “mentally ill” play in the neoliberal state. I have shown that this system’s legitimacy depends on these categories to justify its necessary abandonment and exploitation of large sectors of the population. It is in this context and, importantly, this individualized framing of structural issues that the “new asylum” thesis
emerged. Relying on neoliberal understandings of incarceration, housing insecurity, and pathology, this framework pins the overcriminalization of individuals with mental health diagnoses on a supposed “homeless mentally ill” subject who faces housing insecurity and incarceration as a result of their pathology (Ben-Moshe, Decarcerating 136). Policies resulting from this thesis have thus sought to solve these structural issues through services aimed at addressing these individuals’ pathology. As I will show in this thesis, operating within a framework of pathology, these services, which include jail-and-prison-based mental health initiatives, further pathologize their recipients.

Pathologizing the Criminal: An Overview of “Race-Ability,” “Criminal Pathologization,” and “Racial Criminal Pathologization”

Alongside the neoliberal construction of individuals as disposable subjects, in the period following deinstitutionalization, psychiatric pathology emerged as a key tool in the identification of danger and, thus, criminality. Foucault explains this phenomenon as an important element of the productive power discussed above, which concerns itself with the supervision, regulation, and, thus, preservation of the population and social security (Iliopoulos 52). Disciplinary power and biopower’s focus on life-making is fundamentally incompatible with the logic of permanent exclusion that defined psychiatric asylums, calling, instead, for the identification, correction, and reintegration into society of deviant individuals deemed to pose a threat to the population at large (Iliopoulos 51). Importantly, this new approach requires the early detection and, thus, prevention of dangerousness, which led criminal legal discourses to adopt an increasingly medicalized understanding of criminality as something to be diagnosed and promptly cured (Iliopoulos 54). In his analysis of Foucault’s work, John Iliopoulos identifies this process as the

1 (Ben-Moshe, Decarcerating 25-28).
“‘psychiatrization’ of criminal danger,” as it views crime as “an event signaling the existence of a dangerous element in the social body,” rather than merely viewing the criminal “as the person to whom the crime could be attributed and who could therefore be punished” (Iliopoulos 54). This shift led psychiatry to occupy an increasingly important position in the criminal legal system, as the clinician came to act “as an expert, as a witness, and as a decision maker” in the judicial system, providing clinical assessments of individuals’ proneness to violence and criminality (Iliopoulos 55-56).

Foucault’s analysis sheds light on the role that claims of psychiatric pathology play in constructing the subject identity of the “criminal,” as they allow state and medical actors to use psychiatric discourses to cast certain individuals as inherently dangerous, criminal, and, thus, in need of correction and incarceration. At the same time, this psychiatrization of criminal danger suggests increasing associations between behavioral deviance, dangerousness, and, thus, criminality – a phenomenon that Ben-Moshe discusses through the term “criminal pathologization” (Ben-Moshe, Decarcerating 25). In other words, Foucault’s analysis suggests that, following deinstitutionalization, psychiatry has greatly focused on identifying, pathologizing, and correcting “deviant” behavior as potentially criminal, thereby criminalizing activities that are not in themselves illegal. In fact, to this point, Foucault shows that this rising psychiatrization of criminality has led criminal legal actors to work alongside clinicians “to identify, prevent, and punish a type of behavior that is not legal,” just as it has led mental health professionals to seek to treat potentially criminal behavior that previously bore no ties to mental illness, such as drug use (Iliopoulos 55-56).

To better understand processes of criminal pathologization, one can consider the simultaneous criminalization and pathologization of the “homeless mentally ill” that Ben-Moshe
outlines (Ben-Moshe, Decarcerating 140). First, citing the works of Judi Chamberlin and David A. Snow et al. (qtd. in Ben-Moshe, Decarcerating 140), Ben-Moshe partially attributes this group’s pathologization to its members’ engagement in activities that, despite being natural responses to housing insecurity, are largely understood as deviant. For example, Snow et al. critique the widespread psychiatrization of behaviors such as “inappropriate affect and appearance, depressed mood, sleeping and eating difficulties, agitation, and unresponsiveness” that, although interpreted as pathological, “may instead be adaptive responses to the arduous nature of life on the streets or patterned manifestations of a subculture or way of life different from the larger normative order” (Snow et al. 421). Second, Ben-Moshe points to the simultaneous criminalization of behaviors resulting from housing insecurity, such as sleeping in public and asking strangers for food or money, that, despite not posing concrete threats to urban populations, are seen as indicators of this group’s deviance and, thus, potential dangerousness (Ben-Moshe, Decarcerating 144).

Importantly, race plays a fundamental role in processes of criminal pathologization, as Ben-Moshe makes clear through her specification of the term as “racial criminal pathologization” (Ben-Moshe, Decarcerating 26). In her analysis, Ben-Moshe uses the term “race-ability” – which she defines as “the ways race and disability, and racism, sanism, and ableism as intersecting oppression, are mutually constitutive and cannot be separated” – to recognize the intrinsic ties between definitions of disability and racist constructions of racialized individuals as deviant (Ben-Moshe, Decarcerating 5). As the paragraphs above have made clear, conceptions of deviance drive psychiatric and criminal legal identifications of individuals as pathological, potentially dangerous, and, thus, criminal. Race plays a fundamental role in notions of deviance and abnormality. As outlined in the previous section, biopower depends on the
constructed deviance of racialized populations as threatening to the population at large and, thus, unworthy of equal life chances (Foucault, “March” 255). Therefore, constructed as inherently-abnormal subjects, racialized individuals are more vulnerable to processes of pathologization and, thus, criminal pathologization than “normal” subjects. For example, Ben-Moshe examines the murder of Mike Brown, a Black American man, by police. She shows that, in their justification of Brown’s murder, police attempted to appeal to his abnormality and, thus, potential dangerousness as a Black man, constructing him as “animalistic [...] crazy, pathological, abnormal” (Ben-Moshe, Decarcerating 25). This same logic applies to other marginalized identities in white supremacist, patriarchal, cisheteronormative societies, which, Ben-Moshe suggests through the works of Lennard Davis and Sylvia Wynter (qtd. in Ben-Moshe, Decarcerating 78), cast women, queer people, and people of color as inherently deviant and, thus, dangerous to the social order.

This section has thus suggested that, in the period following deinstitutionalization, psychiatry and the criminal legal system have come to play a shared role in the carceral state in their identification of (constructed) deviance as pathological, potentially dangerous, and, thus, criminal. I have thus shed light on a second, albeit related, function of pathologization in the neoliberal, life-affirming state: its role in identifying, correcting, and reintegrating deviance into society, as opposed to merely justifying the abandonment of deviant populations. As Ben-Moshe suggests, logics of racial criminal pathologization clearly define the “new asylum” thesis, sustaining its associations between pathology and criminality and, thus, its attribution of individuals’ housing insecurity and incarceration to their supposed pathology (Ben-Moshe, Decarcerating 138-147).
“New Asylums,” Mentally Ill, Incarcerated Subjects, and Carceral Expansion

My purpose in these two sections has been that of contextualizing the “new asylum” thesis within broader processes of criminalization and pathologization that define and sustain the neoliberal, life-affirming state in an effort to trace its individualization of the structural issues of housing insecurity and mass incarceration (Ben-Moshe, *Decarcerating* 26, 140). In this thesis, I examine this framework’s manifestations in the carceral setting through an analysis of jail-and-prison-based mental health initiatives resulting from its underlying logics. I consider these services as individual, pathology-focused solutions to structural issues that, operating within the aforementioned neoliberal and carceral logics, further pathologize incarcerated individuals. As my analysis will suggest, these services’ invitation of psychiatric discourse in the carceral setting fundamentally shapes constructions of incarcerated individuals and redefines carceral practices aimed at their management, thereby calling for an independent analysis of the “new asylum” thesis and its resulting policies in this setting.

Through a case study of DC’s jails, I argue that, through their construction of the mentally ill, incarcerated individual, jail-and-prison-based mental health services expand carceral control in two principal ways. First, I posit that this subject identity’s constructed need for simultaneous “care” and incapacitation has given way to depictions of carceral facilities as mental health providers and, thus, legitimized their expansion through psychiatric services in a context of rising abolitionist efforts. Second, I show that jail-and-prison-based mental health services expand carceral actors’ access to and control over mentally ill, incarcerated individuals, thereby making this group especially vulnerable to carceral violence.

I structure my argument across three chapters. My first chapter will focus on the CDF and CTF’s production of mentally ill, incarcerated subjects. I examine DC DOC’s mental health
services, including DC DOC’s contract with Unity Health Care, its mental-health-focused intake process, its specialized mental health units, and its discharge services, through theory on disciplinary and biopolitical construction of disabled subjects (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”; Medical Management; Mental Health Step-Down Unit; Reentry Program and Services; Foucault, “Afterword” 208; Tremain). I suggest that, lying at a unique intersection of psychiatric and criminal legal knowledge (Galenek), these services and their surrounding discourses construct individuals into mentally ill, incarcerated subjects that are fundamentally distinct from non-mentally ill, incarcerated subjects and non-incarcerated, mentally ill subjects in their simultaneous need for “care” and incapacitation.

My second chapter will examine the role that this subject identity plays in strengthening and expanding carceral systems. Through a framework of carceral humanism and carceral ableism – two concepts that shed light on carceral actors’ construction of racialized, gendered, and pathologized individuals as vulnerable, invulnerable, or both in an effort to legitimize their position in the state as caretakers – I argue that the mentally ill, incarcerated subject serves important political and economic functions for DC DOC (Kilgore; Ben-Moshe, Decarcerating 17; Rodriguez et al.). I posit that this subject identity fuels depictions of the Department as DC’s “largest single-location mental health care provider,” which, in turn, legitimize its financial expansion in the form of mental health initiatives and strengthen its credibility as a service provider in an increasingly anti-carceral political context (District of Columbia, Council, Committee on the Judiciary & Public Safety [2018] 1:34:29-1:34:31; Performance Oversight Responses [2021] 40; Mental Health Step-Down Unit).

My third chapter focuses on the impact that the subject identity of the mentally ill, incarcerated individual has on incarcerated people constructed as such. Through Foucault,
Ben-Moshe, and disability studies and abolitionist scholars’ analyses of the shared role of psychiatric services and carceral punishment in the carceral state, I situate mental health services in jails and prisons as unique loci of power in the latter (Foucault, *Discipline*; Ben-Moshe, *Decarcerating*; Schenwar and Law; Tremain). I argue that, operating on compounded psychiatric and correctional goals of incapacitation and normalization and, thus, on doubly-carceral aims, these services extend a distinctive form of carceral control over mentally ill, incarcerated individuals that non-mentally-ill, incarcerated individuals and non-incarcerated, mentally ill individuals do not experience. I therefore show that, rather than caring for incarcerated individuals, increasing mental health initiatives in jails and prisons extend carceral control over this group in explicitly-restrictive and seemingly-therapeutic ways.

My hope with this thesis is to problematize uncritical demands for the further development of mental health screening and treatment services in jails and prisons and to shed light on the harm that they inflict on incarcerated people. Framing these services as tools of carceral expansion and violence, I wish to center and begin conversations on alternative, humanizing ways to support people on the inside as abolitionist movements work toward the decarceration of all people. As this thesis will show, jails and prisons are fundamentally dehumanizing, violent, and disabling spaces that have a profound impact on individuals' physical and mental health (Terwiel; Ben-Moshe, *Decarcerating* 147-151). Abolitionists on the outside thus have a responsibility to work with incarcerated people to meet their immediate needs, but we must do so critically and, most importantly, following the lead of those most impacted by carceral violence (Ben-Moshe, *Decarcerating*; Piepzna-Samarasinha; “Our Framework”). My conclusion offers a starting point for these efforts. I examine healing justice frameworks that center the dismantlement of oppressive systems in discussions of emotional and physical
well-being and their implementation inside and outside of the carceral setting (“What Is Healing Justice?”). I will also consider efforts to develop anti-racist and anti-ableist psychiatric services for individuals who wish to incorporate medical approaches in their healing practices. In short, my thesis ends with the question: how can we support incarcerated people in life-affirming ways that do not lead to their further dehumanization and confinement?
Chapter 1 – The “New Asylum” and Its Patients: Constructing Mentally Ill, Incarcerated Subjects in DC’s Jails

Medical and mental health services have had a tumultuous history at DC’s Central Detention Facility (CDF) and Central Treatment Facility (CTF). As discussed in the introduction, the DC Department of Corrections (DC DOC) faced decades of lawsuits, court supervision, and, eventually, a receivership for its failure to provide sufficient healthcare services to incarcerated individuals (Smith; District of Columbia, District Court [1995]). Following national conversations on the overrepresentation of individuals with mental health diagnoses in the criminal legal system, prisoners’ rights and mental health advocates mobilized to improve DC DOC’s mental health services in the early 2000s (Criminal Justice/ Mental Health Consensus Project; From the Inside Out; Gordon). DC-based advocates called on the Department to address “the substantial numbers of people with mental illness in the justice system,” describing this group as a population that “recycles from the jail to the streets and back again on a regular basis” due to insufficient mental health service inside and outside of DC’s carceral facilities (Gordon 1-2). Beginning with its 2006 contract with Unity Health Care, the Department has since implemented an increasing number of mental health initiatives at the CTF and CDF, now self-identifying as DC’s “largest single-location mental health care provider” (District of Columbia, Council, Committee on the Judiciary & Public Safety [2018] 1:34:29-1:34:31).

Advocates and state actors’ rhetoric surrounding DC DOC’s insufficient mental health services in the early 2000s echoed key logics of the “new asylum” thesis. Prominent advocacy groups, such as DC’s Council for Court Excellence (CCE) and DC’s Prisoners’ Legal Services Project (the Project), informed by national efforts, portrayed incarcerated individuals as uniquely
vulnerable to mental and physical pathologies, housing insecurity, and insufficient health care services, situating the CDF and CTF as key actors in a public health crisis that extended beyond the jails (From the Inside Out; Gordon; Criminal Justice/ Mental Health Consensus Project). Importantly, these approaches illustrate advocates’ and state actors’ implicit associations between mental illness, housing insecurity, and incarceration – and, thus, their adoption of the “new asylum” thesis – as they depicted pathologized incarcerated individuals as a subsect of the “homeless mentally ill” who faced incarceration as a result of their lack of access to mental health care services and shelter (Ben-Moshe, Decarcerating 33; Gordon 2; From the Inside Out). For example, in a 2005 DC Council Hearing, the CCE’s Steven D. Gordon argued that the CDF and CTF’s failure to connect mentally ill, incarcerated individuals to community-based services upon their release led “some released mentally ill offenders [to] become homeless,” which, in turn, rendered them especially vulnerable to reincarceration (Gordon 2). To justify this latter point, Gordon suggested that housing insecurity complicates individuals’ ability to comply both with their medication, which leads to individuals “self-medicating with street drugs,” and with the conditions of their release, thereby contributing to “an increase in the criminalization of the mentally ill” (Gordon 2-3). The DC DOC mental health services that resulted from such advocacy, then, provide an important locus of analysis for the “new asylum” thesis’ manifestations and repercussions inside jails and prisons.

These reforms began to take shape at the CDF and CTF in the early 2000s. DC DOC contracted its medical and mental health services to Unity Health Care in 2006, a contract that persists to this day with recently upgraded evidence-based, trauma-informed care and behavioral health services (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”; “Unity Health Care”). The facilities now administer mental health screenings to all
incarcerated individuals at intake, leading to individuals’ placement in the men’s or women’s acute mental health units or the general population (*Performance Oversight Responses* [2021] 178; *District of Columbia Department of Corrections 2018 Inspection Report* 8,11). In April 2016, in response to efforts by incarcerated individuals and their advocates, DC DOC opened a Men’s Mental Health Step-Down Unit (MHSUD) for individuals transitioning between the jail’s acute mental health unit and general population housing (*Performance Oversight Hearing Questions and Answers* “OBJECTIVE 2: Maintain/Improve Inmate Physical and Mental Health”; District of Columbia, Council, Committee on the Judiciary & Public Safety [2014] 02:56:24-02:57:17). DC DOC advanced a similar effort for incarcerated women at the CTF in August of 2021, developing a Women’s Wellness Unit providing a continuum of behavioral health services for women with mental health and substance use issues (*Performance Oversight Responses* [2022] “Please Provide an Update on the Specialized Step-Down Unit at CDF”). DC DOC also provides incarcerated individuals with mental health diagnoses with thorough discharge planning. Unity begins release planning at intake, working alongside liaisons from the DC Department of Behavioral Health (DBH) to connect returning citizens to a primary healthcare and a mental healthcare provider (*Performance Oversight Responses* [2021] 180).

My aim in this chapter is to examine these rising mental health services at the CDF and CTF not as mere responses to incarcerated individuals’ existing, matter-of-fact pathologies, but as key tools in this group’s pathologization. Specifically, I document their construction of the unique subject identity of the mentally ill, incarcerated subject. In an effort to trace the impact that the “new asylum” thesis had and continues to have on incarcerated individuals, I will examine key DC DOC mental health initiatives. I argue that these mental health services extend the “new asylum” thesis’ pathologization of houseless and criminalized populations to the
carceral setting, constructing incarcerated individuals as mentally ill subjects. Moreover, as unique sites of intersecting psychiatric and carceral knowledge (Galanek), DC DOC mental health services produce a distinct subject identity: the mentally ill, incarcerated subject. I posit that this subject identity fundamentally differs from that of the non-incarcerated, “homeless mentally ill” and the incarcerated, non-mentally-ill subjects, subjecting mentally ill, incarcerated individuals to uniquely-compounded systems of criminal legal and psychiatric knowledge. I specifically argue that claims of this group’s unique dangerousness and vulnerability construct them as especially vulnerable to carceral control in the form of incapacitation and “care.”

Theoretical Framework

Foucault and Subject Formation

As this thesis’ introduction establishes, disciplinary and biopolitical power systems rely on processes of subject formation to abandon, commodify, surveil, and control large sectors of the population. In this section, I will outline specific processes of subject formation that contribute to the construction of “disabled” and “mentally ill” subjects, including mental health screenings and treatment programs. My aim is to develop a theoretical framework on subject formation through which to analyze the CDF’s and CTF’s mental health services and their construction of the mentally ill, incarcerated subject as a unique subject identity. I will first provide a broad overview of such processes and, second, position them in a context of disability.

Foucault identifies three modes of subject formation that will be central to my analysis of the mentally ill, incarcerated subject: 1) that which produces the subject as an object of knowledge in the so-called sciences – including biology, philology, etc., 2) that which occurs through “dividing practices” that divide the subject from others into categories like “the mad and
the sane” and “the sick and the healthy,” and 3) that which occurs within the individual themselves (Foucault, “Afterword” 208). These processes clearly overlap, as the study of subjects in fields of knowledge often occurs through dividing practices that construct certain individuals in juxtaposition to others, and as individuals often come to self-identify with their assigned subject identities. For the purposes of this thesis, which, outside of a limited number of testimonies before the DC Council, does not include incarcerated individuals’ first-person accounts of their experiences with the CDF’s and CTF’s mental health services, I will largely focus on the first two processes outlined above; however, one need only think of individuals’ acceptance of medical diagnoses and self-identification as mentally ill to understand the crucial role that this third process plays in subject formation.

Constructing the Disabled Subject

The concept of disability plays a fundamental role in neoliberal and carceral systems’ differential construction of subjects. Unsurprisingly, then, medical and political differentiations between abled and disabled and sane and insane individuals uniquely exemplify processes of subject formation and their exertion of power over individuals through constructed subjectivities. I will now consider the role that medical screening and treatment programs play in constructing the disabled subject, which will inform my later analysis of such processes at the CTF and CDF.

In their piece, “Breaking the Boundaries of the Broken Body,” Margrit Shildrick and Janet Price examine the role that medical screenings play in constructing disabled bodies (Shildrick and Price 93). The authors analyze a Myalgic Encephalomyelitis (ME) screening that individuals applying for Disability Living Allowance (DLA) – a form of disability benefits in the UK – have to complete (Shildrick and Price 102). Shildrick and Price specifically consider ME
because, as an illness characterized by changing symptoms and treatments, it serves as a useful example of the arbitrary nature of rigid constructions of disability (Shildrick and Price 94). In their analysis, the authors argue that medical screenings construct respondents’ bodies as disabled, assigning meaning to their behaviors through established medical norms, while, in turn, “multiplying the norms of function/dysfunction” through their assessment (Shildrick and Price 100). This process is clear in that the questionnaire exerts a field of “total visibility” onto respondents, inquiring about their cooking, washing, dressing, and toilet needs, and measuring their responses against rigid definitions of disability in order to categorize respondents as able-bodied or disabled (Shildrick and Price 102). Through these questions, medical screenings not only construct individuals based on fabricated norms and categorizations but also refine notions of what it means to be disabled – for example, establishing and reinforcing normative associations between one’s inability to cook and one’s status as a disabled subject (Shildrick and Price 94).

Importantly, Shildrick and Price point to the role that respondents play in their own construction as disabled subjects in need of government assistance. The questionnaire tasks individuals with scrutinizing their body, reporting “in intricate detail its failure to meet standards of normalcy,” and requires them to construct themselves as disabled subjects in order to receive government benefits (Shildrick and Price 100). Therefore, Shildrick and Price showcase the questionnaire’s employments of all three of Foucault’s modes of subject formation, as it 1) relies on medical constructions of the body and bodily functions as abled or disabled to assign meaning to individuals’ behaviors, 2) assigns individuals to distinct categorizations – namely, that of the disabled individual who is eligible for government assistance and that of the able individual who
is not – based on this normative knowledge, and 3) forces individuals answering its questions to identify with its definitions of disability in order to receive disability benefits.

Medical facilities themselves serve as important sites of subject formation. In “Subjected Bodies: Paraplegia, Rehabilitation, and the Politics of Movement,” included in Tremain’s *Foucault and the Government of Disability*, Martin Sullivan explores the creation of “the paraplegic body-subject” at a rehabilitation facility for individuals with spinal cord injuries (Sullivan 27). According to Sullivan, this facility subjects individuals to “medical (and rehabilitative) discourse on paraplegia that maintains the person as a particular subject, one who knows and experiences its body in a highly medicalized way, and for whom the possible ways to be a subject constrained by the disciplinary techniques that knowledge imposes” (Sullivan 30). He shows that the facility’s medical staff strip newly-admitted individuals of knowledge of and control over their bodies, forcing a homogenous understanding of paraplegic bodies and their abilities onto them (Sullivan 31). For example, Sullivan describes medical professionals’ enforcement of universal bowel and bladder programs and skin checks on hospitalized individuals and their simultaneous rejection of the latter’s individual experiences and reactions to such programs as “body practices” aimed at the creation of a “homogenized, paraplegic population” (Sullivan 32, 35, 38). He therefore shows that individuals’ physical deviance – in this case, their experience of a spinal injury – leads to their subjection to established medical fields of knowledge that distinguish them from able-bodied individuals and, through standardized medical practices, further construct them as a homogenous, distinct population with limited sets of actions (Sullivan 27). Like the questionnaire discussed by Shildrick and Price, these practices clearly highlight the three modes of subjectification discussed by Foucault, as
they operate on medical constructions of the paraplegic body to assign meaning to individuals’ bodies and limit their individuality and range of possible actions.

Scott Yates examines processes of subject formation in community care facilities for individuals with learning difficulties (Yates 72). According to Yates, these individuals’ categorization as people with learning difficulties renders them vulnerable to “institutional interventions, judgments, decisions, prohibitions, imperatives, and sanctions around their lives and their conducts” that construct them “as punishable beings” occupying a distinct, inferior position to staff members in these facilities (Yates 73). Therefore, similarly to the rehabilitative facility in Sullivan’s piece, community care facilities strip pathologized individuals of control over their bodies and subject them to normative medical knowledge based on the facilities’ ability and, thus, on their acceptable range of action based on their constructed deviance. For example, Yates’ interviews reveal that individuals are not allowed out to cook for themselves or leave the facility to shop and that they need to ask for permission in order to throw away their own garbage and decorate their rooms (Yates 72-73). Such restrictions point to constructed medical associations between one’s mental deviance and one’s inability to care for themselves that pathologized individuals are made to comply with. Further, hierarchies between staff and individuals with learning difficulties significantly restrict the latter’s behavior – as one individual in Yates’ interview put it, people at the facilities are expected to be quiet and “just take what they give you, and not say no” (Yates 72). This latter point exemplifies the productive nature of subject formation as a form of power, as individuals’ construction as “punishable beings” subject to medical knowledge leads them to restrict their own behavior, rendering more explicitly-punitive forms of control unnecessary (Yates 73).
Chris Drinkwater’s “Supported Living and the Production of Individuals,” adds to Yates’ analysis by examining power dynamics in supported-living facilities for pathologized individuals. Drinkwater specifically analyzes the role that “social role valorization” (SVR), a form of treatment that works “to bring about valued lifestyles for people who have been traditionally devalued,” plays in supported-living facilities (Drinkwater 233). He argues that such programs force pathologized individuals to abandon their individuality, reducing their “[a]spirations, dreams, plans [...] to the desire to be assimilated into the social body” and stigmatizing deviant behaviors that do not align with this goal (Drinkwater 233). After denying pathologized individuals their individuality, thus marginalizing their individual needs and desires, SVR subjects them to normative notions of acceptable, “[v]alued behaviors,” thereby constructing them into a homogenous, normalized population that can be successfully reintegrated into society (Drinkwater 233-234).

Sullivan, Yates, and Drinkwater’s works thus show that medical and psychiatric treatments play a fundamental role in constructing individuals as distinct subjects with assigned actions and restraints based on their perceived mental or physical deviance. In conjunction with Shildrick and Price’s work, then, these analyses suggest that medical screenings measure individuals against established medical and psychiatric norms to construct them as deviant, pathological subjects – constructions that, in turn, justify individuals’ medical or psychiatric treatment and, thus, further subjectification inside medical facilities.

Of special relevance to this thesis, some scholars have analyzed jail-and-prison-based mental health services as unique sites of pathologization at the intersection of criminal legal and psychiatric discourses. For example, Joseph D. Galanek examines “prison mental health” as “a particular local form of psychiatric knowledge” (Galanek 195). Galanek points to the
hyper-contextual nature of mental health assessments in the carceral setting, which must consider incarcerated individuals’ disproportionate experiences with trauma, housing insecurity, and sexual abuse, the prevalence of people who use drugs in jails and prisons, and the impact of the prison context on incarcerated individuals’ well-being (Galanek 207, 209, 213). Notably, he argues that carceral facilities’ “safety and security” aims exert significant influence on these facilities’ mental health assessments, “constituting aberrant behavior as psychiatric disorder [...] [and, thus,] identifying inmates as in need of treatment and minimizing risks to the orderly operation of the institution” (Galanek 218-218).

To this latter point, Lorna A. Rhodes analyzes the construction of pathologized identities along discourses of treatment and confinement in jails and prisons (Rhodes, “Taxonomic”; Rhodes, “Psychopathy”). She specifically examines jails’ and prisons’ reliance on distinctions between Axis I pathologies, or diagnoses of “major mental illness,” and Axis II pathologies, or diagnoses of “character disorders,” to determine incarcerated individuals’ need for treatment or incapacitation (Rhodes, “Taxonomic” 346-347). Shaped within neat distinctions between “custody and treatment” functions in the jail and prison context, the former pathologies infantilize incarcerated people, undermine their rationality and, thus, culpability in relation to their crimes, and construct them as requiring protection (Rhodes, “Taxonomic” 348, 357-358). The latter, or Axis II, pathologies, on the other hand, construct individuals as incorrigible members of the incarcerated population whose criminality is especially calculated and who require intensified confinement (Rhodes, “Taxonomic” 360-362). In a later piece, Rhodes expands on the role of Axis II pathologies in the carceral setting, examining the subject identity of the “psychopath” in supermax prisons. She argues that these already-exclusionary settings construct the “psychopath” as a “monstrous” and inhuman individual who requires “extreme
isolation” (Rhodes, “Psychopathy” 443-444). Galanek and Rhodes thus consider the interplay between constructions of pathology and the securitization aims that characterize carceral facilities, which will be central to my analysis of the CDF’s and CTF’s production of the mentally ill, incarcerated subject.

These theorists emphasize the role that fields of knowledge, as well as medical, psychiatric, and carceral practices that directly work with pathologized individuals, play in the construction of disability and disabled subjects. This chapter will situate mental health services at the DC jails in this framework to analyze the increasing medicalization of incarcerated populations at the CDF and CTF and these facilities’ production of a unique subject identity: the mentally ill, incarcerated subject. I argue that these services extend individuals’ pathologization as “homeless mentally ill” subjects to the carceral setting, subjecting them to psychiatric knowledge in the latter and, therefore, constructing them as mentally ill subjects. Expanding on Galanek’s analysis, I further posit that this group’s positionality as mentally ill, incarcerated individuals renders them vulnerable to uniquely-compounded psychiatric and criminal legal fields of knowledge that construct them as such (Galanek). Through an exploration of this subject identity’s divergence from constructions of mentally ill, non-incarcerated individuals, including the “homeless mentally ill,” and non-mentally-ill, incarcerated individuals, I thus show that mental health initiatives influenced by the “new asylum” thesis hold significant consequences for incarcerated individuals.

Subject Formation in DC’s Jails

My analysis will cover five principal programs at the CDF and CTF: DC DOC’s contract with Unity, mental health screenings, the men’s and women’s acute mental health units, the
mental health step-down unit, and DC DOC release planning procedures. In the forthcoming sections, I will briefly describe and contextualize each program in the theoretical framework outlined above to trace the construction of the mentally ill, incarcerated subject in DC’s jails.

*Unity Health Care Contract*

2006 marked a turning point for medical services at the CDF and CTF with the implementation of DC DOC’s contract with Unity. The contract went into effect on October 1, 2006, as part of a nationwide initiative to spread the “community-oriented model of inmate healthcare.” This model, first developed in Hampden County, MA in 1992, views incarcerated individuals “as temporarily displaced members of the community and utilizes community health centers as the critical link to care both in-and-out of jail.” In 2006, the Robert Wood Johnson Foundation invested $7.5 million in spreading the program beyond Hampden County and founded Community-Oriented Correctional Health Services (COCHS) to assist jails and prisons across the US in its implementation. DC DOC was the first beneficiary of this program, working alongside COCHS and Unity to bring the model to the CDF and CTF (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”).

I argue that the community-oriented health care model and Unity’s contract invite the medical and psychiatric fields to study and, thus, pathologize incarcerated populations in two principal ways. First, on a larger scale, these initiatives depict incarcerated individuals and incarceration as public health concerns, thereby applying medical solutions to larger social, political, and economic problems. The community-oriented health care model views jails and prisons as “reservoirs of physical and mental illness and of psychosocial problems,” calling for the greater collaboration of correctional and community-based health care services in an effort to
address public health concerns inside carceral facilities and in outside communities (Conklin et al. 1-2). Notably, early research on the model operates on a close association between incarcerated individuals’ status as a population that is “overwhelmingly poorer, less educated and more likely to be persons of color than the general population” and its supposed experience of disproportionate rates of illness (Conklin et al. ix, 14). Therefore, the model recognizes the structural issues that contribute to this group’s greater vulnerability to health conditions; however, it greatly individualizes these issues by proposing an exclusively-medical solution to them.

This pathologization of incarcerated individuals mirrors the construction of the “homeless mentally ill” outlined in previous sections, as both processes involve the individualization of social, political, and economic issues. Housing insecurity, poverty, criminalization, and incarceration are disabling in two important and distinct ways: 1) these conditions expose individuals to unsafe and unhealthy conditions that can lead them to experience physical and psychological challenges, and 2) as this thesis’ introduction has made clear, individuals’ membership to marginalized, deviant social groups renders them especially vulnerable to pathologization as a form of otherization and justified abandonment (Ben-Moshe, Decarcerating 137, 147; Stewart and Russell). For example, police interactions, arrests, and other forms of contact with the criminal legal system, as well as extended periods spent without shelter, can seriously impact individuals’ mental and physical health (McLeod et al.; Sugie and Turney; Ben-Moshe, Decarcerating 140). By attempting to address this physical and psychological trauma as a public health concern, rather than meaningfully acknowledging the role that neoliberal and carceral policies play in incarcerated individuals’ pathologization and abandonment, this model constructs this group’s reaction to structural issues as a medical
problem that requires the involvement of the medical and psychiatric fields, in the words of DC DOC, “aligning the goals of public safety and public health” (emphasis added; “Department of Corrections Institutes Community-Oriented Healthcare for Inmates”). As the next paragraph will explore, this solution further pathologizes incarcerated individuals.

Second, on an individualized scale, the community-oriented health care model and Unity’s contract depict jails and prisons as health care providers, subsequently constructing incarcerated individuals as medical patients. This dynamic is clear in the structure of the community-oriented health care model. The model’s five elements are: 1) “Early Detection and Assessment,” including physical health exams, mental health screenings, etc. to determine incarcerated individuals’ needs, 2) “Treatment,” 3) “Prevention,” consisting of education programs, immunizations, and tests to limit the spread of disease after individuals’ release, 4) “Health Education,” and 5) “Discharge Planning, Case Management and Continuity of Care,” which begins at intake and links incarcerated individuals to community-based services (Conklin et al. 24-27). The 2006 contract between DC DOC and Unity mirrored this model, tasking the health care provider with conducting thorough mental health screenings of all individuals entering the CDF and CTF – which, for instance, asked individuals about their mental health diagnosis and treatment history, any recent losses, and drug use history – prescribing individuals with psychotropic medication, providing treatment to individuals “with the most severe forms of mental illness,” and collaborating with DC’s Department of Mental Health on discharge planning for individuals in need of community-based treatment (“Award/Contract” 9, 15). Mental health services at the CDF and CTF have since evolved to more comprehensively follow the community-oriented health care model, as the next paragraph will show. This program’s implementation as a standard procedure at the CDF and CTF positions all individuals entering
the facilities, regardless of health status, as medical patients to be assessed, treated, educated, and, thus, returned to the community as healthy citizens. As the next sections will show, such procedures differentially construct incarcerated individuals, subjecting some – those constructed as mentally ill, incarcerated subjects – to further pathologization in the form of extensive mental health screenings and treatment.

DC DOC’s partnership with Unity underwent significant changes in April 2019, with the implementation of the DOC Inmate Comprehensive Medical Services contract (“Unity Health Care”). The new contract emphasizes the CDF’s and CTF’s use of evidence-based, trauma-informed care and expands mental health services provided at the facilities (“Unity Health Care”). In a 2019 document, DC DOC explained its motivations for the new contract:

Mindful that the DOC serves one of the largest mental health populations in the city and keenly aware of the role of trauma in our residents’ lives, compared to previous DOC healthcare contracts, the current healthcare contract has been innovatively written to serve the District’s needs by being more comprehensive regarding Mental Health Services (*Performance Oversight Responses* [2019] 146).

These new services, which are to be administered through a trauma-informed lens, include: “Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Cognitive Behavioral Social Skills Training for Schizophrenia, Moral Reconation Therapy, psychoeducation, social skills training and cognitive remediation.” The contract also requires Unity to provide incarcerated individuals with Narcotics Anonymous, Alcoholics Anonymous, Anger Management, and Trauma-Informed Care groups and connect with community organizations to organize “yoga and
mindfulness, art therapy, and music therapy groups” (Determinination and Findings for Price
Reasonableness 14-15). This contract enhances the 2006 contract’s construction of the CDF and
CTF as healthcare providers, placing a specific emphasis on the facilities’ provision of mental
health services. This emphasis adds to incarcerated people’s construction as medical patients,
specifically situating them as mentally ill subjects to be assessed and treated.

I have thus shown that the community-oriented health care model and the resulting 2006
contract between DC DOC and Unity extend the “new asylum” thesis to the carceral setting by
constructing incarceration and incarcerated individuals as public health concerns and situating
the latter as medical patients inside jails and prisons. Despite clear similarities between processes
of pathologization inside and outside of the carceral setting, I seek to explore the mentally ill,
incarcerated subject as a unique subject identity that is distinct from that of the non-incarcerated,
mentally ill subject and the non-mentally-ill, incarcerated subject. The community-oriented
health care model and DC DOC’s 2006 contract with Unity begin to shape these distinctions.

Despite advocates’ efforts to attribute this group’s incarceration to its members’
diagnosed mental health conditions, as opposed to intentionally-criminal behavior, the advocacy
surrounding the contract and the community-oriented health care model construct mentally ill,
incarcerated individuals as distinct from their counterparts who do not come into contact with the
criminal legal system due to their compounded housing insecurity and pathological criminality
(Criminal Justice/ Mental Health Consensus Project xii). Prisoners’ rights’ and mental health
advocates’ calls for increased mental health screening and treatment in DC’s jails largely
operated on constructed associations between mental illness, housing insecurity, and
incarceration and, thus, between houseless individuals’ mental illness and criminality. Claims
such as Steven D. Gordon’s before the DC Council, discussed in this chapter’s introduction,
portrayed mentally ill, incarcerated individuals as a unique sector of the mentally ill population that, due to insufficient health care services at the CDF, CTF, and in their respective communities, as well as their struggle with housing insecurity, continuously “recycles” from the facilities “to the streets” (Gordon 2). Such discourses thus construct mentally ill, incarcerated individuals as a uniquely problematic population that requires the joint attention of public safety and public health actors, thereby constructing this group as distinct from non-incarcerated, mentally ill individuals. “[A]lligning the goals of public safety and public health,” this distinction thereby situates mentally ill, incarcerated individuals as a population requiring greater supervision, incapacitation, and treatment compared to mentally ill individuals who do not come into contact with the criminal legal system because of their unique propensity to criminality (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”).

To this latter point, the mentally ill, incarcerated individual health care model differs from non-incarcerated, mentally ill individuals in their lack of agency. The model operates on the logic that “a tremendous public health opportunity exists within the penal system,” reflecting state actors’ greater access to mentally ill individuals in the carceral setting. Although this statement may be referring to incarcerated individuals’ lack of access to health care in their communities, due in part to this group’s demographics, its language also points to criminalized and incarcerated individuals’ lack of agency in the carceral setting, which renders them vulnerable to unwanted and unnecessary psychiatric treatment or correction (Conklin et al. ix). Constructions of this group’s pathology as a public safety concern and, thus, their criminalization, thereby call for and justify their greater incapacitation and forced correction.

Importantly, however, Gordon’s language towards this group is largely sympathetic, portraying its members as individuals who “need treatment,” as opposed to intentionally-violent
or criminal individuals (Gordon 2). Gordon’s portrayal of this group largely agrees with other early-2000s efforts depicting mentally ill, incarcerated subjects as unintentionally-criminal individuals who require treatment to prevent their constant re-incarceration (*Criminal Justice/Mental Health Consensus Project*). In this way, mentally ill, incarcerated individuals’ pathological criminality also situates them as requiring more immediate “care” than non-criminalized, mentally ill individuals. Therefore, the community-oriented health care model and DC DOC’s contract with Unity distinguish mentally ill, incarcerated individuals from their non-incarcerated counterparts by virtue of their innate criminality, which calls for their greater incapacitation and, at the same time, “care.”

Although less explicitly, the community-oriented health care model and the 2006 contract also construct mentally ill, incarcerated individuals as distinct from non-mentally ill, incarcerated individuals, granting carceral actors extended control over the latter. Interestingly, in a similar way to how this group’s subjection to a public safety lens distinguishes it from non-incarcerated, mentally ill individuals, its subjection to a public health lens distinguishes it from non-mentally-ill, incarcerated individuals. The community-oriented health care model and the 2006 contract envision this group, as well as all incarcerated individuals with physical pathologies, “as temporarily displaced members of the community” who require a continuum of care inside and outside carceral facilities (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”). This logic calls for this group’s screening, treatment, education, and thorough discharge planning, thus subjecting its members to heightened levels of supervision compared to their non-mentally ill counterparts on the basis of “care” provision (Conklin et al. 1-2). Further, state actors and advocates’ association between unaddressed pathologies and recidivism suggests their understanding of mentally ill, incarcerated
individuals as more likely to “re-offend” than their non-mentally-ill, incarcerated counterparts, which suggests constructions of this group’s unique dangerousness even in the carceral context – a concept that future sections will explore at length.

The mentally ill, incarcerated subject thus stands as a distinct subject identity from the non-incarcerated, mentally ill individual and, as the next sections will further show, the non-mentally-ill, incarcerated individual. The points outlined above suggest that this distinction relies on constructed rhetoric of this group’s unique propensity to criminality, which justifies its members’ incapacitation through incarceration and normalization, and their simultaneous need for specialized care, which justifies their extended supervision and treatment. As the next sections and remaining chapters will explore in detail, this dual construction allows for psychiatric and carceral actors’ extended access to mentally ill, incarcerated individuals, compared to their mentally sane and non-incarcerated counterparts.

The Intake Process

The detection of illness at intake plays a central role in Unity’s community-oriented health care approach, which subjects all individuals entering the CDF and CTF to thorough mental health screenings. Health care professionals or “health/mental health trained personnel” are responsible for identifying the following behaviors among individuals entering the CDF and CTF: “1) General appearance (e.g., sweating, tremors, anxious, disheveled, mental status, conduct); 2) Behavior (e.g. disorderly, appropriate, insensible); 3) State of consciousness (e.g., alert, responsive, lethargic); 4) Current symptoms of psychosis, depression, anxiety, and/or aggression” (Medical Management 25). All incarcerated individuals also undergo a twenty-question mental health screening at the facilities’ Inmate Reception Center (IRC)
The screening, displayed in Figure 1 below, asks individuals about their psychiatric treatment history, suicidal ideation, recent experiences with loss and grief, whether they feel that “there is nothing to look forward to in the immediate future,” and other determined indicators of mental challenges. Importantly, some of the questions are directed at individuals’ records, as opposed to individuals themselves, including an inquiry on “Court, MPD [Metropolitan Police Department of the District of Columbia], U.S. Marshall Services or Transportation Officers” reports on individuals’ “mental health problem and suicide risk” and the presence of a suicide risk marker on individuals’ medical records (“Mental Health Screening”).

Figure 1: “Mental Health Screening.” District of Columbia Department of Corrections. [This document was obtained by the author through a Freedom of Information Act request submitted to the DC Department of Corrections in October of 2023].

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF CORRECTIONS

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**Mental Health Screening**

1. Is there an alert from Court, MPD, U.S. Marshall Services or Transportation Officers about a mental health problem or suicide risk?
2. Is there a suicide alert indicated in the electronic medical record?
3. Currently receiving mental health services in community?
4. Have you received mental health services in the past?
5. Are you coming from St. Elizabeth Hospital or a psychiatric facility?
6. Have you ever received treatment for alcohol or substance use?
7. Do you have any mental health issue that you would like to talk to the mental health staff about?
8. Do you hold a position of respect in the community and/or charged with crime of notoriety?
9. Are you now or have you ever been accused of committing a violent crime and/or sexual offense?
10. Have you ever been a victim of a physical or sexual act or abuse?
11. Is this your first DC incarceration?
12. Do you feel you will have difficulty adjusting to jail?
13. Do you feel there is nothing to look forward to in the immediate future?
14. Have you ever attempted or considered suicide?
15. Are you thinking of hurting or killing yourself?
16. Do you have a family member, close friend, or significant other that has attempted or committed suicide?
17. Is this person a juvenile?
18. Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
19. Have you ever received special education services?
20. Patient referred for a Comprehensive Mental Health Assessment due to a positive response to the screening questions?
Through these screenings, CDF and CTF staff flag certain individuals – including those at risk for suicide, those with mental health needs, individuals experiencing first-time incarceration, and those with high-profile cases – for further evaluation by a mental health professional within 24 hours (District of Columbia Department of Corrections 2018 Inspection Report 10; Determination and Findings for Price Reasonableness 16). A striking number of people at the CDF and CTF are identified as experiencing mental health issues. In the fiscal years of 2020 and 2021, up to December 30, 2020, the facilities detained an average of 1994 individuals each month, of which 1144 had a history of mental health diagnoses and 809 had active diagnoses (Performance Oversight Responses [2021] 178).

The CDF’s and CTF’s compulsory screenings of all individuals entering the facilities significantly contribute to this population’s construction as mentally ill, incarcerated subjects. As Shildrick and Price’s piece on disability benefit applications suggests, medical assessments play a fundamental role in processes of subject formation (Shildrick and Price 94). The authors identify the body “as the very locus of knowledge production,” through which medical and psychiatric screenings construct individuals as disabled subjects and, in turn, reinforce and produce widespread definitions of disability and mental illness (Shildrick and Price 99). The screenings outlined above clearly engage in these practices. First, similarly to the disability benefit screening that Shildrick and Price examine, these screenings place a field of “total visibility” on incarcerated people (Shildrick and Price 102). They subject individuals’ “[g]eneral appearance,” “[b]ehavior,” and “[s]tate of consciousness,” as well as their medical history, to the scrutiny of CTF and CDF staff and clinicians (Medical Management 25; Shildrick and Price 102). Importantly, DC DOC also collaborates with liaisons from the DC Department of Health (DBH) at intake to identify individuals receiving DBH services in the community, as “not all
residents may admit to MH [mental health] services” (Performance Oversight Responses [2022]
“61. Please Describe DOC’s Current Release and Reentry Planning Procedures Relating to
Residents with Mental or Behavioral Health Needs”). This latter point suggests these screenings’
invasive nature, as DC DOC staff actively work to obtain information on individuals’ psychiatric
treatment history that they themselves may wish to keep private.

Second, in their scrutinization of individuals’ behavior, history, and appearance, DC DOC
and Unity screenings operate on constructions of disability and mental illness to assign meaning
to the latter, thereby constructing individuals entering the facilities as mentally ill (Shildrick and
Price 104). For example, staff or clinicians at the CDF or CTF may flag an individual they
perceive as “lethargic” and unresponsive, or another they perceive as exhibiting a “disheveled”
appearance and “disorderly” behavior, for further assessment based on definitions of mental
illness that identify these behaviors as abnormal (Medical Management 25). Behaviors that, left
unscreened, may appear as normal reactions to individuals’ recent incarceration or experience of
housing insecurity, thus become pathological and, as later sections will show, subject individuals
to treatment programs and mental health housing units that further pathologize them.

This latter point suggests that these screenings medicalize political, economic, and social
issues in their pathologization of incarcerated people. According to Shildrick and Price, the
specificity and rigidity of disability screening inquiries, as well as their focus on individuals as
opposed to their surroundings, point to their understanding of disability as “fixed,”
“unchanging,” and innate to an individual (Shildrick and Price 102). This phenomenon is clear in
the CDF and CTF’s mental health screening, which not only overlooks important environmental
factors that could impact individuals’ psychological state, such as, for example, their housing
status, but also constructs natural responses to incarceration as pathological – consider, for
instance, the question “Do you feel you will have difficulty adjusting to jail?” (“Mental Health Screening”). Flagging an individual for further screening because they appear anxious, disheveled, or aggressive and exhibit “insensible” behavior directly after their arrest or trial and as they enter a carceral facility that is likely to subject them to poor living conditions and verbal or physical abuse clearly pathologizes a natural response to an extremely traumatic situation (Medical Management 25). This same logic applies to houseless individuals entering these facilities, which consisted of 22.37% of women and 15.94% of men at the CDF and CTF (DC Department of Corrections Facts and Figures 18, 21). As discussed in previous sections, housing insecurity holds serious physical and psychological consequences for individuals that mental health assessments reduce to individual pathology (Ben-Moshe, Decarcerating 141; Snow et al. 421).

Further, as Ben-Moshe’s analysis of racial criminal pathologization suggests, these screenings, as well as DC DOC officers’ and mental health clinicians’ assessments of incarcerated individuals, may render Black Americans more vulnerable to pathologization than their white counterparts. Ben-Moshe shows that processes of racial criminal pathologization depend on constructed associations between Blackness, abnormality, and, thus, mental illness, which, in turn, lead to associations between Blackness, pathological dangerousness, and, thus, criminality (Ben-Moshe, Decarcerating 25). The prominence of such associations, as exemplified by Ben-Moshe’s analysis of Mike Brown’s danger, sheds doubt on the objectivity of CDF and CTF’s clinicians and staff’s assessment of incarcerated individuals’ levels of “aggression,” “disheveled” appearance, and “disorderly” behavior (Medical Management 25). Clinical and criminal legal discourses of Black Americans, as well as other non-white,
non-cisheterosexual individuals, as innately abnormal thus inform perceptions of members of this group’s demeanor as also inherently pathological (Ben-Moshe, Decarcerating 78).

It is important to note, however, that, on a national level, white individuals in jails and prisons are more likely to receive mental health diagnoses than incarcerated people of color (Bronson and Berzofsky 4). This phenomenon may result from one of the two aspects of the mentally ill, incarcerated individual that the previous section discusses: their need for “care.” As Ben-Moshe’s analysis of Brown’s murder suggests, Black Americans’ pathology often leads to their construction as “animalistic[,] [...] crazy, pathological, abnormal,” which may preclude them from discourses of supposed needed “care” and, thus, impede their construction as mentally ill, incarcerated individuals. This situation is different in DC, however. Data on the racial demographics of individuals with mental health diagnoses at DC DOC is unavailable, but 90.23% of the Department’s residents are Black Americans and 4.97% are white, which suggests that a significant portion of individuals with mental health diagnoses at the DC jail are Black Americans (DC Department of Corrections Facts and Figures 17).

Even seemingly objective inquiries in these screenings, such as questions on individuals’ involvement with DC’s Department of Behavioral Health (DBH), greatly target houseless and low-income individuals of color entering the CTF and CDF. Houseless individuals and Black Americans’ pathologization, as well as the medicalization of housing insecurity as a public health concern, suggest that these populations are exposed to public mental health services at disproportionate rates (Snow et al. 420; Ben-Moshe 138-143). The Substance Abuse and Mental Health Services Administration (SAMHSA)’s 2020 Mental Health National Outcome Measures (NOMS) report shows that this is the case in DC. The report indicates that, during this year, 80.3% of DBH’s clients were Black, 1.2% were white, and 23.6% were houseless (District of
Columbia 2020 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System 3). For reference, DC’s population is 45.8% Black and 45.9% white, and, as of January 2020, 6,380 individuals (out of a total population of 689,545 in April 2020) in the District were experiencing houselessness (“Quick Facts: District of Columbia”; “District of Columbia Homelessness Statistics”). I specifically highlight Black Americans’ and houseless populations’ overrepresentation in DC’s public mental health services, as opposed to private mental health services, because of DC DOC’s collaboration with DC’s DBH in its detection of individuals with mental health diagnoses. As explained above, DC DOC closely works with DBH liaisons to identify individuals in need of mental health services at intake through the DBH database, as well as to connect returning citizens who have received DBH services in the past with the same services following their release (Performance Oversight Responses [2022] “61. Please Describe DOC’s Current Release and Reentry Planning Procedures Relating to Residents with Mental or Behavioral Health Needs”). Therefore, although, on a national level, white Americans are more likely to receive mental health services than Black Americans, the latter’s overrepresentation in public mental health services makes them more vulnerable to pathologization at the CDF and CTF (Racial/Ethnic Differences in Mental Health Service Use Among Adults 1).

Third, the CDF and CTF screenings’ categorization of incarcerated individuals dictates their trajectory within the facilities, thereby constructing them as distinct subjects with predetermined courses of treatment and service provision. DC DOC outlines four possible outcomes to these screenings: “1) referral to a staff psychiatrist for further evaluation; 2) referral for housing on the acute mental health unit based on acute care needs; 3) regularly scheduled individual or group counseling; and/or 4) prescriptions for required psychotropic or other
medications” (Performance Oversight Hearing Questions and Answers “23. Please Describe, in Detail, the Mental Health Services Offered to DOC inmates. What is the average monthly number of inmates that receives these services?”). Admitting to a history of hospitalization, for example, can mark an individual as mentally ill for the remainder of their incarceration, assigning them to screenings and treatment that individuals without this label do not experience. Next sections will explore the subject formation that occurs within various courses of treatment inside the facilities, which suggests that screenings play an important role in rendering incarcerated individuals vulnerable to further pathologization at the CDF and CTF. Importantly, however, the mere subdivision of individuals into different housing units and programs based on their diagnoses clearly restricts their individuality and agency and constructs them as mentally ill, incarcerated subjects who are distinct from their non-mentally-ill, incarcerated counterparts.

This latter point suggests the role that the CDF and CTF’s mental health screenings play in constructing mentally ill, incarcerated subjects as distinct from non-mentally-ill, incarcerated individuals. Expanding on Galanek and Rhodes’ analyses, I argue that, motivated by carceral aims of securitization, such screenings work to distinguish between mentally ill, incarcerated individuals and non-mentally-ill, incarcerated individuals, painting the former as a danger to the latter that must be contained and normalized before their reintegration into the jail’s general population (Galanek 218-219; Rhodes, “Taxonomic”). I further suggest that this focus on securitization also constructs mentally ill, incarcerated individuals as distinct from non-incarcerated, mentally ill individuals.

DC DOC’s screenings serve two primary purposes: that of identifying appropriate housing placements for mentally ill, incarcerated individuals and that of providing this group with thorough discharge planning that begins at intake (Performance Oversight Responses...
According to the Department, “[i]t’s of paramount importance that DOC have inmates’ mental health reviewed prior to housing in order to minimize the risk of acute decompensation due to suicidality, the impact of illicit drugs or the often seen fact of residents not being on their usual psychiatric medications at the time of intake” (Performance Oversight Responses [2021] 178). The term “decompensation,” in this context, seems to refer to the threat that mentally ill, incarcerated individuals pose to themselves, as suggested by the Department’s mention of their potential suicidality, and others. This latter point is clear in the stated purpose of DC DOC’s mental health units, which, as the next sections will explore in detail, work towards ensuring the “stabilization” of mentally ill, incarcerated individuals’ conditions and reintegrating them into the CDF and CTF’s general population and, eventually, their communities (Performance Oversight Responses [2021] 178; Mental Health Step-Down Unit 2). This language thus points to mentally ill, incarcerated individuals’ depiction as unstable and potentially dangerous to non-mentally-ill, incarcerated individuals if allowed to live in the general population and, thus, as requiring additional incapacitation compared to other incarcerated individuals. At the same time, stated concerns over mentally ill, incarcerated individuals’ ability to “function” in the CDF’s general population suggest this group’s portrayal as one requiring enhanced levels of “care” and support compared to their non-mentally-ill, incarcerated counterparts.

The Department’s emphasis on these screenings’ role in ensuring mentally ill, incarcerated individuals’ thorough, mental-health-focused discharge planning also reflects rhetorics of this group’s necessary extended care and incapacitation. As the previous section on DC DOC’s 2006 contract with Unity Health Care made clear, efforts to successfully re-integrate mentally ill, incarcerated individuals into their community hold clear public safety aims that
operate on constructed associations between these individuals’ pathologies and their supposed dangerousness (Conklin et al. ix). Associations between this group’s mental health diagnoses and their propensity to re-arrest suggest their construction as a more unstable and risky sector of the incarcerated population that requires more hands-on re-entry supervision than their non-mentally-ill counterparts. Calls for this extended supervision also originate from efforts to ensure mentally ill, incarcerated individuals “continued care” upon their release, thus exemplifying this group’s constructed enhanced vulnerability and need for “care” in contradistinction with non-mentally-ill, incarcerated individuals (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”).

As I have suggested above, due to their position at the intersection of psychiatric and criminal legal fields of knowledge, the CDF’s and CTF’s mental health screenings construct mentally ill, incarcerated subjects that fundamentally differ from non-mentally-ill, incarcerated subjects. As my analysis of the community-oriented health care model began to show, criminal legal and psychiatric discourses’ association of this group’s pathology to innate criminality exposes them to public safety aims that, based on this criminality, justify their subjection to involuntary and unnecessary incapacitation and correction. This justification partially relies on notions of criminality that legitimize state actors’ denial of individuals’ agency and humanity, thereby creating a firm distinction between non-incarcerated and incarcerated, mentally ill individuals that depends on the latter’s inherent dangerousness and lack of agency (Guenther; Terwiel). Aims of further supervision and incapacitation on the basis of one’s pathological dangerousness and one’s lack of agency as a criminalized, incarcerated individual are clearly at the center of DC DOC’s mental health screenings. As next sections will show, based on these constructions, individuals pathologized through such screenings are automatically confined in
separate sections of the facilities and subjected to psychiatric treatment and constant mental health assessments. I have thus far suggested that this group’s distinction from non-incarcerated, mentally ill individuals and non-mentally-ill, incarcerated individuals subjects them to increased “care,” supervision, and incapacitation – which, chapter three will suggest, render this group especially vulnerable to psychiatric and carceral violence.

Mental Health Units

I. Acute Mental Health Units

The CDF and CTF’s acute mental health units serve as housing placements for individuals with pressing mental health concerns. Officers and mental health professionals can place individuals in these units at intake or at any point during their incarceration, often following a mental health crisis (D.C. Department of Corrections: Correctional Treatment Facility & Central Detention Facility Inspection Report FY 2017 32). The CDF’s Acute Mental Health Unit, which has an 80-person capacity, typically houses individuals who “are a threat to themselves, or do not take their medication,” who “medical staff has determined need to be on suicide watch or precaution,” or who are “not able to function with the assistance of medication” (District of Columbia Department of Corrections 2018 Inspection Report 11; D.C. Department of Corrections: Correctional Treatment Facility & Central Detention Facility Inspection Report FY 2017 32). As of 2018, the unit’s staff consisted of a 24/7 on-call nurse, a 24/7 on-call psychiatric nurse, a psychologist, a clinician, a case manager, and corrections officers (District of Columbia Department of Corrections 2018 Inspection Report 11). Individuals on this unit experience significant restrictions compared to individuals living in the CTF’s and CDF’s general populations, including extremely limited out-of-cell time (ranging from two to five hours),
constant exposure to light, and increased supervision by DC DOC correctional and clinical staff (Mental Health Step-Down Unit 11). The CTF has a Women’s Mental Health Unit, with a fifty-person capacity, for individuals “who have acute mental health needs, a special housing status, or women completing the intake process” (District of Columbia Department of Corrections 2018 Inspection Report 8). For the purposes of this section, due to limited available information on the women’s unit, I will primarily focus my analysis on the CDF’s Acute Mental Health Unit.

The theoretical framework outlined in this chapter shows that mental health screenings and treatment facilities play a fundamental role in constructing disabled subjects (Shildrick and Price; Yates; Sullivan; Drinkwater). As a pseudo-medical facility inside a jail – I use this term to distinguish this unit from medical facilities outside jails and prisons and, thus, emphasize its uniquely carceral elements – the Acute Mental Health Unit displays similar processes of pathologization to the facilities discussed in Yates, Sullivan, and Drinkwater’s works. Importantly, however, as Galanek and Rhodes’ works suggest, due to its position in the carceral setting, this unit adopts distinct functions from psychiatric services outside of jails and prisons. In this section, I show that the unit’s unique position at the intersection of criminal legal and psychiatric fields of knowledge leads it to engage in unique processes of subject formation, thus producing the mentally ill, incarcerated subject as a distinct subject identity from the non-incarcerated, mentally ill subject and the non-mentally-ill, incarcerated subject.

I will first consider the Acute Mental Health Unit’s construction of mentally ill, incarcerated subjects as especially dangerous individuals who require increased monitoring and incapacitation. As the previous section has suggested, the existence of mental health units at the CDF and CTF in itself is predicated on this supposed dangerousness, as their purpose is that of
stabilizing individuals who are prone to “decompensation” in the facilities’ general population settings (Performance Oversight Responses [2021] 178). The structure and procedures of the unit clearly reflect this focus on incapacitating and stabilizing mentally ill, incarcerated individuals before their return to the general population. The unit is separated into an intake and a general population side. Individuals first arriving at the unit are housed on the intake side for an average of two weeks to one month, during which they are only allowed out of their cells for two hours a day. Lights on the intake side are on 24/7 “so that officers are able to see into the cells at all times” (District of Columbia Department of Corrections 2018 Inspection Report 11). This group receives daily assessments to determine their eligibility for transfer to the general population side, which occurs when individuals “are deemed to be stable” and “able to function with the assistance of medication” (D.C. Department of Corrections: Correctional Treatment Facility & Central Detention Facility Inspection Report FY 2017 32). Those on the general population side can spend five hours out of their cells every day, have more opportunities to interact with other people on the unit, and are able to access programming, including yoga or art. Importantly, the unit also holds a number of “safe cells” for individuals at risk of suicide that deprive incarcerated people of basic necessities – including mattresses and running water – and subject them to inhumane living conditions (District of Columbia Department of Corrections 2018 Inspection Report 11, 17; Ryals).

As Sullivan, Yates, and Drinkwater suggest, subject formation inside medical facilities occurs as individuals’ diagnoses subject them to standardized treatment services that strip them of their individuality and construct them into distinct subject identities consistent with their diagnoses (Sullivan; Yates; Drinkwater). Individuals’ identification as mentally ill, incarcerated subjects justifies their heightened incapacitation in the CDF’s Acute Mental Health Unit, which,
in turn, further constructs them as such. One’s mere placement in the unit depicts one as having “acute mental health needs,” as dysfunctional, as “a threat to themselves” – according to the standard requirements for one’s admission to the unit – and, thus, as requiring enhanced confinement and supervision (District of Columbia Department of Corrections 2018 Inspection Report 8, 11). Once in the unit, individuals’ subdivision into distinct groups based on their stability further constructs them as unstable, mentally ill, incarcerated subjects who must be separated from the rest of the jail population and only re-integrated following their progressive stabilization. This process is clear in that individuals’ identification as especially unstable, mentally ill, incarcerated subjects who require confinement in the unit’s acute side results in their deprivation of basic “privileges” – including necessary out-of-cell time and periods of time without light – that they can only gain or regain by presenting as stable (District of Columbia Department of Corrections 2018 Inspection Report 11). This policy strengthens associations between mental illness in the carceral setting and necessary incapacitation, justifying mentally ill, incarcerated individuals’ inhumane confinement until they can adapt to behaviors associated with non-mentally-ill, incarcerated individuals. Importantly, internal divisions in the Acute Mental Health Unit fabricate distinctions between mentally ill, incarcerated individuals – that of the stable and unstable mentally ill, incarcerated subject – which merely strengthen distinctions between both categorizations and the jail population at large.

Now, I will consider this unit’s construction of mentally ill, incarcerated individuals as an especially vulnerable group within the jail population that requires protection and care. Importantly, discourses of care for pathologized individuals in the carceral setting also largely revolve around discourses of securitization, as language surrounding the unit emphasizes its role in stabilizing individuals “who are a threat to themselves” (District of Columbia Department of
Corrections 2018 Inspection Report 11). As chapter two will discuss in detail, depictions of pathologized individuals as requiring protection from themselves, which contribute to mentally ill, incarcerated individuals’ construction as vulnerable/invulnerable subjects, are common in carceral justifications for this group’s increased supervision and control (Rodriguez et al. 540). In fact, such claims justify the constant supervision of individuals in the CDF’s Acute Mental Health Unit by DC DOC staff and clinicians. For example, cell lights on the unit’s intake section are on all day every day of the week “so that the officers are able to see into the cells at all times,” officers walk through the unit every 15 minutes, and nurses make rounds every two hours (District of Columbia Department of Corrections 2018 Inspection Report 11). Further, depending on their placement within the unit, individuals undergo daily mental health assessments, weekly meetings with their multidisciplinary treatment team, and monthly meetings with their psychiatrist – which I will also discuss below in an analysis of the Acute Mental Health Unit’s role in further pathologizing mentally ill, incarcerated individuals as mentally ill (District of Columbia Department of Corrections 2018 Inspection Report 8, 11; Performance Oversight Responses [2021] 178). As a more extreme example, safe cells also subject incarcerated individuals to constant supervision and inhumane conditions, including the lack of mattresses and running water, in a stated effort to protect these individuals from themselves (District of Columbia Department of Corrections 2018 Inspection Report 17; Ryals). As constructed in the CDF’s Acute Mental Health Unit, the mentally ill, incarcerated individual is one that, due to their instability and to the threat that they pose to themselves and others, requires extensive supervision and enhanced confinement.

As a pseudo-medical facility, the CDF’s Acute Mental Health Unit also engages in processes of pathologization that more closely resemble those analyzed by Yates, Sullivan, and
Drinkwater (Yates; Sullivan; Drinkwater). As suggested in previous paragraphs, part of mentally ill, incarcerated individuals’ distinction from non-mentally-ill, incarcerated individuals lies in their construction as vulnerable subjects in need of psychiatric counseling, medication, and support in order to “function” in the carceral setting (D.C. Department of Corrections: Correctional Treatment Facility & Central Detention Facility Inspection Report FY 2017 32). Therefore, this distinction relies on this group’s continuous pathologization within the CDF’s Acute Mental Health Unit. This pathologization largely results from the unit’s screening of individuals and its prescription of standardized treatment plans to individuals based on their diagnosis. On the CDF’s Acute Mental Health Unit, such screenings include daily assessments to determine one’s eligibility for the unit’s general population side (reserved for individuals on the unit’s intake side) and regular meetings with a multidisciplinary Treatment Team that assesses their needs and follows up on their treatment (District of Columbia Department of Corrections 2018 Inspection Report 11; Performance Oversight Responses [2021] 178). At the CTF’s Women’s Mental Health Unit, individuals on medication meet with the facility’s psychiatrist once a month, and all women on the unit meet with their treatment team once a week, which “determines if women are stable on their medication, and can be transferred to a general population unit” (District of Columbia Department of Corrections 2018 Inspection Report 8).

It is important to note that assessments of “stability” inside a carceral facility are inherently prone to pathologize and, thus, individualize one’s normal reactions to one’s environment and structural issues within it. In her discussion of the disabling impact that houselessness has on individuals, Ben-Moshe argues that “[o]ne needs to call into question the assumption that there is anything normal about being housing insecure in such an affluent society” (Ben-Moshe, Decarcerating 141). This same logic applies to the disproportionate
incarceration of low-income, Black Americans in the nation’s capital. DC has one of the highest rates of incarceration in the country, with 90.38% of the jail population identifying as Black American, compared to 45% of individuals in DC’s population at large (Herring; DC Department of Corrections Facts and Figures 17). This absurdity is compounded by the conditions of incarceration, which, as discussed in previous sections, are disabling in themselves. Conditions in the CDF and CTF’s acute mental health units are especially restrictive, rendering the facilities’ staff and mental health professionals’ expectations for incarcerated individuals’ “stability” all the more unreasonable. The Acute Mental Health Unit’s constant assessment of incarcerated individuals’ stability thus renders this group’s normal reaction to an inhumane environment vulnerable to pathologization, thereby further contributing to their construction as incarcerated individuals requiring more extensive “care” and psychiatric treatment.

II. Men’s Mental Health Step-Down Unit

DC DOC’s opening of a men’s Mental Health Step-Down Unit (MHSDU) was received as a success by prisoners’ rights advocates, mental health advocates, and incarcerated individuals in DC. The unit offers incarcerated individuals with mental health needs a less restrictive housing environment and more thorough programming, allowing for their transition into the jail’s general population or the community upon discharge (Performance Oversight Hearing Questions and Answers “OBJECTIVE 2: Maintain/Improve Inmate Physical and Mental Health”). A 2016 document introducing this “therapeutic housing community” defines its purpose as: “to provide community therapy in order to maximize an inmate’s ability to function, and minimize relapse and the need for more acute care.” (Ciaramella; Mental Health Step-Down Unit 2). Staff and clinicians transfer individuals to this unit once they have been “stabilized” in the Acute Mental
Health Unit. In the MHSDU, individuals undergo a 9-week program involving daily group therapy and other programming preparing them for transfer into the general population (Performance Oversight Responses [2022] “59. Please Provide an Update on the Specialized Step-Down Unit at CDF”). In fiscal years 2021 and 2022, the MHSDU held 15 residents per month (amounting to 73 residents in total up to December 30, 2020); however, due to COVID-19 restrictions, only one participant graduated from the unit’s 9-week program during this time (Performance Oversight Responses [2022] “59. Please Provide an Update on the Specialized Step-Down Unit at CDF”; Performance Oversight Responses [2021] 148, 178). This section investigates processes of subject formation at the unit through an examination of its purpose and structure, as outlined in a 2017 document announcing the opening of the unit (Mental Health Step-Down Unit). It is crucial to note that 1) the MHSDU’s stated programming and structure may significantly vary from its operations in practice, and 2) the unit’s programming has been significantly decreased due to the COVID-19 pandemic, suggesting that it likely lacks some of the programming discussed below (Performance Oversight Responses [2022] “59. Please Provide an Update on the Specialized Step-Down Unit at CDF”).

The MHSDU’s stated mission and operations largely mirror those of the Acute Mental Health Unit, albeit providing a clearer example of mentally ill, incarcerated individuals’ depiction as requiring extended “care.” As suggested above, the unit also greatly relies on associations between mentally ill, incarcerated individuals, instability, dysfunction, and, thus, danger, thereby continuing to construct these individuals as such upon their transfer into the unit. Reflecting this logic, individuals’ transfer to the unit results from their subjectification as “stable” mentally ill individuals in the Acute Mental Health Unit (Performance Oversight Responses [2022] “59. Please Provide an Update on the Specialized Step-Down Unit at CDF”).
This label, which results from DC DOC staff’s and clinicians’ assessments of one’s behavior, thus constructs individuals as more proximate to non-mentally-ill, incarcerated individuals than those residing in the CDF’s Acute Mental Health Unit, while continuing to distinguish them from the rest of the jail population as requiring additional treatment and incapacitation before their return to their CDF’s general population. In fact, similarly to individuals in the Acute Mental Health Unit, MHSDU residents are subjected to greater monitoring, mental health assessments, and treatment than non-mentally-ill, incarcerated individuals (District of Columbia Department of Corrections 2018 Inspection Report 11).

This distinction continues throughout individuals’ progress within the MHSDU. Within five days of their arrival at the unit, individuals participate in the development of their Individualized Treatment Plan (ITP) alongside their treatment team, which includes a primary care provider, DC DOC caseworkers and officers, mental health professionals, and a social worker (Mental Health Step-Down Unit 4-8). ITPs, which are reviewed every four weeks, work towards “supporting [individuals’] movement towards independent functioning, and toward successful movement to the general population or the community (Mental Health Step-Down Unit 4, 6). To successfully transition through the MHSDU and, thus, through one’s ITP, one must be “psychiatrically stable” and “determined to be able to function within the structure, services and support available in the outpatient mental health service area” (Mental Health Step-Down Unit 11). Importantly, DC DOC officers’ involvement in the development of one’s ITP, as well as these assessments’ administration in the carceral setting, further point to the fundamental role that discourses of securitization play in defining one’s construction and trajectory within the MHSDU (Mental Health Step-Down Unit 5-6). The ITPs thus build on mentally ill, incarcerated individuals’ construction as unstable threats to the CDF’s and CTF’s general populations,
subjecting them to constant assessments of their stability that further distinguish them from each other and, more importantly, from non-mentally-ill, incarcerated individuals on the basis of their supposed dysfunction. Such assessments assign meaning to individuals’ behavior – for example, associating an individual’s failure to comply with their medication with their supposed instability – that can subject individuals to further confinement and treatment in the unit and, thus, further contribute to their construction as mentally ill, incarcerated subjects that must be segregated from the rest of the jail population and normalized (District of Columbia Department of Corrections 2018 Inspection Report 11).

The MHSDU also distinguishes this group from non-mentally-ill, incarcerated individuals through its implementation of a three-level program of “privileges and rewards” (Mental Health Step-Down Unit 9). Level 1, reserved for “Level 1 Patients,” allows individuals ten hours of “structured activities” – which include “treatment team meetings and facilitated groups, individual sessions, and detailed work” – and ten hours of “unstructured activities” – including “TV watching, exercise classes, outside recreation, video visitation, phone calls, showers, etc.” (Mental Health Step-Down Unit 4, 9). One must show “three (3) consecutive weeks of positive cooperation and participation” to transition to Level 2. Level 2 allows for a weekly ten and fifteen hours of structured and unstructured activities and Level 3 grants individuals ten and twenty hours, respectively. These units, mirroring the Acute Mental Health Unit’s intake and general population sides, distinguish between MHSDU residents on the basis of their stability and functionality, requiring them to express increased levels of “cooperation” to access basic necessities and “privileges” (Mental Health Step-Down Unit 9). The MHSDU thus constructs “Level 3 Patients” as mentally ill, incarcerated subjects who are most proximate to their non-mentally-ill, incarcerated counterparts and, thus, can be safely allowed greater liberties.
within the unit. In doing so, the MHSDU’s levels not only further construct Acute Mental Health Unit residents and “Level 1 Patients” as unstable individuals requiring incapacitation and care, but also distinguish between “Level 3 Patients” and non-mentally-ill, incarcerated individuals. Chapter three will discuss the role that these levels play in coercing individuals into complying with jail policies and expected, acceptable behaviors; however, the purpose of this section is that of highlighting these levels’ role in differentially constructing the MHSDU’s residents.

I have thus far shown that the MHSDU contributes to constructions of mentally ill, incarcerated individuals as requiring incapacitation and correction. Another important aspect of the unit, however, similarly to the Acute Mental Health Unit, lies in its pathologization of mentally ill, incarcerated individuals as subjects requiring extensive “care.” Compared to the CDF’s Acute Mental Health Unit, in fact, this unit most closely resembles a medical facility due to its more extensive programming and less restrictive policies, calling for its analysis as such. Sullivan and Yates’ analyses suggest that subject formation in medical facilities occurs as clinicians strip admitted individuals of knowledge of and control over their bodies on the basis of their pathology, subjecting them to standardized assessments and treatment programs that construct them as members of homogenous, pathologized populations (Sullivan; Yates). Operating on subjective, albeit universal, understandings of stability and independence, medical facilities subject incarcerated individuals to standardized treatment regimens that limit their agency and individuality. Individuals’ assignment to a treatment team for the development of their ITP exemplifies their construction as medical patients requiring the supervision and support of clinicians (Mental Health Step-Down Unit 4-8). Similarly to clinicians in Sullivan’s and Yates’ research, through treatment teams and ITPs, DC DOC staff and clinicians subject mentally ill, incarcerated individuals to medical knowledge, constructing them as individuals
who, by virtue of their pathology, are unable to make decisions for themselves and require the assistance of social workers, case managers, clinicians, and DC DOC officers. The power dynamics that characterize one’s relationship with one’s treatment team are especially clear in the carceral setting, which allows all incarcerated individuals little to no agency.

Based on this group’s constructed disability, the MHSDU assigns its members to standardized treatment plans that further construct them as especially-vulnerable individuals requiring extensive psychiatric care, while also working to develop them into stabilized, mentally ill, incarcerated individuals (Mental Health Step-Down Unit 11). The standardized nature of ITPs is clear in that they work towards the same goal, namely, individuals’ stabilization, and adopt the same structure (Mental Health Step-Down Unit 4, 6). In fact, all ITPs include “a) a “Mental Health assessment,” b) a Nursing Care Plan, and c) Transition and aftercare plans” (Mental Health Step-Down Unit 9). All individuals on the unit attend mandatory therapy sessions in addition to various therapy groups and programming options (D.C. Department of Corrections: Correctional Treatment Facility & Central Detention Facility Inspection Report FY 2017 33). As of 2016, programs at the MHSDU included: “Job Readiness Groups,” “The purpose Drive: Life Groups,” an “Art Therapy Group,” a “Self-management Group,” “Re-entry Group/AA [Alcoholics Anonymous]/NA [Narcotics Anonymous] Group[s],” “Behavioral Health Groups,” and “Job Readiness Groups” (Performance Oversight Responses [2017] 535). More recently, a 2022 document lists pre-COVID programs available at the unit: “a Trauma-Informed Care (TIC) group called Trauma, Addictions, Mental Health (TAMAR) and recovery, Art therapy, Anger management, a DBH [Department of Behavioral Health]-focused group run by DBH, Yoga and Mindfulness.” The document suggests that COVID-19 seriously derailed most of this programming. At the time of its writing, MHSDU residents could participate in an Anger
Management Group and a Trauma Informed Care group, with other programming set to resume in early March 2022 – information on whether these programs were actually reinstated is unavailable (Performance Oversight Responses [2022] “59. Please Provide an Update on the Specialized Step-Down Unit at CDF”). The MHSDU’s treatment programs thereby mirror the processes of subject formation that Sullivan and Drinkwater discuss in their pieces (Sullivan; Drinkwater). Like the standardized treatment programs in these theorists’ analyses, the MHSDU’s programming simultaneously distinguishes mentally ill, incarcerated individuals from their mentally sane counterparts by constructing them as needing such extensive care and supervision, while working to assimilate the former into the latter, thus creating a homogenous group of stabilized, mentally ill, incarcerated individuals.

Two crucial aspects of the MHSDU’s operations are also worth mentioning. First, as I have stated in previous sections and wish to reiterate, this unit’s pathologization of mentally ill, incarcerated individuals is fundamentally distinct from that of non-incarcerated, mentally ill individuals. The former’s existence as criminalized individuals in the carceral setting significantly dehumanizes them and denies them agency, thereby subjecting them to a level of supervision and psychiatric and carceral control that non-mentally-ill, incarcerated individuals do not experience. Second, as the previous section has suggested, assessments of individuals’ stability within the carceral setting are inherently prone to pathologize individuals’ natural reactions to an inhumane setting, suggesting that DC DOC largely creates the reactions that it pathologizes. To this point, chapter three will examine the Acute Mental Health Unit’s and MHSDU’s roles in mitigating these normal reactions, thereby using psychiatric assessments and treatments to increase individuals’ compliance with the CDF and CTF’s rules and conditions.
In this section, I have thus shown that the MHSDU plays a fundamental role in constructing the mentally ill, incarcerated subject as a dually dangerous and helpless subject who simultaneously requires enhanced incapacitation and “care” in the form of psychiatric treatment. It is important to note that this subject identity follows individuals even as they transition from the MHSDU to the CDF or CTF’s general population. In fact, thorough discharge planning on the MHSDU works to connect these individuals to consistent screening and treatment following their release to the general population, thereby situating them as stabilized and, yet, at-risk-for-dysfunction, mentally ill, incarcerated subjects (*Mental Health Step-Down Unit 11-12*). The next section will consider the role that this subject identity plays outside of the CDF and CTF, following individuals’ release.

*Release Planning*

The community-oriented health care model and the Unity contract begin release planning at intake in an effort to ensure pathologized individuals’ appropriate treatment inside carceral facilities, which, in turn, allows for their successful reintegration into their communities (Conklin 27; *Performance Oversight Responses* [2021] 180). Operating on this logic, the model thus requires that individuals’ construction as mentally ill, incarcerated subjects at the CDF and CTF define their re-entry process, calling, as previous sections have established, for their increased supervision and support. This chapter’s second section on the CDF and CTF’s intake progress began to highlight DC DOC’s emphasis on mentally ill, incarcerated individuals’ need for more extensive discharge planning. The present section specifically examines DC DOC’s re-entry planning procedures to assess the Department’s differential construction of the District’s returning citizens.
DC DOC assesses incarcerated individuals’ re-entry needs through the Northpointe Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) Risk Screening and Needs Assessment – a software developed to assist criminal legal agencies in “offender management,” “treatment and case planning,” and “post-release supervision” (Risk and Need Assessment 2; Brennan and Dieterich 49). This model, which clearly holds carceral aims of safety preservation outside of carceral facilities, exemplifies increasing intersections between psychiatric and criminal legal fields of knowledge in assessments of dangerousness and criminality. In fact, COMPAS bases its assessment of returning citizens on studies in “social learning theory,” “the general theory of crime,” “strain theory/social marginalization,” “routine activities theory,” “social disorganization/subcultural theories,” and “control/restraint theories” that associate individuals’ behaviors and interpersonal relationships with their propensity to crime (Bennan and Dieterich 57-58). For example, the general theory of crime “integrates elements of antisocial personality (e.g., impulsivity, anger), antisocial unstable families and inadequate parenting with a high-risk opportunity lifestyle as basic causes of criminal behavior” (Gottfredson & Hirschi qtd. in Bennan and Dieterich 57). This theory thus associates antisocial personalities, a constructed category that assigns meaning to individuals’ supposedly abnormal social behaviors, with criminality, marking individuals deemed to be socially deviant as more likely to face re-arrest after their release. COMPAS thus relies on psychiatric and criminal legal associations between mental and social pathology and criminality to construct returning citizens as distinct subjects posing varying levels of risk to their communities. Importantly, this assessment’s focus on returning citizens’ mental and social deviance suggests that it associates mentally ill, incarcerated individuals with greater risk and, thus, a need for more extensive supervision and support upon their release.
This latter connection is especially clear in the Risk-Need-Responsivity (RNR) Model, which informs COMPAS and a number of other risk and need assessments in the criminal legal system (Andrews et al. 19). The model provides a framework for assessing individuals’ risk, need, and responsivity – or “learning styles and abilities” – to “determine [their] level, targets, and type of rehabilitative effort” (Andrews et al. 20). The model distinguishes risks and needs as respectively static and dynamic factors that may influence one’s chances of recidivism, the latter of which can be addressed and changed (Andrews et al. 31). Static risk factors include one’s age at the time of arrest and other demographic information, and dynamic risk factors, or needs, include, for example, “Antisocial Attitudes,” “Antisocial Associates,” “Antisocial Personality” (High Anxiety/Low Self-Esteem” (Osher et al. 23; Andrews et al. 34). Informing COMPAS, this framework thus clearly operates on logics of criminal pathologization that associate one’s behavioral normalization with one’s reduced criminality, thereby portraying pathologized individuals as especially prone to criminal behavior. Importantly, the RNR model explicitly addresses the role that mental health diagnoses play in its assessment of returning citizens, situating them as responsivity factors that can interfere with one’s ability to engage with programs meant to address one’s criminogenic risks and needs (Osher et al. 26). Mental health diagnoses’ portrayal as responsivity factors clearly point to mentally ill, incarcerated individuals, or returning citizens’, construction as requiring increased supervision and care due to their increased propensity to criminality and, in this latter instance, their inability to independently reintegrate into their communities.

Mentally ill, incarcerated individuals’ increased supervision throughout the re-entry process is clear in the CDF’s and CTF’s specialized re-entry services for members of this group. For instance, based on individuals’ assessed needs, the COMPAS software recommends
institutional and community-based services for individuals to follow up with following their release (*Risk and Needs Assessment* 9). DC’s DBH’s partnership with DC DOC is also a crucial example of these services, as the agency works to connect incarcerated individuals with community-based mental health care services and Core Service Agencies (CSAs) prior to their release (*Reentry Program and Services* 7). According to a 2022 document, Unity partners with a DBH liaison at the CDF and CTF to work on re-entry planning with individuals who are 30 days away from release. The liaison reconnects individuals who received DBH services prior to their incarceration to DBH CSAs – public mental health providers – and assesses others’ eligibility for DBH services (*Performance Oversight Responses* [2022] “61. Please Describe DOC’s Current Release and Reentry Planning Procedures Relating to Residents with Mental or Behavioral Health Needs”; “Washington, D.C. Mental Health Services Guide”). COVID-19 disrupted the DBH liaison’s partnership with Unity; however, the liaison continues to work offsite to provide Unity with a list of individuals who are 30 days from release and have received DBH services, allowing Unity to reconnect them with DBH services and set up follow-up visits for them upon their release (*Performance Oversight Responses* [2022] “61. Please Describe DOC’s Current Release and Reentry Planning Procedures Relating to Residents with Mental or Behavioral Health Needs”). Such policies thus clearly reflect DC DOC’s construction of mentally ill, incarcerated individuals as requiring additional supervision and assistance in their re-entry compared to non-mentally-ill, incarcerated individuals.

Upon their release from DC DOC or the Federal Bureau of Prisons, some DC residents are placed under the supervision of DC’s COURT Services and Offender Supervision Agency (CSOSA). In accordance with DC DOC’s increasing focus on mental health diagnoses and psychiatric treatment, CSOSA places great emphasis on utilizing evidence-based practices
to identify and appropriately support mentally ill returning citizens (Strategic Plan 4). The agency holds specialized units for the supervision of mentally ill returning citizens, which “provide intensive case management services to special needs offenders who have medically diagnosed mental health conditions that require focused monitoring as an important aspect of their overall prescriptive supervision plans” (Community Supervision Services Operations Manual “c. Branch III: Substance Abuse and Treatment”). For this reason, mental health diagnoses are crucial to CSOSA’s assessment of returning citizens’ “criminogenic risk and needs” through its AUTO Screener, which specifically considers one’s mental health history, mental health status, and previous or current participation in mental health treatment (Strategic Plan 6; Community Supervision Services Operations Manual “B. AUTO Screener). Similarly to the RNR assessment, the agency views mental health issues as “stabilization needs” that, although, unlike “criminogenic needs,” do not directly enhance one’s criminality, may interfere with mentally ill, returning citizens’ ability to adhere to their supervision plan (Strategic Plan 13). As chapter three will explore in detail, CSOSA’s associations between mental illness, increased risk, and a greater need for more comprehensive re-entry services lead mentally ill, returning citizens to face extensive screenings, treatment programs, and treatment-compliance requirements that their non-mentally-ill counterparts do not face (Community Supervision Services Operations Manual).

DC DOC and CSOSA’s re-entry services thus suggest that mentally ill, incarcerated individuals’ construction as such follows them outside of the CDF and CTF, portraying them as returning citizens with an increased likelihood of re-incarceration and a need for more comprehensive assistance in their re-entry. Such discourses of mentally ill, incarcerated individuals’ dangerousness and vulnerability thus distinguish them from non-mentally-ill,
incarcerated individuals, rendering them especially vulnerable to psychiatric and carceral supervision and violence, as chapter three will make clear. Similarly, as criminalized individuals, mentally ill returning citizens continue to differ from non-incarcerated, mentally ill individuals in their unique lack of agency over the psychiatric treatment that they receive.

Conclusion

This chapter has thus extended Ben-Moshe’s critique of the “new asylum” thesis and its pathologization of houseless, incarcerated individuals to the carceral setting through an analysis of the rising jail-and-prison-based mental health services that resulted from its widespread acceptance (Ben-Moshe, Decarcerating 135). Through a case study of DC’s jails, I have argued that, lying at the intersection of psychiatric and criminal legal fields of knowledge, these services construct incarcerated individuals into a unique subject identity: the mentally ill, incarcerated subject. Characterized by discourses of inherent danger and, simultaneously, greater vulnerability in the carceral setting, this subject identity differs from those of the non-mentally-ill, incarcerated subject and the non-incarcerated, mentally ill subject in important ways. I have shown that DC DOC’s mental health services, as well as rhetoric surrounding their implementation, construct mentally ill, incarcerated individuals as necessitating greater incapacitation and, at the same, psychiatric “care” than the former, thereby justifying their confinement and correction in specialized mental health units. I have also suggested that this group’s criminalization significantly distinguishes them from non-incarcerated, mentally ill individuals in their lack of agency and, thus, greater vulnerability to unwanted and unnecessary psychiatric treatment.

I relied on Foucault’s theory of subject formation as a fundamental element of disciplinary power and biopower, as well as the works of Ben-Moshe and other disability rights
theorists, to analyze five mental health programs at the CDF and CTF (Foucault, “Afterword”; Ben-Moshe; Tremain). I first examined the community-oriented health care model and DC DOC’s 2006 contract with Unity Health Care as sites of intersection for criminal legal and psychiatric knowledge (Conklin et al.; “Department of Corrections Institutes Community-Oriented Healthcare for Inmates”). I argued that these services construct incarcerated individuals as medical patients and mentally ill individuals as public safety concerns, thereby giving way to the mentally ill, incarcerated individual as a dually criminalized and pathologized subject identity that is uniquely vulnerable to systems of carceral and psychiatric control. Then, I analyzed specific screening and treatment services at the CDF and CTF – namely, the facilities’ mental-health-focused intake process, mental health units, and mental-health-focused discharge planning – as similar sites of intersection. I argued that these services’ position inside carceral facilities greatly informs their assessments of pathology, leading them to construct mentally ill, incarcerated individuals as uniquely dangerous individuals who require incapacitation and correction before their reintegration into the jail’s general population and DC’s greater community. I also posit that, as pseudo-medical services, these screenings and programs simultaneously construct mentally ill, incarcerated individuals as more vulnerable and, thus, as requiring more “care” than their non-mentally-ill counterparts.

The next two sections will examine how state actors rely on this unique subject identity to strengthen and expand carceral power. The second chapter will use theory on carceral humanism to analyze the role that the mentally ill, incarcerated individual, as a dually vulnerable and invulnerable subject identity, plays in situating jails and prisons and, more broadly, the criminal legal system as service providers in the carceral state (Rodriguez et al.). I argue that claims of this subject identity’s necessary incapacitation and extended care legitimate the
financial and social expansion of DC DOC in the face of increasingly-anti-carceral politics through mental health initiatives that increase its budget and strengthen its credibility in the District – including, for example, DC DOC’s contract with unity and the MHSDU. The third chapter will rely on disability studies theory to examine mentally ill, incarcerated individuals’ unique vulnerability to psychiatric and carceral violence. I will examine jail-based psychiatric services as loci of intersecting psychiatric and carceral power that extend carceral actors’ control over mentally ill, incarcerated individuals in explicitly-restrictive and seemingly-therapeutic ways. Through this thesis, I thus seek to show that the widespread adoption of the “new asylum” thesis and its impact on criminal legal policies have led to the construction of a unique subject identity that has strengthened and expanded the carceral state while rendering incarcerated individuals more vulnerable to its violence.
Chapter 2 – Repackaging, Funding, and Expanding DC’s Jails: The Mentally Ill.

Incarcerated Subject in a Context of Carceral Humanism

Many in DC have called for and supported the DC jails’ mental health initiatives. In a 2010 DC Council hearing, for example, the director of the DC Prisoners’ Project, Philip Fornaci, praised the DC Department of Corrections (DC DOC)’s contract with Unity as “one of the high grades we always give the department” for its role in addressing the healthcare issues that plagued DC’s jails in the 20th century (District of Columbia, Council, Committee on the Judiciary & Public Safety [2010] 05:54:51-05:57:10). In a 2011 hearing, Wallace Kirby, working with University Legal Services (ULS), urged DC DOC to increase mental health programming in its mental health units and improve its mental-health-focused discharge planning services (District of Columbia, Council, Committee on the Judiciary [Mar. 2011] 02:07:20-02:08:57). The previous chapter clearly complicated such praise and recommendations, pointing to these services’ role in pathologizing, supervising, and controlling incarcerated individuals. This chapter focuses on the impact that DC DOC’s mental health initiatives, as well as the activist efforts behind them, have on the Department itself. Through an abolitionist lens, I suggest that these mental health initiatives exemplify a type of reformist reform that, relying on DC DOC’s construction of the mentally ill, incarcerated subject, ultimately reinforces carceral systems and harms abolitionist efforts.

Reformist reforms, a term coined by André Gorz and adapted to prison abolitionist politics by Thomas Mathiesen, “have goals which are subordinated to the facilities and the presuppositions of a system and a policy presented by the adversary” (Mathiesen 211). In the case of the carceral state, such reforms do not challenge the logics of punishment and
confinement that underlie the criminal legal system, instead working to develop more effective or “humane” ways to confine and punish. Reformist reforms thus benefit carceral actors in two principal ways, first, allocating more resources to policing and incarceration efforts and, second, depicting carceral actors as “more reasonable, better, more correct, more rational, etc.” (Mathiesen 202, 211; Davis et al. 185). Key examples of contemporary reformist reforms include efforts to build new jails and prisons in response to overcrowding issues, the construction of specialized carceral facilities for sectors of the incarcerated population (including, for example, individuals with mental health diagnoses), and the development of home-arrest technology (Davis et al. 185-187). DC DOC’s $34,839,617 contract with Unity Health Care, its construction of specialized mental health units, and its implementation of trauma-informed programming also fall under this category of reforms, expanding DC DOC’s budget and establishing its role as a service provider for “one of the largest mental health populations in the city” (Performance Oversight Responses [2021] 75, 177).

In this chapter, I critique the reformist nature of DC DOC’s mental health initiatives through a framework of carceral humanism, as defined by James Kilgore (Kilgore). Carceral humanism, a key logic underlying reformist reforms in the last few decades, is the repackaging of the criminal legal system in response to rising abolitionist efforts, which “recasts the jailers as caring social service providers” (Kilgore). According to Kilgore, such constructions of carceral actors allow for the expansion of carceral facilities on the premise of service provision through, for example, the implementation of extensive mental health services in jails and prisons (Kilgore). My analysis will specifically focus on carceral humanism’s reliance on processes of subject formation. Through a discussion of carceral feminism and carceral ableism as two manifestations of carceral humanism, I show that carceral humanism depends on the constructed
vulnerability or invulnerability of racialized, gendered, and pathologized individuals (Ben-Moshe, Decarcerating 17; Rodriguez et al.). I thus position the previous chapter’s analysis of the mentally ill, incarcerated subject in this framework to establish this subject identity’s role in DC-based carceral humanist efforts. Through an abolitionist lens that opposes carceral reform and expansion, I argue that efforts to repackage DC’s carceral actors as service providers and, thus, reinforce and expand DC DOC’s role in DC depend on constructions of the mentally ill, incarcerated individual as a simultaneously vulnerable and invulnerable subject identity that requires greater “care” and incapacitation than the rest of the jail population.

To structure my analysis, I will first develop a framework of Kilgore’s carceral humanism through which to analyze mental health initiatives at DC DOC. I distinguish Kilgore’s conception of carceral humanist the term from its earlier definitions to establish its unique reliance on the construction of vulnerable, invulnerable, or simultaneously vulnerable and invulnerable subject identities (Rodriguez et al.; Bernstein; Musto). I specifically focus on carceral humanism’s dependence on the latter subject identity through an analysis of the mentally ill, incarcerated individual. Developing on the previous chapter’s analysis of mentally ill, incarcerated individuals as distinct from non-mentally-ill, incarcerated individuals and non-incarcerated, mentally ill individuals in their requirement of greater “care” and incapacitation, I suggest that this subject identity fuels carceral expansion through jail-based psychiatric. Second, I situate efforts to develop mental health initiatives in DC’s jails in this framework to examine their reliance on this subject identity. I argue that constructions of mentally ill, incarcerated individuals legitimate DC DOC’s mental health initiatives as efforts to incapacitate and treat this group, thereby constructing DC DOC as DC’s “largest single-location

Theoretical Framework

Carceral Humanism

Kilgore’s concept of carceral humanism finds its origins in earlier critiques of humanist discourse in prisoners’ rights activism. Lisa Guenther and Anna Terwiel argue that efforts to achieve “humane treatment” in jails and prisons often result in the legitimization of extreme forms of violence and confinement in these facilities as such (Guenther; Terwiel 70). Citing Foucault’s work (qtd. in Terwiel 77), Terwiel shows that jails and prisons are founded on the widely-held “expectation and desire that incarcerated people suffer” and, thus, on constructions of criminalized, incarcerated individuals as less-than-human subjects deserving of punishment. Operating within this framework, calls for “humane treatment” in jails and prisons equate the preservation of incarcerated individuals’ humanity to the preservation of their biological livelihood, thus holding these facilities to standards of “humane treatment” that merely accomplish this latter goal (Terwiel 76; Guenther 132-133). Such humanist efforts fail to challenge jails and prisons’ inherent dehumanization of incarcerated people, instead allowing carceral actors to present themselves as “humane” places of confinement on the basis of their provision of “what is necessary for human life” (Guenther 132; Terwiel 77).

For example, Terwiel considers the role that health-based arguments against extreme heat conditions in US jails and prisons play in this legitimization. Such claims demand cooler temperatures in these facilities for individuals with pre-existing health conditions on the basis of incarcerated individuals’ right to biological life, as opposed to their right to comfort as human
beings, thereby constructing extreme heat conditions that do not threaten individuals’ life as “humane” (Terwiel 76). Guenther traces a similar phenomenon in her analysis of solitary confinement. Citing Karamet Reiter’s work (qtd. in Guenther 132), she shows that challenges to this practice have failed to problematize its inhumane nature, instead seeking to render it “humane” through evolving food, water, cell size, and other requirements aimed at keeping individuals held in solitary confinement alive. Such reforms, which include efforts to exempt individuals with mental health conditions from solitary confinement, have legitimized this practice as “humane” and, thus, ensured its continued use across US jails and prisons (Guenther 136). Importantly, these efforts are examples of reformist reforms, as they leave carceral logics unchallenged while affording more funding – in the form of, in the aforementioned instances, air conditioning units and solitary confinement cells – and credibility to carceral actors.

Kilgore’s definition of carceral humanism takes Guenther and Terwiel’s claims on the limitations of humanist discourse a step further (Kilgore). Kilgore suggests that, rather than merely gaining legitimacy as “humane” places of confinement through their provision of prisoners’ basic survival needs, carceral facilities are now expanding their services beyond this minimum threshold to establish themselves as benevolent service providers. He describes the field of mental health as the “cutting edge of carceral humanism,” as mental health initiatives emerge in carceral facilities across the country on the premise of serving incarcerated individuals with mental health issues (Kilgore). This repackaging relies on a similar and, yet, importantly-distinct process than that of Terwiel and Guenther’s carceral humanism. Through fabricated standards of “humane” treatment that largely focus on individuals’ biological survival, Terwiel and Guenther’s carceral humanism applies humanist discourse to a fundamentally-inhumane place of confinement to construct it as “humane.” Similarly, through its
depiction of sectors of the jail population as requiring additional protection and support, Kilgore’s carceral humanism introduces discourses of “care” in the carceral setting to construct this inherently punitive space as a service provider. Therefore, both forms of carceral humanism rely on fabricated notions of incarcerated individuals’ needs and carceral facilities’ ability to meet them to soften the image of jails and prisons, while leaving their nature unchallenged.

An important difference between these two forms of carceral humanism lies in the subject identities that they rely on and in their use of notions of vulnerability and invulnerability (Rodriguez et al.). The carceral humanism that Guenther and Terwiel discuss largely deals with one subject identity: the incarcerated subject. This form of carceral humanism operates on widely-held notions of this subject as less-than-human and deserving of punishment to reduce incarcerated people’s humanity to their biological needs and, thus, legitimize inhumane confinement that allows for their survival as “humane” (Terwiel; Guenther). This conceptualization of incarcerated people defines this framework’s depiction of this group’s vulnerability, which merely concerns individuals’ greater vulnerability to the loss of biological life – thereby, for example, exclusively allowing individuals with life-threatening medical conditions to access air conditioning (Terwiel 76).

On the other hand, as the next section will show, Kilgore’s concept of carceral humanism moves beyond the incarcerated subject, constructing distinct subject identities that, due to their unique vulnerability, invulnerability, or both, require greater carceral protection, “care,” or incapacitation (Rodriguez et al.). Consider, for example, the subject identity of the mentally ill, incarcerated individual. In chapter one, I argued that this subject identity is fundamentally distinct from that of the non-mentally-ill, incarcerated individual in its constructed need for extended “care” and incapacitation in the form of psychiatric treatment. It is through such
constructed notions of vulnerable, invulnerable, or vulnerable/invulnerable subject identities’ needs, then, that policies based on Kilgore’s carceral humanism apply a language of “care” to carceral spaces, thereby legitimizing these innately inhumane spaces as service providers.

Due to the distinct subject identities that they deal with, Guenther and Terwiel’s carceral humanism and Kilgore’s carceral humanism grapple with questions of incarcerated individuals’ humanity and “humane” treatment in different ways that are important to note. As discussed above, the former conception of carceral humanism focuses on achieving “humane” treatment for incarcerated individuals based on a reductive understanding of this group’s humanity as its members’ biological life (Guenther 132; Terwiel 77). Although operating within constructions of criminality that depict incarcerated individuals as innately less-than-human and, thus, fundamentally failing to meaningfully conceptualize this group’s humanity, these carceral humanist efforts nevertheless appeal to this hum. Efforts based on Kilgore’s definition of the term, however, appeal to individuals’ vulnerability, which often signals their constructed inhumanity. For example, as the next sections will show, depictions of individuals with disabilities as vulnerable individuals requiring protection reflect ableist notions that portray this group as less-than-human on the basis of their perceived disability and, thus, as requiring (sometimes involuntary) “care” (Ben-Moshe, Decarcerating 17).

Notably, this reconfiguration of mentally ill, incarcerated individuals’ needs also shifts carceral actors’ responsibility towards this group and, thus, its role within frameworks of carceral humanism. Guenther and Terwiel’s definition of carceral humanism strictly focuses on the incarcerated subject and, thus, on carceral facilities’ “humane” treatment of the latter as such (Guenther; Terwiel). As this chapter’s analysis of DC DOC’s mental health initiatives will show, however, present carceral humanist constructions of mentally ill, incarcerated subjects as distinct
from non-mentally-ill, incarcerated subjects on the basis of their pathologies – which go as far as identifying this group’s members as “psychiatric patients” – lead to conceptualizations of carceral facilities as make-shift psychiatric facilities (From the Inside Out i). In other words, in depicting incarcerated individuals as simultaneously vulnerable and invulnerable “psychiatric patients,” these constructions require carceral facilities to act beyond their role as such and, thus, adopt the role of service providers.

_Carceral Humanism and Subject Formation_

According to SM Rodriguez et al., the US justifies carceralism through its construction of certain groups “as requiring additional attention and protection vis a vis ‘threatening places, populations and conditions’” (Rodriguez et al. 537-538). These logics thus legitimize state actors’ incarceration and murder of the “invulnerable” in stated efforts to protect the “vulnerable,” casting them as legitimate punishers of the former and as “allies and saviors” of the latter (Rodrigue et al. 538; Bernstein 144). Importantly, such justifications largely overlook state actors’ role in inflicting the harm they seek to address with carceralism, pinning, for example, structural causes for gender-based violence on invulnerable “others” in an effort to preserve their image as protectors (Bernstein 144). This section positions carceral humanism in this context to examine its reliance on notions of various subject identities’ vulnerability, invulnerability, or simultaneous vulnerability and invulnerability. My aim is that of constructing a theoretical framework through which to understand the role that the mentally ill, incarcerated subject plays in DC’s carceral humanist efforts.

Distinctions between perpetually vulnerable and invulnerable groups are largely racialized, gendered, and pathologized and, thus, rely on processes of subject formation that tie
distinct subject identities to notions of vulnerability and invulnerability. For example, Ben-Moshe’s concept of racial criminal pathologization, as well as my own analysis of the mentally ill, incarcerated subject, suggest that normative associations between race, psychiatric deviance, danger, and criminality construct racialized and pathologized subjects as invulnerable (Ben-Moshe, Decarcerating 26; Rodriguez et al. 539). Inversely, some subject identities – according to Rodriguez et al., those “of the heterosexual, abled, white woman and child” – are intrinsically tied to vulnerability (Rodriguez et al. 538). An important instance of the latter can be found in Elizabeth Bernstein’s concept of carceral feminism, which refers to the exertion and expansion of carceral power in a stated effort to advance feminist goals and, thus, protect women as a vulnerable subject identity (Bernstein 131; Musto 387). In the US, carceral feminist efforts against domestic violence largely focused on protecting vulnerable, white, and heterosexual women through carceral tactics that targeted and greatly impacted invulnerable, Black American and brown men (Davis et al.; Kim; Bernstein 144). Importantly, carceral constructions of vulnerability subject individuals to normative and dehumanizing notions of vulnerability that hold important racialized and gendered dimensions (Rodriguez et al. 537-538; Musto 387-389). Jennifer Musto, for example, considers trafficked women’s paternalistic and sexist depiction as “perpetual victim[s]” and, thus, as helpless individuals devoid of agency in carceral, anti-trafficking efforts (Musto 387).

Constructions of vulnerability also rely on notions of disability. Ben-Moshe explores this relationship through the term “carceral ableism,” a form of carceral humanism that she defines as “the praxis and belief that people with disabilities need special or extra protections, in ways that often expand and legitimate their further marginalization and incarceration” (Ben-Moshe, Decarcerating 17). Considering psychiatric treatment as a form of incarceration, Ben-Moshe
suggests that ableist and sanist constructions of individuals with disabilities as requiring such protections legitimate carceralism through the expansion of carceral psychiatric services. Note, sanism refers to “oppression faced due to the imperative to be sane, rational, and non-mad/crazy/mentally ill/psychiatrically disabled” (Ben-Moshe, Decarcerating 16-17). For example, she considers the role that prisoners’ rights litigation plays in this expansion. She shows that such litigation emphasizes the supposed “vulnerability and abjection” of incarcerated individuals with disabilities to advocate for their release from jail or prison, which merely justifies their further incarceration in medical and psychiatric facilities upon their release (Ben-Moshe, Decarcerating 16, 261-264). Crucially, pathologized individuals’ vulnerability in carceral ableist frameworks fundamentally differs from that of women in carceral feminist frameworks, as carceral efforts aimed at the former’s protection result in their own incarceration.

This latter point suggests that carceral ableist approaches construct pathologized individuals as requiring carceral protection from themselves and their own pathology, surfacing a third subject identity that fuels carceralism: that of the simultaneously vulnerable and invulnerable subject (Rodriguez et al. 537). Rodriguez et al. discuss this duality in the context of processes of racial criminal pathologization. Citing Ben-Moshe’s work (qtd. in Rodriguez et al. 541), they suggest that such processes construct racialized individuals as inherently pathological, dangerous, and, thus, invulnerable and deserving of state incapacitation. Simultaneously, however, ableist notions of pathology construct individuals as vulnerable and requiring state “care” and protection from themselves – in the form of, for example, forced psychiatric treatment (Rodriguez et al. 540).

The mentally ill, incarcerated subject is a clear example of a simultaneously vulnerable and invulnerable subject identity used to justify carceral expansion. As chapter one suggested,
emerging from a unique intersection of psychiatric and carceral knowledge, this subject identity is constructed as requiring more extensive treatment and, at the same time, incapacitation than non-mentally-ill, incarcerated individuals and non-incarcerated, mentally ill individuals. As I have shown, processes of racial criminal pathologization construct this group as innately dangerous and, thus, as threatening to the jail population and society at large. Simultaneously, ableist and sanist notions of pathology lead to this group’s depiction as requiring extensive “care” and protection from themselves in the carceral setting and in their communities. Such constructions thereby call for explicit forms of carceral violence against this group, including restrictive mental health units aimed at its members’ separation from the rest of the jail population, and seemingly-therapeutic forms of carceral violence against this group, including inhumane safe cells meant to protect individuals from themselves, psychotropic medication, and less restrictive mental health units. Both forms of violence depict carceral actors as protectors in their efforts to, in the former instance, protect non-mentally-ill, incarcerated individuals and the population at large from mentally ill, incarcerated individuals and, in the latter instance, to protect the latter from themselves.

Such saviorist depictions of carceral actors and the carceral practices that emerge from them reflect a key tactic of carceral humanism: its transfer of responsibility for carceral harm from state actors to invulnerable others (Rodriguez et al. 537-538; Bernstein 144). In the case of the mentally ill, incarcerated subject, efforts to address incarcerated individuals’ pathologies through jail-and-prison-based mental health services and other forms of carceral incapacitation and “care” largely overlook the role that carceral facilities play in this group’s supposed mental deviance (Rodriguez et al. 538). On the one hand, as chapter one has shown, carceral actors are instrumental in the pathologization of mentally ill, incarcerated individuals, as their constant
screening and treatment of this group continuously construct them as especially-dangerous and dysfunctional members of the jail and prison population. On the other hand, incarceration itself is disabling, as its dehumanizing conditions can significantly impact incarcerated individuals’ psychological state (Ben-Moshe, *Decarcerating* 149-150; Stewart and Russell).

In this section, I have examined Kilgore’s concept of carceral humanism as a framework of carceralism that relies on constructed vulnerable and/or invulnerable subject identities to situate carceral actors as protectors of vulnerable populations and, thus, justify carceral expansion in the face of increasingly-abolitionist politics. The next sections will examine DC DOC’s mental health initiatives, as well as activism and DC DOC rhetoric surrounding their implementation, in this context.

**Repackaging and Expanding DC’s Jails**

*Pre-2006 Litigation*

2006 marked a turning point in DC DOC’s approach to healthcare and, specifically, mental health care provision in its carceral facilities (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”). Resulting from years of litigation challenging DC DOC’s inhumane treatment of incarcerated DC residents, the Department’s contract with Unity Health Care serves as a prime example of its transition into a caretaker role in the city (Smith; “Department of Corrections Institutes Community-Oriented Healthcare for Inmates”). This section examines the over three decades of litigation that led to this transition (“Case: Campbell v. McGruder”). Relying on Guenther and Terwiel’s concept of carceral humanism, I explore how two cases challenging conditions at the CDF, *Campbell v. McGruder* and *Inmates of D.C. Jail v. Jackson*, employed a humanist approach to construct “adequate” mental health
services as “humane” treatment at the jail and, thus, as a source of legitimacy for DC DOC. My aim is twofold. First, I wish to examine how mental health care services came to occupy such a prominent role in present carceral humanist efforts in DC. Second, I seek to contrast this litigation, as an example of Guenther and Terwiel’s conception of carceral humanism, to the activist efforts that gave way to DC DOC’s 2006 contract with Unity, as examples of Kilgore’s definition of the concept, in an effort to highlight these approaches’ differential construction of incarcerated individuals and their vulnerability and invulnerability.

_Campbell and Inmates_, filed in 1971 and 1975, respectively, and later consolidated, challenged the constitutionality of conditions at the CDF on behalf of convicted and pre-trial individuals incarcerated at the facilities (United States, Congress, House, Subcommittee on the District of Columbia of the Committee on Government Reform). The centrality of civil and human rights discourse to both cases is clear in a 1985 memorandum addressing the plaintiffs’ complaints. The memorandum finds the jail’s health care system in violation of incarcerated people’s Eighth and Fourteenth amendment rights, citing common “instances of bizarre and self-destructive behavior among prisoners” and the CDF’s failure to, among other things, provide “mentally ill” individuals with separate housing, hire sufficient mental health staff, and perform psychiatric screenings at intake (District of Columbia, District Court [1985] 25-27, 44). More broadly, the court found that “the jail has created conditions which are so acute that they deny inmates the _minimum of life’s necessities_ and inflict punishment on pre-trial detainees, thus establishing plaintiffs’ claims of constitutional violations” (emphasis added; District of Columbia, District Court [1985] 49). Both cases thus operate within a humanist framework, supposing the possibility of humane carceral confinement and constructing standards for the
CDF to meet that would legitimize incarceration at the facility as such – including, importantly, its provision of “adequate” medical and mental health care.

In fact, through a series of court orders spanning the cases’ 30-year litigation, the court provided the facility with a series of specific guidelines for improving its mental health services. For example, in 1994, a court-appointed special officer charged with overseeing conditions at the CDF crafted an “Initial Remedial Plan for Mental Health Care, Medical Care and Compliance Monitoring” (District of Columbia, District Court [1994] 2). The plan provides that DC DOC assign a mental health clinician to perform intake screenings of all individuals entering the CDF, staff mental health units for 24 hours a day seven days a week, provide mental health assessments and treatment options for incarcerated people in the CDF’s general population, and develop “at risk high acuity services” for all individuals with mental health concerns in the facility (District of Columbia, District Court [1993] 5; District of Columbia, District Court [1994] 15-17). In accordance with Terwiel and Guenther’s critiques of carceral humanist approaches, these guidelines leave the inhumane nature of confinement unchallenged, instead developing arbitrary standards of “adequate” care at the CDF that, if met, legitimize the facility as a “constitutional” and, implicitly, “humane” place of confinement (District of Columbia, District Court [1985] 49). These cases thus provide context for the present role that mental health services play in carceral humanist efforts at DC DOC. In fact, many of the guidelines outlined above, including, for example, the special officer’s push for DC DOC to develop mental health questionnaires for individuals entering the CDF and uniform guidelines for the CDF’s mental health units, match current practices at the CDF and CTF (District of Columbia, District Court [1994] 19, 26).
Campbell and Inmates also exemplify key differences between the two distinct forms of carceral humanism that this chapter considers. Efforts centering incarcerated individuals’ constitutional right to mental health services largely focus on the incarcerated subject, equating this group’s “humane” treatment to their access to “the minimum of life’s necessities” (District of Columbia, District Court [1985] 49). Thus, even when dealing with distinct groups within the incarcerated population, such as mentally ill, incarcerated individuals, these arguments conceptualize their vulnerability as their differential access to these necessities. In other words, operating within this carceral humanist framework, Campbell and Inmates construct mental health services as basic living necessities for mentally ill, incarcerated individuals, thereby continuing to construct the latter as incarcerated subjects whose “humane” treatment depends on their access to these necessities (Terwiel; District of Columbia, District Court [1985] 49). As the next section will show, carceral humanist efforts based on Kilgore’s definition of the term rely on constructions of mentally ill, incarcerated individuals as vulnerable and invulnerable individuals that fundamentally distinguish them and, thus, their needs from the rest of the jail population.

It is important to note, however, that Campbell and McGruder signify the early beginnings of this distinction and its manifestations at DC DOC. One court order refers to “the quality of care provided to patients,” as well as the facility’s “[c]are of the mentally ill,” and compares “[t]he activities provided for residents [at the CDF] [...] [to] those provided at a typical out-patient ‘day-care’ facility” (District of Columbia, District Court [1985] 26, 28). In addition to centering mental health services in carceral humanist efforts and beginning to distinguish mentally ill, incarcerated individuals from the rest of the jail population – albeit, as suggested above, in a limited way – this language creates a line of comparison between this group and non-incarcerated, mentally ill individuals, referring to its members as “patients” and setting their
standard of “care” to that of the latter (District of Columbia, District Court [1985] 26, 28). This comparison thereby begins to construct this group’s vulnerability outside of the subject identity of the incarcerated individual, introducing this group’s construction as vulnerable and invulnerable mentally ill subjects, which, as suggested in this chapter, is central to DC’s present carceral humanist efforts. The next section examines the development of this construction in prisoners’ rights and mental health activism leading up to DC DOC’s 2006 contract with Unity.

The Lead-Up to the Unity Contract

Judge Bryant dismissed Campbell and Inmates in 2003 due to new prisoners’ rights litigation guidelines under the Prison Litigation Reform Act (PLRA), ending all court supervision of the facilities (“Case: Campbell v. McGruder”; “Mayor Announces the End of Court Intervention for DC Department of Corrections”). The period following this decision witnessed worsening conditions and medical services at the CDF and CTF, with rising complaints regarding unresponsive medical staff and the facilities’ failure to provide incarcerated individuals with basic medical and mental health services (From the Inside Out). This section situates nationwide and DC-based prisoners’ rights and mental health activism during this time in a framework of Kilgore’s carceral humanism (Criminal Justice/ Mental Health Consensus Project; Gordon; From the Inside Out). I specifically consider efforts aimed at improving mental health services at the CDF and CTF to establish and trace their divergence from earlier carceral humanist approaches, discussed above, in their construction of the mentally ill, incarcerated individual as requiring special incapacitation and “care” in the form of psychiatric treatment. I argue that these efforts depended on this subject identity to depict carceral actors as benevolent
service providers and, thus, legitimize carceral expansion in the form of, for example, DC DOC’s 2006 contract with Unity.

It is important to note that my analysis will consider mentally ill, incarcerated individuals’ constructed vulnerability and invulnerability separately to examine the role that each construction plays in justifying carceral expansion. As chapter one made clear, however, processes of racial criminalization render these individuals’ vulnerability as mentally ill subjects inseparable from their invulnerability as pathologically criminal and incarcerated subjects (Ben-Moshe, Decarcerating 25; Terwiel 77). In fact, the paragraphs below will consider nationwide and DC-based activism’s reliance on widely-accepted associations between mentally ill, incarcerated individuals’ pathology, criminalization, and incarceration as a simultaneous indicator of this group’s constructed vulnerability and invulnerability.

The “new asylum” thesis underlied nationwide and DC-based activism surrounding incarcerated individuals with mental health diagnoses between 2003 and 2006 (Ben-Moshe, Decarcerating 135; Criminal Justice/Mental Health Consensus Project). The thesis attributes the criminalization of mentally ill, incarcerated individuals to a lack of community-based mental health services, partially conceptualizing this group’s criminality as an indicator of its members’ vulnerability as pathologized individuals and, thus, as fundamentally distinct from that of non-mentally-ill, incarcerated individuals (Ben-Moshe, Decarcerating 135). This messaging is clear in the “Criminal Justice / Mental Health Consensus Project” – a publication by the Council of State Governments proposing nationwide reforms to the criminal legal system's treatment of individuals with mental health diagnoses. The report states that “a large number of people with mental illness in prison (and especially in jail) have been incarcerated because they displayed in public the symptoms of untreated mental illness,” which “[p]roviders in the mental health system
have been either too overwhelmed or too frustrated” to treat (Criminal Justice/Mental Health Consensus Project xii). This language thus differentiates mentally ill, incarcerated individuals from “real criminals” who intentionally committed crimes and, thus, deserve to be incarcerated. In fact, in linking this group’s incarceration to their display of symptoms related to mental health issues, the report specifically addresses misconceptions that these individuals “have committed serious, violent crimes” (Criminal Justice/Mental Health Consensus Project xii). Importantly, this depiction of mentally ill, incarcerated individuals calls for this group’s treatment inside and outside of carceral facilities. On this basis, the report recommends a number of pre-arrest, jail-and-prison-based, and re-entry-focused mental health initiatives to address this group’s pathology and prevent their further criminalization (Criminal Justice/Mental Health Consensus Project xv).

DC-based efforts during this period also adopted this approach. As chapter one showed, for example, Steven Gordon’s 2005 testimony before the DC Council Committee on Health and Committee on the Judiciary clearly attributes the criminality of mentally ill, incarcerated individuals in DC to the District’s failure to provide this group with “need[ed] treatment” inside and outside of its carceral facilities (Gordon 2). In fact, Gordon – who, at the time, served as the Chair of the Criminal Justice Committee for the Council of Court Excellence (CCE) – identifies individuals “who have not been acknowledged or been screened for mental health problems but who also need treatment” as “the population that recycles from the jail to the streets and back again on a regular basis” (Gordon 2). Gordon thus associates this group’s continued re-incarceration to their untreated pathology, calling on DC DOC to develop its collaboration with DC’s Department of Mental Health, expand its jails’ mental health units, improve its provision of psychotropic medication inside its facilities, and ensure medication and treatment
continuity for individuals released from its custody in an effort to prevent mentally ill, incarcerated individuals’ re-incarceration (Gordon 2-3). During the same hearing, Mike Berler, with the DC Prisoners’ Legal Services Project, also criticized DC DOC’s failure to care for its incarcerated population with mental health diagnoses, stressing “the recycling of the homeless and mentally ill” in and out of the system (Cosmos). Similarly to the Council of State Governments, Gordon and Berler thus construct this group’s greater vulnerability to criminalization as a result of its members’ pathology, thereby depicting its members as requiring more extensive “care” than their non-mentally-ill, incarcerated and non-incarcerated, mentally ill counterparts.

These carceral humanist approaches extend beyond conceptions of the incarcerated subject that efforts based on Guenther and Terwiel’s definition of the term operate within (Guenther and Terwiel). The latter framework views incarcerated individuals, by virtue of their criminality, as fundamentally less-than-human and undeserving of comfort, thereby defining their “humane” treatment as the mere preservation of their biological life (Terwiel 77; Guenther 132-133). Even when distinguishing between mentally ill and non-mentally-ill, incarcerated individuals, as in Campbell and Inmates, these approaches view incarcerated individuals with mental health diagnoses as incarcerated subjects whose right to mental health services depends on their right, as criminalized individuals, to “the minimum of life’s necessities” (District of Columbia, District Court [1985] 49). The efforts discussed above, on the other hand, conceptualize mentally ill, incarcerated individuals’ criminality as a result of their vulnerability as pathologized individuals and, thus, as fundamentally distinct from the criminality of the rest of the incarcerated population. One report by the DC Prisoners’ Project, in fact, goes as far as labeling individuals diagnosed with “serious” mental health issues in DC’s jails as “psychiatric
patients” (From the Inside Out). Thus, this group’s criminality, rather than constructing its members as undeserving of punishment and merely deserving of basic life necessities, depicts them as requiring extensive “care” within the carceral setting. As future paragraphs will discuss, this distinction of mentally ill, incarcerated individuals’ needs from those of the rest of the prison population allows for the extension of carceral actors’ role to that of service providers.

It is important to note that, despite their reliance on a seemingly-softer image of incarcerated individuals as deserving of “care,” such constructions actually dehumanize mentally ill, incarcerated individuals and, as chapter three will explore in detail, render them especially vulnerable to psychiatric violence. As this chapter’s discussion of carceral ableism has suggested, disability-based constructions of vulnerability often rely on ableist and sanist depictions of pathologized individuals to justify their psychiatric treatment and confinement (Ben-Moshe, Decarcerating 16-17). The activism outlined above clearly relies on these dehumanizing logics, operating on ableist and sanist – by Ben-Moshe’s definition, based on the “imperative to be sane, rational, and non-mad/crazy/mentally ill/psychiatrically disabled” – assumptions that pathologized individuals are incapable of caring for themselves and require psychiatric treatment (Ben-Moshe, Decarcerating 16-17). In fact, the “new asylum” thesis itself is founded on the assumption that untreated mental illness among houseless individuals results in their incarceration and, thus, that the “homeless mentally ill” require psychiatric treatment (Ben-Moshe, Decarcerating 135). More specifically, Gordon’s testimony calls for improvements in DC DOC’s mental-health-focused discharge planning “[b]ecause persons with mental illness have limited ability to comply with conditions of release” and, thus, are more likely to face reincarceration (Gordon 2-3). These carceral ableist logics thereby construct mentally ill,
incarcerated individuals as vulnerable by virtue of their inferiority to “sane” individuals, thus justifying psychiatric, carceral efforts to “care” for and treat them.

As suggested above, one cannot disentangle mentally ill, incarcerated individuals’ constructed vulnerability from their invulnerability, as processes of racial criminal pathologization inevitably associate this group’s vulnerability, or their pathology, with its members’ dangerousness and, thus, invulnerability (Ben-Moshe, *Decarcerating* 25; Iliopoulos 54). In fact, the Council of State Governments and Gordon’s depiction of this group’s greater vulnerability to incarceration as a result of its members’ pathology also points to their constructed invulnerability. Gordon’s recommendation for more extensive mental-health-focused discharge services at the CDF and CTF suggests his understanding of released, mentally ill incarcerated individuals’ pathology as a threat to their personhood, thus emphasizing carceral actors’ responsibility to protect these individuals from themselves (Gordon 2). The Council of State Governments’ publication presents a similar logic, stating: “Experiencing delusions, immobilized by depression, or suffering other consequences of inadequate treatment, many of these individuals have struggled, at times heroically, to fend off symptoms of mental illness” (*Criminal Justice/Mental Health Consensus Project* xii). This language reflects advocates’ understanding of mental illness as a dangerous, independent entity that harms the individuals that it supposedly inhabits. Importantly, these arguments for mentally ill, incarcerated individuals’ extended care differ from the vulnerability-based appeals discussed above, as they construct this group’s vulnerability as a result of its members’ own dangerousness and, thus, invulnerability.

To this point, carceral humanist efforts also conceptualize mentally ill, incarcerated individuals' invulnerability as the threat that this group poses to the population at large and non-mentally-ill, incarcerated individuals. In chapter one, I argued that efforts arising from the
“new asylum” thesis and, thus, the processes of racial criminal pathologization and criminalization that underlie it construct mentally ill, incarcerated individuals as uniquely dangerous subjects compared to their non-mentally-ill, incarcerated counterparts and non-incarcerated mentally ill counterparts (Ben-Moshe, Decarcerating 25). These logics are clear in the activism discussed above. For example, as discussed in chapter one, Gordon and the Council of State Governments’ depiction of mentally ill, incarcerated individuals – and, especially, formerly-houseless, mentally ill, incarcerated individuals – as a sector of the mentally ill population whose pathology leads them to exhibit a greater propensity to criminality constructs them as uniquely-invulnerable, mentally ill individuals who pose a distinct threat to the population at large (Gordon 1; Criminal Justice/Mental Health Consensus Project xii). This logic underlies Gordon and the Council of State Governments’ demands for enhanced community-and-jail-based mental health services, as well as comprehensive mental-health-focused re-entry services, for this group as efforts to protect the wider community from their members’ unique invulnerability (Gordon 1; Criminal Justice/ Mental Health Consensus Project xii). In fact, the Council of State Governments’ reports positions mental health services in mentally ill, incarcerated individuals’ re-entry as crucial to ensuring that these individuals “safely” re-enter their communities (Criminal Justice/ Mental Health Consensus Project 127).

These efforts also depict mentally ill, incarcerated individuals as a threat to non-mentally-ill, incarcerated individuals. For example, the Council of State Governments’ publication frames increased mental health services as “good corrections policy” that can “protect people with mental illness while they are incarcerated, [...] maintain calm environments at the facilities, and [...] promote staff safety” (Criminal Justice/ Mental Health Consensus Project 127).
Project 126). Through processes of racial criminal pathologization, this statement clearly differentiates mentally ill, incarcerated individuals from the rest of the jail population on the basis of their innate dangerousness as pathologized subjects, calling for their identification and treatment to protect the jail population at large. Demands for mentally ill, incarcerated individuals’ psychiatric treatment on the basis of their unique dangerousness and, thus, the unique threat that they pose to themselves and others suggest this group’s incapacitation as another crucial motivator of its members’ increased “care” or treatment.

These constructions of mentally ill, incarcerated individuals’ simultaneous vulnerability and invulnerability thus justify carceral efforts aimed at their “care” and incapacitation in the form of psychiatric screening and treatment. Crucially, this group’s depiction as distinct from the rest of the jail population on the basis of their unique vulnerability and dangerousness expands the role of jails and prisons from that of carceral actors working solely with incarcerated subjects to that of service providers working with mentally ill, incarcerated subjects. This expansion is clear in the demands presented by the aforementioned advocates, which task jails and prisons with developing thorough screening services, individualized treatment plans, specialized housing units, and other psychiatric interventions for mentally ill, incarcerated individuals’ protection, “care,” and incapacitation (Criminal Justice/ Mental Health Consensus Project 128, 136). I suggest that demands for such services, as well as widespread depictions of mentally ill, incarcerated individuals as an increasing sector of the incarcerated population, contributed to later constructions of DC DOC as “a major provider of basic human services” – in the words of former DC DOC Director Devon Brown (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”).
Such depictions of carceral actors, as well as demands for carceral interventions to address mentally ill, incarcerated individuals’ supposed need for “care” and incapacitation, accomplish a crucial goal of carceral humanism: its construction of state actors as the “allies and saviors” of vulnerable groups as opposed to key players in their vulnerability (Bernstein 144). This depiction of carceral actors renders them part of the solution to the carceral harm that they caused, thereby justifying their expansion in the face of increasingly-anti-carceral politics (Kilgore; Bernstein 144). The efforts discussed above fuel these depictions, positioning the criminal legal system as a passive, impacted actor in the larger phenomenon of deinstitutionalization and insufficient community-based mental health services.

The Council of State Governments’ report, for example, states that the criminal legal system’s overwhelming contact with individuals with mental health diagnoses “frustrates criminal justice officials,” as “they know they are failing the person who suffers from mental illness and his or her loved ones” (Criminal Justice/Mental Health Consensus Project 5). The report adds that this “situation not only exacts a significant toll on the lives of people with mental illness, their families, and the community in general, it also threatens to overwhelm the criminal justice system” (emphasis added; Criminal Justice/ Mental Health Consensus Project 6). For example, the Council of State Governments stresses that police departments invest “thousands of hours each year” in transporting individuals with mental health symptoms to care facilities that are often unable to admit them, that prosecutors, judges, and defense attorneys face a significant backlog of cases involving individuals with mental health issues, and that the latter consistently crowd jails and prisons, displaying a recidivism rate of 70 percent in some locations (Criminal Justice/ Mental Health Consensus Project 6). Although adopting a critical stance towards DC DOC’s insufficient care of mentally ill, incarcerated individuals, Gordon’s testimony reflects
similar logics. He critiques DC DOC’s “inadequate response” to the rising numbers of individuals with mental health diagnoses in the criminal legal system while recognizing that “diagnosis has outpaced the ability of the government and service providers to offer treatment” (Gordon 1-2). Further, as discussed above, Gordon’s testimony, as well as that of representatives of the DC Prisoners’ Project at the same hearing, largely attribute mentally, incarcerated individuals’ repeated incarceration to their pathology, largely overlooking the role that DC DOC plays in continuously incarcerating large sectors of its population (Gordon 2; Cosmos).

This language clearly overlooks the criminal legal system’s active role in the criminalization, pathologization, and disablement of large sectors of the population. As Ben-Moshe’s critique of the “new asylum” thesis makes clear, criminal legal actors are fundamental to the criminalization of houseless and pathologized individuals, operating on associations between deviance, dangerousness, and criminality to construct and respond to these individuals’ supposed threat (Ben-Moshe, Decarcerating 144). Further, although the efforts discuss above partially attribute mentally ill, incarcerated individuals’ continued incarceration to carceral actors’ failure to provide them with psychiatric services, they overlook the disabling nature of jails and prisons, which can seriously harm incarcerated individuals facing repeated incarceration (Ben-Moshe, Decarcerating 147). Finally, these efforts also fail to consider the role that jail-and-prison-based mental health services play in pathologizing and constructing mentally ill, incarcerated individuals, discussed in chapter one, thereby demanding these services’ expansion and, thus, rendering this group increasingly vulnerable to this pathologization. To this point, depicting carceral actors as “allies and saviors” of mentally ill, incarcerated individuals, these efforts attempt to address this group’s pathologization and incarceration through increased
jail-and-prison-based psychiatric services, thereby legitimizing carceral expansion and carceral actors’ construction as service providers (Bernstein 144).

The Unity Contract as a Reformist Reform

In this section, I consider DC DOC’s contract with Unity Health Care as a carceral humanist, reformist reform that legitimizes and expands the Department’s role in DC. As chapter one discusses in detail, rhetoric surrounding the contract and the community-oriented health care model that it operates on reflect carceral humanist constructions of mentally ill, incarcerated subjects as simultaneously vulnerable and invulnerable individuals requiring incapacitation and “care” in the form of psychiatric treatment (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”; Conklin). For this reason, I situate DC DOC’s contract with Unity as a reformist reform that draws legitimacy from carceral humanist discourse, thereby examining it as an example of the carceral expansion that the carceral humanist efforts discussed above called and allowed for. I show that, constructing carceral actors as care providers for mentally ill, incarcerated individuals, the 2006 contract, as well as its subsequent, more extensive 2019 version, grant more resources and credibility to DC DOC in the face of increasingly-anti-carceral politics.

Before examining the Unity contract, I will provide a brief overview of the broader context of healthcare-based carceral expansion that it originated from. DC DOC was the first corrections department to adopt the community-oriented health care model in a nationwide effort to spread the model beyond Hampden County, MA (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”). To fund this effort, in January 2006, the Robert Wood Johnson Foundation (RWJF) invested $7.4 million in founding Community-Oriented
Correctional Health Services (COCHS), a non-profit organization supporting jurisdictions across the country in implementing the model (“Department of Corrections Institutes Community-Oriented Healthcare for Inmates”; “History”). In its description of the grant, the foundation states that “[i]nmates suffer from high instances of chronic disease and at-risk lifestyles with little or no idea how to care for themselves,” positioning COCHS as a means to “support the health of the ex-inmate” and “provide holistic health care to [...] families, and communities” (“Awarded Grants”). Through this language, RWJF thus justifies its investment in the betterment of medical services in carceral facilities and the construction of a “post-release system of care” as efforts to care for incarcerated individuals with medical conditions and protect non-incarcerated communities from this group’s pathologies (“Awarded Grants”). This framework is clearly carcal humanist in nature, as it plays on constructions of mentally ill, incarcerated individuals – albeit, more broadly, of incarcerated individuals with “chronic disease and at-risk lifestyles” – as requiring extensive “care” and, importantly, positions carcal actors as saviors of this group to justify further investments in their care-taking functions (“Awarded Grants”).

RWJF’s grant, COCHS, and the community-oriented health care model signify the financial and political expansion of carcal actors that carcal humanist frameworks allow for. RWJF’s investment in COCHS and the latter’s continued work to expand the community-oriented health care model in the US render them part of the network of industries and government agencies that constitute the Prison Industrial Complex (PIC) (“What is the PIC?”). In his analysis of houseless individuals’ organized abandonment, Craig Willse argues that non-profit organizations tasked with their “management” are key actors in this group’s economic exploitation, as they benefit from its perpetual housing insecurity and constructed need
for social services other than housing (Willse 12-14). Similarly, non-profit organizations like COCHS depend on the continued incarceration of large sectors of the population, as their work focuses on “improving,” rather than abolishing, pathologized individuals’ confinement. RWJF’s grant, COCHS, and the community-health care model thus expanded the network of economies that constitute the PIC, also leading to, as the paragraphs below show, direct investments into the criminal legal system. Further, as carceral humanist and reformist reforms, this grant and COCHS also afford legitimacy to carceral institutions that adopt the community-oriented health care model, depicting them “as another healthcare delivery site within the community” rather than inhumane places of confinement (“Home”).

Resulting from this growing network of carceral-healthcare-based economies, DC DOC’s contract with Unity expanded the former and, of crucial importance to this section, granted DC DOC financial and political resources. The contract signifies a material expansion to DC DOC’s budget. For a base period that spanned from its implementation in September of 2006 to September of 2009, the contract amounted to over $84 million. The contract’s yearly amount increased from $26 million in 2006, with an additional $1.5 million to account for transition costs immediately after its implementation, to $28.84 million in 2009 (“Award/Contract” 2). Notably, DC DOC’s budget underwent a significant expansion during this period. In 2005, the Department’s “Medical and Mental Health Services” budget amounted to over $21.6 million compared to its 2006 budget of over $29.4 million (Public Safety and Justice c-46; FY 2008 Proposed Budget and Financial Plan c-46). This change came with a rise of over $12 million in DC DOC’s total operating budget (Public Safety and Justice c-41; FY 2008 Proposed Budget and Financial Plan c-39). It is important to note that Unity also greatly benefitted and continues to benefit from its contract with DC DOC – in 2020, for example, DC DOC’s contract constituted
18% of its revenue (Consolidated Financial Statements and Supplementary Information 5). Alongside COCHS, Unity thus offers another example of non-profit organizations that rely on the continued incarceration and medical management of pathologized individuals and, thus, are part of the PIC.

Alongside this financial expansion to DC DOC, the Unity contract also strengthened the Department’s credibility, which greatly suffered in the decades of litigation that followed Campbell and Inmates (From the Inside Out 1; Smith). Prominent activists recognized the contract as a turning point for the DC jails’ healthcare provision. In a 2010 DC Council hearing, Philip Fornaci with the DC Prisoners’ Project (the Project) – an organization that, as shown in this chapter, played a fundamental role in pre-2006 activism for the provision of improved health care services at the CTF and CDF (D.C. Women in Prison: Continuing Problems and Recommendations for Change; Cosmos) – had “very few complaints about medical services” at the facilities (District of Columbia, Council, Committee on the Judiciary & Public Safety [2010] 5:55:02-5:55:03). Commending DC DOC’s “very good situation with Unity,” Fornaci pointed to Unity’s ability to resolve medical issues that had seemed “unsolvable” in, as stated by Councilmember Phil Mendelson, the “history of monumental failure” that characterized the CDF and CTF’s health care services (District of Columbia, Council, Committee on the Judiciary & Public Safety [2010] 5:54:46-48-5:56:41). He testified that the Project was able to develop close relationships with Unity staff that allowed it to quickly address and resolve the few, health-related complaints that its clients surfaced. Responding to possible budget cuts to DC DOC’s contract with Unity, Fornaci stated that jeopardizing the contract would be “the most foolish thing in the world” (District of Columbia, Council, Committee on the Judiciary & Public Safety [2010] 5:56:41-5:56:45). Fornaci’s praise greatly contrasts the Project’s previous stance
on medical services at the CDF and CTF. In a 2004 publication, for example, the Project reported that, following the dismissal of *Campbell* and *Inmates*, it had “received hundreds of complaints” from incarcerated individuals at the facilities providing “alarming accounts of failures to provide even basic medical and mental health treatment to people with chronic conditions” (*From the Inside Out* 1).

A 2015 controversy over the possibility of a new medical services contractor also points to public support for the contract. During this year, DC’s government considered contracting DC DOC’s health services to Corizon Health, a for-profit corporation based in Tennessee with a history of lawsuits for poor service provision (Hauslohner). Advocates quickly opposed the contract, critiquing Corizon’s track record and its ulterior motives as a for-profit company – a Human Rights Defense Center letter to the DC Council, for example, remarks: “Corizon, as a for-profit company, wants the $66.1 million contract; it is not seeking to provide medical care to D.C. prisoners for altruistic or humanitarian reasons” (Friedmann 3). In this controversy, Unity’s role as a “locally run nonprofit group” that directly works with DC’s communities afforded it and, thus, DC DOC credibility as a benevolent service provider at the facilities (Hauslohner). Therefore, the Unity contract played a fundamental role in DC DOC’s transition from a non-court-compliant, unconstitutional place of confinement, per *Campell* and *Inmates*’ findings, to DC’s “largest single-location mental health care provider” (District of Columbia, District Court [1985]; District of Columbia Council, Council, Committee on the Judiciary & Public Safety [2018] 1:34:29-1:34:31).

In 2019, DC DOC awarded Unity the “Department of Corrections (DOC) Inmate Comprehensive Medical Services” contract, which specifically expands behavioral health services at the facilities (“Unity Health Care”). The contract partially emerged from concerns
over the overrepresentation of mentally ill, incarcerated individuals at the CDF and CTF – in DC DOC’s words, “Mindful that DOC serves one of the largest mental health populations in the city [...] the current healthcare contract has been innovatively written to serve the District’s needs by being more comprehensive regarding Mental Health Services” (*Performance Oversight Responses* [2019] 146). This language clearly operates within a carceral humanist framework that casts mentally ill, incarcerated individuals as requiring special “care” and monitoring in the carceral setting and carceral actors as service providers tasked with meeting this group’s distinct “needs” (*Performance Oversight Responses* [2019] 146). Following this logic, the contract, for example, requires that Unity provide incarcerated individuals with “integrated therapeutic modalities [including Cognitive Behavioral Therapy, Moral Reconation Therapy, and Dialectical Behavioral Therapy] organized under a Trauma-Informed Care structure,” as well as “yoga and mindfulness, art therapy, and music therapy groups by outside community organizations” (*Determination and Findings for Price Reasonableness* 14-15).

The 2019 contract led to a significant expansion in DC DOC’s budget (“Unity Health Care”; *Performance Oversight Responses* [2019] 146). In 2018, DC DOC budgeted under $23 million for the contract, compared to over $32.5 million in 2020, the first full year of the new contract (*Performance Oversight Responses* [2018] 87; *Performance Oversight Responses* [2019] 42). Importantly, the Department of Behavioral Health (DBH)’s Statewide Opioid response funded nearly $2 million of the Unity contract in 2021 and 2022 to provide personnel for the DC jails’ Substance Use Disorder Units and medication for substance use issues (*Performance Oversight Responses* [2022] “14. Please List Each Grant or Sub-Grant Granted by Your Agency in FY21 and FY22, to Date”). With this expansion to Unity’s contract came a rise in the DC DOC’s operating budget and funding – in fact, DC DOC’s 2019 proposed budget
included an enhancement of over $9.4 million for “inmate healthcare initiatives,” specifically allocating $4.9 million of this amount to DC DOC’s healthcare contracts (FY 2019 Proposed Budget c-47). The historical context of these rising budgets is especially relevant to consider. In the summer of 2020, the US witnessed unprecedented calls for the defunding and abolition of police and prisons, and, yet, DC DOC’s budget increased by $8 million between 2020 and 2021 – with a specific proposed increase of $2.1 million to support the Department’s healthcare contracts in 2020 (Taylor; FY 2023 Approved Budget and Financial Plan c-23; Department of Corrections). Thus, as the DC Council cut $15 million from the city’s police budget in the summer of 2020, DC DOC continued to enhance its budget on the basis that “comprehensive mental health services must be provided to this group [mentally ill, incarcerated individuals] in need,” thus strengthening its credibility in the face of increasingly-abolitionist efforts by framing itself as a service provider in DC (Swalec; Performance Oversight Responses [2022] “60. Please Describe the Mental or Behavioral Health Services Offered to Residents in DOC Custody”).

Beyond the Unity Contract

The Unity contract is just one example of the many mental health initiatives that have emerged at DC DOC’s facilities in the last few decades. The previous chapter provided a comprehensive overview of these initiatives, which include the CDF and CTF’s various mental health units, programming efforts, and thorough discharge planning. In this section, I will briefly situate DC DOC’s Mental Health Step Down Unit (MHSDU), which houses individuals transitioning between the CDF’s Acute Mental Health Unit and the general population and includes extensive mental health programming, in a context of carceral humanism to examine its role in preserving and expanding DC DOC’s role as a service provider in DC (Performance
Oversight Hearing Questions and Answers “OBJECTIVE 2: Maintain/Improve Inmate Physical and Mental Health”).

Although the MHSDU’s development did not significantly increase DC DOC’s budget, it greatly strengthened the Department’s credibility as a service provider in DC. DC-based advocates worked toward the MHSDU’s construction for a number of years. For example, Dr. Lindsay M. Hayes’ 2013 report on suicide prevention at the facilities critiqued DC DOC’s frequent segregation of mentally ill, incarcerated individuals, claiming that “to every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located in close proximity to staff” (Lindsay M. Hayes 22). Classifying DC DOC’s practices as “anti-therapeutic,” Hayes recommended that the Department implement a step-down mental health unit with thorough mental health programming (Lindsay M. Hayes 24, 28). Drawing on Hayes’ report, at a 2014 DC Council hearing, DC Jail and Prison Advocacy Project Direct Tammy Seltzer also urged DC DOC to develop a mental health step-down unit that “would provide treatment [...] and interaction [...] to better prepare people for reentering the community” (District of Columbia, Council, Committee on the Judiciary [2014] 2:56:55-2:57:10). This advocacy clearly operates within a carceral humanist framework that identifies mentally ill, incarcerated individuals as requiring extensive “care” before their safe reintegration into the jail’s general population or the DC community at large and, importantly, situates DC DOC as a potential care provider for this group. Crucially, Hayes and Seltzer identify the construction of a mental health step-down unit as a means for DC DOC to occupy this role, thereby legitimizing DC DOC’s identification as a service provider upon its implementation of this initiative.
In fact, in a 2016 document, DC DOC describes the MHSDU as a “unit to better care for persons who would benefit from a treatment community environment before transitioning to appropriate correctional housing” that will act as “an additional step in [...] [this group’s] care continuum” (Performance Oversight Hearing Questions and Answers “Summary of Services”). Largely mirroring Hayes and Seltzer’s language, this description of the unit clearly portrays DC DOC as a care provider for mentally ill, incarcerated individuals, while affording the Department credibility among DC’s activist community. At a 2015 forum discussing DC’s school-to-prison pipeline, for example, Seltzer praised the MHSDU and its extensive programming, urging DC residents to express their support for such programs to the DC Council (Prewitt). Further, the Jail and Prison Advocacy Project’s website celebrates the organization’s role in the development of the MHSDU, portraying it as a unit where mentally ill, incarcerated individuals “can enjoy group activities, such as social skills, trauma support, yoga, and mindfulness” (“DC Jail and Prison Advocacy Project”). This latter description and, specifically, its choice of the word “enjoy” point to the softened image that these treatment services afford DC DOC as a provider of care for mentally ill, incarcerated individuals.

A 2017 City Paper article on the MHSDU’s programming, titled: “Jail, Break: Yoga Is an Hour of Unmitigated Contentment for People Behind Bars,” perfectly captures the CDF and CTF’s softened image. The article discusses yoga classes taught in the unit, describing that “[s]ave for the guard at the door, the blinding orange outfits, and the basketball hoop on one side of the room, it’s hard to tell the class is being taught inside D.C.’s Central Detention Facility” (Laura Hayes). The piece quotes DC DOC’s medical director to emphasize the mental health benefits that these courses bring to incarcerated individuals: “They [the courses] show a good impact in terms of sleeping and decreased anxiety and those are two very important issues in
terms of life in general, but especially in an incarcerated setting” – note the irony of a carceral
actor praising a mental health initiative for its ability to mitigate conditions caused by the
carceral setting (Laura Hayes). The article thus implies the CDF and CTF’s potential to act as
places of care and healing, going as far as to suggest that the facilities’ yoga classes create an
environment that escapes their carceral structures. Such constructions clearly afford the CDF and
CTF legitimacy as “humane” and “caring” places of confinement, opening up venues for further
investment in DC DOC’s implementation of similar services.

Importantly, however, the article’s emphasis on the MHSDU’s yoga classes as an escape,
or a “Jail, Break,” for incarcerated individuals suggests its acknowledgment that carceral
facilities are fundamentally incapable of serving as healing spaces or spaces of “unmitigated
contentment for people living behind bars.” The yoga classes themselves are not provided by DC
DOC instructors but, rather, by Yoga Activist, a non-profit division of Yoga District, and, as DC
DOC’s medical director’s comment suggests, are aimed at addressing stressors that directly result
from individuals’ incarceration (Laura Hayes). This distinction between the carceral setting as an
inherently harmful living environment and mental health initiatives, or other programming, as
possibilities for relief from it shows potential for developing life-affirming services in jails and
prisons that do not reframe these facilities themselves as “caring.” I will further consider this
point in this chapter’s conclusion.

The MHSDU is just one additional example of mental health-based reformist reforms in
DC. Others include the Department of Behavioral Health (DBH)’s $1.9 million grant to DC
DOC’s contract with Unity, DBH’s $40 thousand funding to DC DOC’s provision of
trauma-informed programming to DC DOC officers and residents, or DC DOC’s development of
a “ comprehensive mental health/SUD therapeutic housing unit” for women in 2021
(Performance Oversight Responses [2021] 177; Performance Oversight Responses [2022] “14. Please List Each Grant or Sub-Grant Granted by Your Agency in FY21 and FY22, to Date”).

Most recently, in March of 2022, DC Mayor Muriel E. Bowser allotted over $250 million to the construction of an annex facility to the CTF, where, in Bowser’s words, “our residents can be rehabilitated, receive the treatment that they need, and, most importantly, [...] come back home” (Davies). Plans for the facility include “creating painting programs to bring bright, vibrant colors to the jail walls along with encouraging messages to help improve incarcerated people’s attitudes [...] [and] creating a landscaped, college campus environment” (Williams). These initiatives clearly point to the financial and political benefits that softened depictions of DC DOC as a care provider afford the Department. Most strikingly, the language surrounding the construction of the annex facility suggests its attempt at investing in a carceral space that actively denies its punitive nature through colorful wallpaper and structures disguising it as an educational, fundamentally-rehabilitative setting.

Conclusion

This chapter examined the reformist nature of DC DOC’s mental health initiatives in the context of Kilgore’s carceral humanism. I distinguished Kilgore’s conception of carceral humanism from its earlier definitions to emphasize its reliance on vulnerable, invulnerable, and simultaneously vulnerable and invulnerable subject identities in its depiction of carceral actors as benevolent service providers (Rodriguez et al.; Kilgore). Specifically considering the mentally ill, incarcerated subject in this framework, I suggested that this form of carceral humanism’s focus on subjects other than the incarcerated subject as a fundamentally-invulnerable subjectivity allows for carceral actors’ construction as caretakers for sectors of the incarcerated population.
Such depictions of incarcerated individuals and carceral actors overlook the latter’s role in inflicting carceral violence on the former, thereby legitimizing their expansion as service providers tasked with incarcerated individuals’ “care” and protection (Rodriguez et al.; Bernstein).

I then positioned DC DOC’s mental health initiatives in this framework to argue that DC-based carceral actors, as well as reformers, construct and rely on depictions of the mentally ill, incarcerated subject as a dually vulnerable and invulnerable subject identity that requires “care” and incapacitation to justify DC DOC’s expansion in the form of psychiatric treatment. Focusing on DC DOC’s contract with Unity and its MHSDU, my analysis showed that carceral humanist constructions of this subject identity have legitimized efforts to financially and politically expand DC DOC as a service provider in DC.

It is important to note that I do not discount the concrete benefits that such funding and programming can bring to incarcerated individuals at the CDF and CTF. Incarcerated individuals interviewed for the City Paper article discussed above, for example, clearly enjoyed the classes. One individual named Philip praised the MHSDU’s yoga classes: “[this] is the first time I’ve kind of enjoyed being here—having this makes the day go by” (Laura Hayes). Instead, I seek to problematize these services’ role in affording legitimacy to carceral spaces as places of care. As Philip makes clear, and as I suggest above, these programs’ strength lies in their ability to carve out a space of care for incarcerated individuals that almost exists outside of the carceral realm that they are confined to. To use such programs’ implementation to legitimize carceral spaces as “humane” or “caring” is to largely overlook their purpose and contradict their underlying logics. Expanding and funding carceral spaces to provide more of these services ultimately strengthens the logics that such programs attempt to defy, providing a clear example of reformist reforms.
This thesis’ conclusion will consider possibilities for services that carve out non-carceral spaces in carceral facilities without legitimizing the latter.

Unlike the yoga classes discussed in the City Paper paper article, some mental health initiatives inside carceral facilities actually harm incarcerated individuals. Psychiatric treatment itself often operates within carceral logics, confining and medicalizing – a process defined by Erick Fabris as “chemical incarceration” – pathologized individuals on the basis of perceived deviance or dangerousness (Schenwar and Law; Fabris; Ben-Moshe, Decarcerating). Within carceral facilities, this treatment can legitimize the unconstitutional punishment of pathologized individuals under the guise of treatment, allowing carceral actors extended access to and control over incarcerated individuals (Opton 607-608). The next chapter explores this issue further through an analysis of DC DOC’s initiatives in the context of disability rights literature.
Chapter 3 – Correction and Confinement as “Care”: Expanding Carceral Control Through Mental Health Services in DC’s Jails

In 2015, Sophia Dalke attempted suicide at her place of work and, after a 10-hour standoff with law enforcement, was hospitalized and, eventually, incarcerated at the DC Jail. At the jail, Dalke was held in a safe cell, or a “suicide-resistant” cell (Ryals; District of Columbia Department of Corrections 2018 Inspection Report 17). The cell was “freezing,” had no mattress or running water, was lit by fluorescent lights 24 hours a day, and had “dark smears on the walls, which she [Dalke] believes were feces from previous occupants” (Ryals). Before confining Dalke to the cell, DC DOC staff stripped her of her clothing, giving her only a “safety smock,” temporarily denied her antidepressant medications, and placed a sign outside her door warning others not to speak with her (Ryals).

Dalke’s experience is not an anomaly at the CDF and CTF. Countless others have been denied running water, family visitation, recreation, and phone calls in the facilities’ safe cells (Ryals). Despite their dehumanizing conditions, DC DOC continues to confine incarcerated people to these cells in a stated effort to ensure their “safety and security” (Suicide Prevention and Intervention 21). Some efforts challenging this practice echo this reasoning. For example, Dr. Lindsay M. Hayes’ 2013 report on improving suicide prevention at the CDF and CTF, discussed in chapter one, critiques these cells’ overly-restrictive nature while continuing to identify them as important measures for the protection of incarcerated individuals at risk for suicide (Lindsay M Hayes 47). More recently, a DC Council bill aimed at dismantling solitary confinement at the jails allows for their continued use on the conditions that 1) one’s confinement “is immediately necessary to prevent death or serious bodily injury,” and 2) “[t]he
penal institution provides the incarcerated person appropriate medical and mental healthcare” (District of Columbia, Council [2022] 5). These justifications are clearly based on constructions of mentally ill, incarcerated individuals as requiring simultaneous “care” and incapacitation, appealing to notions of “safety” and “security” to legitimize this group’s inhumane confinement as needed treatment (Suicide Prevention and Intervention 21). Safe cells thus problematize simplistic assumptions that increased mental health services in the carceral setting are inherently beneficial to mentally ill, incarcerated individuals, suggesting, instead, that they expose this group to unique and exacerbated forms of violence.

The previous chapter examined the role that constructions of mentally ill, incarcerated subjects play in depicting DC DOC as DC’s “largest single-location mental health care provider” and, thus, in allowing for the expansion of carceral systems as places of care (District of Columbia, Council, Committee on the Judiciary & Public Safety [2018] 1:34:29-1:34:31). This chapter extends this critique to consider the impact that this subject identity and the mental health services that it legitimizes have on incarcerated individuals. I contextualize these services in disability studies and abolitionist theory to shed light on their function as sites of carceral and psychiatric violence. Relying on existing literature, I suggest that psychiatric services are inherently carceral and, thus, adopt a doubly-carceral function in jails and prisons that renders their recipients uniquely vulnerable to psychiatric and carceral violence (Iliopoulos; Galanek; Schenwar and Law). I thereby argue that constructions of mentally ill, incarcerated individuals not only strengthen and expand DC DOC’s role in DC but also grant carceral actors extended access to and control over this group.

To structure my argument, I will first examine theory on the shared role of psychiatry and criminal legal systems in the carceral state. I show that, on the one hand, psychiatry has come to
adopt increasingly carceral functions, and that, on the other hand, criminal legal systems have placed a growing focus on psychiatric treatment as a means for targeting and correcting criminality (Iliopoulos). I then examine the unique function that jail-and-prison-based mental health services adopt in this context, expanding on Joseph D. Galanek and chapter one’s analyses of these services as distinct sites of psychiatric and criminal legal knowledge and on literature considering their inherently punitive role in carceral settings (Galanek; Opton; Hatch). I suggest that these services extend jail and prison officials’ power over incarcerated individuals in explicitly-restrictive and seemingly therapeutic ways – such as safe cells and Cognitive Behavioral Therapy programs, respectively. I then position mental health screenings and treatment programs at the CDF and CTF in this framework to call attention to DC DOC’s exertion of uniquely-compounded forms of psychiatric and carceral violence over incarcerated people with mental health diagnoses.

Theoretical Framework

Psychiatry and the criminal legal system have come to play an increasingly shared role in the carceral state. As this thesis’ introduction discussed in detail, the late twentieth century witnessed the pathologization of criminality through processes of criminal pathologization and racial criminal pathologization (Iliopoulos 52-56; Ben-Moshe, Decarcerating 24-26). Constructing criminality as an innate pathology that must be detected and treated, these processes positioned medical and criminal legal institutions on two ends of a “practice continuum” of institutions and policies concerned with the prevention of danger (Foucault qtd. in Chapman et al. 10).
This continuum tasks psychiatry with detecting and correcting potentially dangerous and, thus, criminal behaviors, extending the reach of the criminal legal system beyond the legal realm (Iliopoulos 55). This phenomenon manifests in the criminalization of deviant behaviors that are not inherently criminal but that, within frameworks of criminal pathologization, are associated with criminality (Iliopoulos 55; Ben-Moshe, Decarcerating 144). Think, for instance, of houseless individuals’ increasing criminalization on no basis other than their deviance, discussed in this thesis’ introduction (Ben-Moshe, Decarcerating 144; Schweik). Alternatively, consider the role that jail-and-prison-like psychiatric institutions as “carceral locales” play in confining and correcting pathologized individuals as potentially-criminal subjects – a phenomenon that this section will examine further (Ben-Moshe, Decarcerating 1; Chapman et al.). In turn, these processes have led the criminal legal system to place increasing emphasis on the correction of criminal individuals as pathologized subjects, giving way to treatment-like approaches to carceral punishment. Consider, for example, the increasing emphasis that carceral actors place on rehabilitation and, as chapter one has shown, mental health treatment as means to address criminal behavior (Foucault, Discipline 294; Criminal Justice/ Mental Health Consensus Project). (Note, corporal punishment in the form of practices such as solitary confinement and inhumane prison conditions continues to play a crucial role in the criminal legal system today alongside the aforementioned services).

Therefore, the carceral state as it exists today relies on jails and prisons adopting psychiatric functions and on mental health institutions adopting carceral functions. In this section, I examine the unique role that psychiatric services in jails and prisons occupy in this context to argue that efforts to increase mental health services in these facilities render mentally ill, incarcerated individuals uniquely vulnerable to carceral and psychiatric control and violence.
I will first offer an overview of theory on the inherent carcerality of psychiatric services. Then, I will rely on this framework to consider the unique carcerality of psychiatric services in the carceral setting and the doubly-carceral violence that they inflict on pathologized and criminalized individuals in these contexts.

*A Wolf In Sheep’s Clothing: The Carcerality of Psychiatric Treatment*

I will examine the carceral nature of three primary forms of psychiatric treatment: psychiatric institutions, community-based services, and psychotropic medication. In *Prison by Any Other Name: The Harmful Consequences of Popular Reforms*, Maya Schenwar and Victoria Law highlight the parallels between jails and prisons and psychiatric facilities. The authors point to how, as Chris Chapman et al. suggest, both use normative, arbitrary notions of pathology and criminality to “correct” individuals and, thus subject them to “confinement, surveillance, coercion, segregation, and punishment” (Schenwar and Law 70; Chapman et al. 6). For example, Schenwar and Law discuss the experiences of Elliot Fukui and Peg Plews, two individuals who experienced significant trauma at the hands of psychiatric actors (Schenwar and Law 64, 71).

Starting at the age of 12, Elliot Fukui was hospitalized twenty times in five different psychiatric hospitals over the span of seven years. Fukui’s parents initiated his first hospitalization, relying on legislation in Minnesota that allows for the involuntary hospitalization of individuals at risk for suicide (Schenwar and Law 64). During this first hospitalization, psychiatric actors subjected Fukui to carceral practices of incapacitation and correction. He was strip-searched upon admission, deprived of his belongings, forced to wear scrubs, heavily medicated, and made to participate in programs aimed at regulating how pathologized people express emotions. On the day-to-day, the facility operated on a level system, granting individuals
exhibiting “good behavior” the “privileges” of eating in the facility’s cafeteria, wearing their own clothes, sleeping for the entirety of the night, and using the restroom alone and depriving those who failed to exhibit “good behavior” of these “privileges” (Schenwar and Law 64-65). When hospitalized people had panic attacks or overtly expressed their emotions, staff would pin them down, strip them, inject them with tranquilizers, tie their legs and arms, sometimes wrap them in a gym mat and sit on them, and carry them to a panic room with no furniture, except for a mat, and no windows – note this room’s resemblance to DC DOC’s safe cells (Schenwar and Law 64-65).

Constructed notions of pathologized individuals’ dangerousness and simultaneous need for “care” and incapacitation play a crucial role in justifying the above practices. Minnesota’s legislation enabling the forced hospitalization of individuals deemed to be suicidal draws legitimacy from notions of mentally ill individuals’ need for protection from themselves (Schenwar and Law 64). At the same time, the facility’s panic room and programs aimed at regulating individuals’ emotions reflect notions that mentally ill individuals pose a danger to others and, thus, must be incapacitated and corrected before their reintegration into a non-carceral setting (Schenwar and Law 64-65). This latter point is especially clear in the facility’s level system, which, recalling that in DC DOC’s Mental Health Step-Down Unit (MHSDU), uses coercive practices to regulate individuals’ pathological and, thus, dangerous behavior (Schenwar and Law 65). Closely resembling carceral practices in jails and prisons, psychiatric facilities thus incarcerate individuals on the basis of the danger that they pose to themselves and others, deprive them of control over their bodies and property, and subject them to forced correction in an attempt to reduce their dangerousness and, therefore, criminality. It is crucial to note that, despite their punitive nature, these psychiatric services often avoid the label
of punishment, operating under the disguise of treatment to subject pathologized individuals to dehumanizing and restrictive conditions (Schenwar and Law 65).

Peg Plews’ story further highlights the role that claims of pathologized individuals’ dangerousness play in justifying their inhumane treatment inside medical facilities. In 2017, Plews visited a Walmart while intoxicated and was kicked out of the store, after which she re-entered the store in order to use the restroom. As she re-entered, a police officer pinned Plews down, and she began to urinate on herself. She asked spectators at the scene to call an ambulance, which brought her to the “psych emergency” section of a nearby ER. At the ER, staff forced Plews to undergo a strip search and let go of her clothes, placed her in a “secure core” cell that could only be opened externally, petitioned for her involuntary hospitalization (arguing that she displayed “persecutorial delusions”), forcibly drugged her, and refused to let her use the restroom until she threatened to urinate on the floor of the cell (Schenwar and Law 71-73).

Plews’ experience not only encapsulates the intertwined nature of claims of pathology, dangerousness, and criminality but also exemplifies the shared role that medical and criminal legal actors operating on these claims play in targeting and incapacitating pathologized individuals. Security at the store initially forced Plews out because, after being unable to access one of the store’s motorized carts as someone with a disability, she began to loudly inquire “Why doesn’t Walmart have enough carts for disabled people on a Friday night?” as she walked around its aisles. She eventually re-entered the store due to an incontinence issue, which led to her hospitalization (Schenwar and Law 72). Plews’ disability, as well as her display of disorderly or abnormal behavior as an intoxicated person speaking at a loud volume, were at the center of her identification as a potentially-dangerous individual. On this basis, the store’s security – criminal legal actors – incapacitated Plews and subjected her to involuntary “correction,” or treatment, in
a psychiatric setting. At the hospital, as Schenwar and Law put it, “staff [psychiatric actors] treated Plews not as a human being but as an intense danger to those around her,” thereby centering safety concerns to justify their efforts to “correct” Plews through forced confinement and medication (Schenwar and Law 74). Fukui and Plews’ experiences thus highlight the criminal legal role that psychiatry plays in identifying threatening individuals and subjecting them to coercive and inhumane treatment in an effort to reduce their dangerousness.

Less-restrictive, community-based mental health services also exemplify the parallels between psychiatric and criminal legal practices. Chris Drinkwater depicts these services as exerting “a purer form of power than the institution” that does not depend on constraint and exclusion and, instead, solely relies on disciplinary practices of surveillance and normalization to make pathologized individuals into docile and productive individuals (Drinkwater 232). These services institute a “system of differentiation” between staff and pathologized individuals that, on the basis of the latter’s pathology, constructs staff as “more able than service users, and thus […] [as] able to guide them” (Drinkwater 235). Recalling pathologized individuals’ construction as “punishable beings” in community care facilities, per Scott Yates’ analysis, this dynamic renders this group vulnerable to constant supervision and assessment by staff and limits their field of action as dependant on the latter’s permission (Drinkwater 235; Yates 71-73). To this point, Drinkwater also notes the surveillance that these services exert on pathologized individuals, specifically highlighting staff’s use of a book to record and share information on individuals’ behavior with each other (Drinkwater 236-237).

These power and surveillance dynamics sustain practices to correct pathologized individuals. One such practice is the “social role valorization” model, which attempts to instill “valued behaviors” in pathologized individuals through a system of rewards and punishments,
thereby working towards their successful assimilation and integration into society (Drinkwater 233). Further, these services also enforce a “regimen on the body,” or standardized, daily practices for hygiene, sleep, etc., on their recipients (Drinkwater 233, 235-236). Similarly to psychiatric institutions, community-based services thus strip individuals of their agency and subject them to carceral restrictions and supervision aimed at their correction on the basis of their pathology. Therefore, the carceral nature of psychiatric services does not lie in their reliance on confinement and large institutions but, rather, on the carceral logics that underlie psychiatric treatment.

Scholars have also specifically examined the carceral nature of psychotropic medication treatments and their role in pathologized individuals’ forced correction. For example, citing Erving Goffman (qtd. in Fabris 6), Erick Fabris argues that psychotropic drugs constitute a form of incarceration, as they execute two of its key functions: restricting individuals’ movements and communication. Referring to these medications as forms of “chemical incarceration,” Fabris challenges their portrayal as therapeutic treatments, arguing that they play a fundamental role in rendering pathologized individuals compliant with corrective treatments (Fabris 4). He shows that, operating on the assumption that mental illness – or, as Fabris refers to it, “madness” – is a biological condition that leads to “confusion, ambivalence, distress, irritability, aggression, and finally unpredictable violence,” psychiatric actors justify their forced medication of pathologized individuals as necessary to the latter’s stabilization and, thus, treatment compliance (Fabris 4, 37-38). These treatments not only fuel sanist notions of “madness” as a condition to be treated, but render pathologized individuals especially vulnerable to corrective treatment aimed at reducing their potential violence and, thus, dangerousness (Fabris 8). Working alongside the
psychiatric treatments discussed above, psychotropic medications thus hold clear carceral functions, as they incapacitate potentially-dangerous individuals in an effort to correct them.

This section has thus shone light on the carceral nature of psychiatric treatment, regardless of its varying manifestations and levels of physical confinement. These accounts complicate uncritical depictions of jail-and-prison-based mental health services as inherently beneficial to incarcerated people, pointing to the violence that psychiatric services inflict on their recipients. It is important to note that, although pathologized individuals receiving psychiatric treatments outside jails and prisons are undoubtedly subject to carceral violence, this group’s members, as non-incarcerated individuals, have more agency than their incarcerated counterparts. As this thesis has made clear, mentally ill, incarcerated individuals, by virtue of their simultaneous criminalization and pathologization, are uniquely dehumanized and vulnerable to psychiatric and carceral violence. Therefore, this group’s experience with psychiatric services inside the carceral setting calls for an independent analysis.

*The Prison Within the Prison: Mental Health Services Inside Carceral Facilities*

Existing literature has investigated key differences between psychiatric services inside and outside of carceral facilities. Chapter one provided an overview of jail-and-prison-based mental health assessments as distinct sites of knowledge production by virtue of incarcerated individuals’ unique demographics, the inherently harmful nature of carceral spaces, and these facilities’ securitization aims (Galanek; Rhodes, “Taxonomic”; Rhodes, “Psychopathy”). Many scholars echo this latter point, positing, as Jamie Fellner puts it, that “[t]here is an inherent tension between the security mission of prisons and mental health considerations” and that “[c]oordinating the needs of the mentally ill with those rules and goals is inherently impossible”
(Fellner 391). On this basis, scholars and mental health activists emphasize jail diversion programs as opposed to jail-and-prison-based mental health services in efforts to address the overcriminalization of individuals with mental health diagnoses (Seltzer 584-585; Abreu et al. 384-385; Bailey et al. 10; Fellner 411; Zaitzow).

These critiques of jail-and-prison-based mental health services operate on a clear distinction between criminal legal and psychiatric practices that disregards the latter’s carceral nature, thus providing a limited perspective on these services as sites of psychiatric and carceral violence. Nonetheless, their differentiation between jail-and-prison-based and community-based mental health services is crucial to consider in analyses of these facilities’ treatment of mentally ill, incarcerated individuals. The carceral nature of psychiatric services in these settings is layered on a pre-existing level of surveillance and restraint that all incarcerated individuals face, regardless of mental health diagnoses. As chapter one has suggested and this chapter will further explore, the introduction of psychiatric services in the carceral setting thus subjects mentally ill, incarcerated individuals to a unique intersection of carceral and psychiatric violence that non-incarcerated, mentally ill individuals do not experience.

Other critiques of jail-and-prison-based mental health services recognize these services’ carceral nature, examining them as extensions of carceral control in these facilities. Edward M. Opton argues that these services disguise unconstitutional forms of punishment as treatment, arguing that “fixing the labels ‘treatment’ and ‘therapy’ on punishments permits the use of procedures [in carceral facilities] up to and including torture, procedures which their [prison officials’] own administrative regulations, the courts, and the public would not permit if the justification were merely punishment” (Opton 607). Consider, for example, the recent DC Council bill’s preservation of safe cells in its efforts to ban solitary confinement at the CDF and
CTF on the basis that these cells provide mentally ill, incarcerated individuals with needed protection (District of Columbia, Council [2022] 5). Echoing Fabris, Ryan Hatch specifically examines the role that psychotropic drugs play in enforcing jails and prisons’ “logic of control and submission” and, thus, in rendering incarcerated people compliant with carceral policies (Hatch 11). Further, many have pointed to the racial and gendered dimensions of the distribution of psychotropic medications in carceral facilities, which tend to target racialized individuals and women as deviant (Zaitzow; Auerhahn and Leonard 600; Hatch 14)

These critiques suggest that psychiatric services, as inherently carceral practices, extend carceral control over incarcerated individuals in jails and prisons. As the previous section established, outside of these settings, psychiatric services are inherently carceral due to their reliance on conceptions of pathology to subject individuals to processes of normalization. Operating within constructed associations between deviance, dangerousness, and, thus, criminality, these services incapacitate and correct individuals in an effort to reintegrate them into society as normalized subjects. The normalizing function of psychiatric services does not change inside carceral facilities; however, their setting and the role that mentally ill, incarcerated individuals are normalized to occupy in it is fundamentally different. As the arguments outlined above suggest, in jails and prisons, one’s normalization consists of one’s compliance with carceral policies (Hatch 11). Galanek and Rhodes’ analyses show that individuals’ pathologization in these settings is closely related to these facilities’ securitization aims and, thus, to individuals’ disruption of jail and prison operations (Galanek; Rhodes, “Taxonomic”; Rhodes, “Psychopathy”). In this setting, then, abnormality is associated with one’s disruption of carceral policies and normality with one’s compliance with them. By this logic, mentally ill, incarcerated individuals’ psychiatric correction in jails and prisons is aimed at their compliance
with this inherently punitive and dehumanizing setting (Hatch 11). Therefore, psychiatric services in these facilities adopt doubly-carceral aims, as they employ carceral practices of pathologization, incapacitation, and normalization to reinforce carceral actors’ control over incarcerated people. The next section will develop this analysis further through an investigation of DC DOC’s mental health initiatives as doubly-carceral practices.

“Punishment-as-Therapy”² in DC’s Jails

Competency Restoration Programs

An important example of mentally ill, criminalized people’s differential treatment in DC’s criminal legal system lies in the city’s competency restoration programs. (Note, in this section, I will refer to individuals awaiting trial outside of the CDF or CTF as mentally ill, criminalized individuals as opposed to mentally ill, incarcerated individuals, with the assumption that the former are also subject to intersecting and unique forms of psychiatric and criminal legal knowledge). In the beginning stages of a criminal trial, either party involved has the option of requesting a competency examination for a defendant if they suspect that they may be incompetent to stand trial (District of Columbia, Council [2001] 3). One is deemed incompetent when “as a result of a mental disease or defect, a defendant does not have sufficient present ability to consult with his or her lawyer with a reasonable degree of rational understanding or does not have a rational, as well as factual, understanding of the proceedings against him or her.” Thus, although competency restoration programs vary from programs that strictly address individuals’ mental health conditions, their purpose is clearly tied to the correction of one’s “mental disease or defect” (District of Columbia, Council [2001] 1). For this reason, this section

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² Opton 615
will analyze these programs as an example of compulsory mental health services for criminalized individuals in DC.

After either party requests a competency examination, the court will order a preliminary screening for the defendant, which will be administered by a mental health clinician in the courthouse or in an outpatient location, at the court’s discretion. During this preliminary assessment, clinicians can either find defendants competent or incompetent or refer them to a more comprehensive examination, which can occur in an inpatient or outpatient setting. Based on the clinician’s assessment, the court will then either determine defendants to be competent or require that they undergo a full competency examination (District of Columbia, Council [2001] 3-4). Although the specific contents of these examinations are unavailable, national guidelines established by the Supreme Court in *Dusky v. United States* provide that competency screenings determine whether “the defendant [is] oriented to time and place and [has] some recollection of events, [...] whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding -- and whether he has a rational as well as factual understanding of the proceedings against him” (United States, Supreme Court). Therefore, these screenings extend beyond assessing individuals’ understanding of legal proceedings, also determining their ability to reason and make informed decisions – assessments that, as suggested by the definition of incompetency provided above, are closely tied to clinicians’ perceptions of an individual’s pathology.

Determinations of incompetence hold important implications for criminalized individuals. When assigning defendants to further examination, the court can choose to do so on an inpatient or outpatient basis, depending on its determination of whether 1) an “adequate examination” for a given individual requires an inpatient setting, and 2) the defendant is likely to
comply with the examination in an outpatient setting (District of Columbia, Council [2001] 3). If assigned to an inpatient examination, individuals can be committed to an inpatient psychiatric facility – in most cases, DC’s only public inpatient psychiatric facility, Saint Elizabeths Hospital – for 30 days, with a possible extension of 15 days (Albright; District of Columbia, Council [2001] 3). Further, if, following this inpatient examination, clinicians find an individual to be incompetent, the court will order them to complete a competency restoration treatment, which can also occur in an inpatient or outpatient setting. According to DC’s code, the court can require that one participates in an inpatient program if it deems 1) this “facility setting is necessary in order to provide appropriate treatment,” or 2) the defendant to be unlikely to comply with outpatient treatment (District of Columbia, Council [2001] 5).

These assessments and the confinement that they can subject individuals to exemplify the role that notions of mentally ill, criminalized individuals’ simultaneous vulnerability and invulnerability play in their differential treatment in the criminal legal system. The concept of competency restoration programs inherently depends on the notion that mentally ill, criminalized individuals, by virtue of their pathology, require special care and support in the criminal legal system. This is clear in the language that DC’s code employs to describe these programs, referring to individuals who, due to “a mental disease or defect,” lack “sufficient present ability” to productively participate in their trial and, thus, require support in the form of competency restoration programs (District of Columbia, Council [2001] 1). Notions of mentally ill, criminalized individuals’ incompetence, as well as volatility, also legitimize their pre-trial confinement as they undergo further examination or competency restoration. DC’s use of inpatient screenings in cases in which one is “unlikely to comply” with outpatient screenings
recalls mentally ill, criminalized individuals’ assumed inability to care for themselves and independently fulfill their obligations.

At the same time, given its criminal legal context and its reference to criminalized individuals who are required to undergo legal proceedings, this language also reflects concerns over mentally ill, incarcerated individuals’ pathological criminality and, thus, consistent disregard for the law on the basis of their pathology. To better understand this latter point, consider DC-based activists’ construction of formerly-houseless, mentally ill, incarcerated individuals as a population that, by virtue of its pathology, continuously “recycles” from the facilities “to the streets,” discussed in chapter one (Gordon 2). These portrayals tie individuals’ pathology to repeated criminality. Similarly, DC’s concern over mentally ill, criminalized individuals’ inability to comply with competency restoration programs and screenings reflects assumptions that this group is unlikely to comply with legal proceedings. Other accounts – namely, Reston N. Bell et al.’s analysis of DC’s competency restoration programs – explicitly imply the dangerousness of individuals assigned to inpatient competency restoration, describing individuals assigned to outpatient programs as “non-dangerous defendants” (Bell et al. 1).

Based on mentally ill, criminalized individuals’ need for “care,” in the form of competency restoration programming, and incapacitation, in the form of psychiatric confinement aimed at ensuring their participation in competency restoration programs, this group is uniquely vulnerable to pre-trial confinement. Individuals assigned to inpatient competency screening can face up to 30 days of confinement at Saint Elizabeths, or another psychiatric facility, before obtaining a new hearing for their competence determination (District of Columbia, Council [2001] 4). Individuals who are deemed incompetent and as requiring inpatient restoration programming typically face confinement for a period spanning 30 and 45 days, after which they
receive further competency evaluation (Bell et al. 3). If, following this initial period, the court continues to find individuals incompetent, their confinement can be prolonged and their competence is re-evaluated every 30 days (Bell et al. 3). On average, according to 2017 data, pre-trials detainees receiving competency restoration services at Saint Elizabeths Hospital stayed at the facility for 74 days – 155 days, if data on individuals who remained hospitalized as their competency determination was contested is included (Moser et al. 49). Cumulatively, individuals receiving inpatient competency restoration can be confined for multiple periods of time for a maximum of 180 days total – this number is largely for people accused of violent crimes, who can face inpatient treatments over multiple periods of time that can each last up to 180 days (District of Columbia, Council [2001] 5).

More strikingly, due to the high volume of inpatient competency evaluation and restoration orders that Saint Elizabeths receives, a significant number of individuals awaiting these services are detained in DC’s jails until they can be hospitalized (Moser et al. ix). Partially due to mental health clinicians and the court’s overreliance on inpatient competency restoration services, Saint Elizabeths’ limited capacity subjects individuals who, on the basis of their incompetence, are deemed unable to participate in court proceedings to pre-trial incarceration (Moser et al. 49). Mentally ill, criminalized individuals’ pre-trial confinement thus points to the role that constructed notions of this group’s simultaneous need for special care and incapacitation play in subjecting its members to more extreme forms of carceral control than their non-mentally-ill counterparts. In fact, pre-trial confinement in DC, as a jurisdiction without cash bail, is remarkably low for criminalized individuals as a whole (Marimow). In the fiscal year 2019, only 6% of all criminal felony and misdemeanor cases filed in DC resulted in individuals’ pre-trial confinement until the end of their trial – 15% faced detention following their
arraignment but were released before the end of their trial following subsequent hearings (FY 2019 Release Rates for Pretrial Defendants within Washington, DC).

It is important to note that, independently of its length, individuals’ confinement at Saint Elizabeths subjects them to punitive and dehumanizing conditions that evidence mentally ill, criminalized individuals’ subjection to extreme forms of incapacitation on the basis of their supposed dangerousness. Recent reports have pointed to practices of physical abuse and solitary confinement at the hospital, which have resulted in the serious injury and death of some hospitalized individuals (Solitary Confinement at St. Elizabeths Hospital; Dangerous Restraints: Mistreatment and Harm at St. Elizabeths Hospital). Of crucial importance to this section, a 2019 report by Disability Rights DC (DRDC) at University Legal Services provides an account of the abuse that John Holmes, an individual awaiting a competency evaluation, experienced at the hospital. After his admission to the facility, staff “restrained and secluded” Holmes three times. During the latest of these three restraints, staff broke down a door that Holmes was standing behind, landing on top of him, fracturing his hip and arm, and leading him to experience significant psychological trauma. Following this initial restraint, staff proceeded to grab Holmes by his extremities, place him in four-point restraints in one of the facility’s restraint rooms, and inject him with two psychotropic medications. Saint Elizabeths’ nurse did not visit Holmes until 16 hours after the restraint, and staff did not transfer him to a hospital for medical intervention until almost 24 hours after the event (Dangerous Restraints 12-14).

Justifications for the staff’s attack and restraint of Holmes largely revolved around the supposed threat that he posed to staff and other patients. According to staff, prior to the incident, Holmes walked into a bathroom and refused to comply with staff’s orders to leave the bathroom, threatening to “mess a staff up.” Then, per staff accounts, Holmes returned to his room and
closed the door behind him, refusing to let staff in and holding a milk carton that, according to him, was filled with his urine. This is when, following Holmes’ supposed threat to throw the milk carton at staff, staff pried the door open and assaulted him (Dangerous Restraints 13). Although staff framed this description of events as an indication of Holmes’ dangerousness and, thus, as justification for his violent restraint, none of Holmes’ behaviors presented a clear physical threat to Saint Elizabeths’ staff. Rather, these behaviors – in conjunction with Holmes’ disorganized schizophrenia diagnosis, which, according to a hospital progress note (qtd. in Dangerous Restraints 12), led him to display symptoms of “being hostile, suspicions, anxious, manic, irritable, angry and disorganized with loud pressured speech” – likely merely reinforced staff’s conception of Holmes as pathological and, thus, dangerous. Staff’s reliance on Holmes’ “deviant” behaviors and mental health diagnosis to justify his subjection to violent forms of restraints thus displays the extreme incapacitation that mentally ill, criminalized individuals’ pathology renders them vulnerable to. Similar notions of the threat that these individuals pose to themselves and others justify other drastic forms of restraint at Saint Elizabeths – including “safety suites,” or solitary confinement rooms that largely resemble DC DOC’s safe cells, and the use of “flex cuffs,” while escorting individuals between locations in the facility (Solitary Confinement at St. Elizabeths Hospital 2, 4).

It is important to note that, as Opton’s analysis suggests, Saint Elizabeths’ status as a psychiatric facility allows it to justify such overt forms of violence as “treatment,” thereby avoiding the scrutiny that statedly-punitive practices face (Opton 608). For example, the hospital’s 2018 “General Protective Security Measures” policy identifies “safety suites” as “general security measure[s],” thereby allowing staff to indefinitely confine individuals who, for example, present a “serious threat to the health and safety” of themselves, other patients, or
hospital staff and supposedly require a disproportionate and unsustainable amount of the staff’s attention (Solitary Confinement at St. Elizabeths Hospital 2-4). Further, the forceful administration of psychotropic medication faces fewer obstacles at Saint Elizabeths, as a therapeutic psychiatric facility, than at the DC jails (Walls Smith). Therefore, on the basis of mentally ill, criminalized individuals’ vulnerability, as indicated by their supposed incapability to stand trial, and invulnerability, as indicated by their inherently dangerous pathologies (as in Holmes’ example), competency restoration policies expose this group to compounded forms of carceral and psychiatric violence that non-mentally-ill, criminalized individuals do not experience.

Due to their explicitly restrictive and punitive nature, this section focused on inpatient competency restoration programs as extensions of carceral violence over mentally ill, criminalized individuals. It is important to mention, however, that outpatient competency restoration programs also exert significant control over this group. These programs require that individuals attend daily sessions from Monday through Thursday and that they participate in one individual restoration session along with its group sessions (Bell et al. 3). Of special relevance to my analysis, these programs operate within a framework of mental health. In fact, mental health professionals facilitate competency restoration group sessions, and the programs offer individuals one-to-one sessions when, according to a journal article on the program, “group sessions appear ineffective and symptomology suggests that one-to-one restoration would be more effective” (Bell et al. 2). Importantly, after a 30-to-45-day restoration, individuals receive a second evaluation, which may result in further restoration with evaluations every 30 days (Bell et al. 2). These programs thus significantly infringe on individuals’ lives, requiring their almost-daily participation, and subject them to constant supervision, treatment, and assessment.
Therefore, in both the inpatient and outpatient settings, competency restoration programs surveil individuals and extend significant control over their routines.

**Psychiatric Treatment at the CDF and CTF**

I. **Acute Mental Health Units**

Mental health units play a central role in the CDF and CTF’s psychiatric services. Acute mental health units, the most restrictive psychiatric settings for individuals incarcerated at the facilities, clearly display the extended control that mental health diagnoses and treatment grant carceral actors over mentally ill, incarcerated people. I specifically show how constructions of mentally ill, incarcerated individuals as requiring simultaneous incapacitation and “care” legitimize these units as unique sites of psychiatric and carceral violence. Although the CDF and CTF hold two acute mental health units, one for women and one for men, my analysis will largely focus on the practices of the men’s unit, as more detailed information on its practices is available (*District of Columbia Department of Corrections 2018 Inspection Report* 8, 10).

CDF and CTF staff can designate individuals to the Acute Mental Health Unit following a mental health assessment, which often occurs at Intake, or following instances of “serious mental health crisis” (*D.C. Department of Corrections: Correctional Treatment Facility & Central Detention Facility Inspection Report FY 2017* 31-32). The unit’s stated functions clearly reflect mentally ill, incarcerated individuals’ constructed need for simultaneous “care” and incapacitation. On the one hand, a Corrections Information Council (CIC) 2017 report states that the unit is reserved for individuals who are “not able to function with the assistance of medication,” employing therapeutic language to frame the unit as a location for the “stabilization” of incarcerated individuals and for the prevention of their “acute decompensation”
through medication and treatment \cite{DCDOC2017}. On the other hand, corrections officials emphasize the unit’s securitization aims and its role in protecting mentally ill, incarcerated people and the jail population at large. A 2018 CIC report specifically describes the unit’s population as “people who are a threat to themselves” or who have been placed on suicide watch or precaution, thereby constructing mentally ill, incarcerated individuals as requiring carceral protection from themselves \cite{DCDOC2018}

At the same time, as discussed in previous sections and as displayed in DC DOC policies requiring the identification of “[i]nmates with unstable mental health status who are suspected of being a danger to themselves or others,” jail officials also justify the incapacitation of mentally ill, incarcerated individuals through claims of the threat that this group poses to the jail population at large (emphasis added; \textit{Mental Health Step-Down Unit} 10).

On the basis of this group’s constructed need for simultaneous “care” and incapacitation, DC DOC segregates them from the rest of the jail population and subjects them to heightened confinement – as individuals can only spend between two to five hours a day outside of their cells – and supervision – as correctional officers round the unit every 15 minutes and nurses every two hours \cite{DCDOC2018}. Individuals can be held in these units and, thus, experience these restrictions for periods spanning two to three months \cite{DCDOC2017}. Depictions of this group’s simultaneous vulnerability and dangerousness also define divisions within the unit itself, which consists of two sections with varying levels of restrictions: the intake side and the general
population side. On the intake side, according to a 2018 CIC report, the lights in individuals’
cells are on 24/7, staff only let people out of their cells for two hours a day, and individuals
receive daily assessments to determine their eligibility for the unit’s general population side
(District of Columbia Department of Corrections 2018 Inspection Report 11). Individuals usually
remain on this side of the unit for three to four weeks (D.C. Department of Corrections:
On the general population side, individuals can spend five hours out of their cells each day,
participate in a number of programming options (such as art and yoga), and sleep with the lights
off (District of Columbia Department of Corrections 2018 Inspection Report 11). This structure
clearly exemplifies the increased incapacitation of mentally ill, incarcerated subjects that results
from this group’s constructed dangerousness, as well as their subjection to therapeutic practices
on the basis of their pathology.

The conditions that individuals experience on the unit’s intake side are clearly inhumane
and more restrictive than those experienced by the majority of non-mentally ill, incarcerated
people at the facilities. This group’s supposed dangerousness, compared to that of their
non-mentally-ill, incarcerated counterparts and of individuals on the unit’s general population
side, justifies their intensive incapacitation. This is clear in that staff portray these individuals’
constant exposure to light and supervision by jail staff and mental health clinicians as forms of
suicide prevention and, thus, as practices for mentally ill, incarcerated individuals’ protection
from themselves. Further, language surrounding individuals’ transfer from the unit’s intake to the
general population side suggests that securitization aims are also crucial to individuals’
segregation within the unit (District of Columbia Department of Corrections 2018 Inspection
Report 11). In order to transfer individuals to the unit’s general population, DC DOC clinicians
and staff must deem them “to be stable” and, thus, ready for the greater liberties that this side affords its residents (D.C. Department of Corrections: Correctional Treatment Facility & Central Detention Facility Inspection Report FY 2017 32). As this chapter has shown, questions of stability in the jail and prison setting are closely tied to carceral actors’ preservation of security and incarcerated people’s compliance with carceral policies (Galanek 218-219; Rhodes, “Axis I” 346-347). Therefore, DC DOC’s efforts to separate individuals requiring stabilization in the unit from its other occupants reflect concerns over the former’s disruption of jail operations and, thus, the danger that they pose to the latter, as well as jail staff. As they “stabilize” and, thus, begin displaying more socially acceptable and “safe” behaviors, mentally ill, incarcerated individuals gain access to increasing levels of privacy and independence.

Psychotropic medication – which, as Fabris and Hatch suggest, is a form of restraint and incapacitation – plays a fundamental role in the Acute Mental Health Unit (Fabris; Hatch). Although the jail’s programs do not explicitly state that all individuals in the Acute Mental Health Unit take these medications, language surrounding the unit suggests that this is the case. A 2021 DC DOC document, for example, reports that individuals in the Acute Mental Health Unit “are generally provided with psychotropic medication therapy for stabilization of their condition” (Performance Oversight Responses [2021] 178). Similarly, the 2018 CIC publication cited above reports that “[i]f a resident is stable and on their medication after being on the intake and then general population side of the Acute Unit, they can either be stepped down to the Mental Health Step-Down Unit, or sent back to the general population” (emphasis added; District of Columbia Department of Corrections 2018 Inspection Report 11). These statements clearly reflect Fabris and Hatch’s portrayal of psychotropic medications as a means of ensuring pathologized individuals’ and, more specifically, mentally ill, incarcerated individuals'
compliance with psychiatric treatments and carceral policies – or, in other words, their achievement of “stability” in the carceral setting (Fabris; Hatch). Therefore, in addition to the physical restraints that this group faces in the unit, they are also subject to heightened restraint in the form of “chemical incarceration” (Fabris 4).

As suggested by the unit’s stated goal of promoting individuals’ stability and functionality in an effort to, eventually, reintegrate them into the jail’s general population, the unit’s function extends beyond the mere incapacitation of mentally ill, incarcerated individuals (District of Columbia Department of Corrections 2018 Inspection Report 11). Drawing legitimacy from constructed notions of the danger that this group poses to the population at large and to themselves, as well as claims of this group’s need for specialized “care” before their successful reintegration into the jail’s general population, as discussed above, the unit works subjects mentally ill, incarcerated individuals to processes of normalization (D.C. Department of Corrections: Correctional Treatment Facility & Central Detention Facility Inspection Report FY 2017 32; Performance Oversight Responses [2019] 178). This is clear in the unit’s structure, which rewards individuals who comply with clinicians’ and staff’s expectations of safe and functioning behaviors with increasing benefits, allowing them to progress through the unit and, ultimately, within the jail (District of Columbia Department of Corrections 2018 Inspection Report 11). Processes of normalization in the unit thus consist of individuals’ constant psychiatric assessment to determine their “stability” and ability “to function with the assistance of medication” and their deprivation or allowance of “privileges” on this basis (D.C. Department of Corrections: Correctional Treatment Facility & Central Detention Facility Inspection Report FY 2017 32). These processes rely on the unit’s punitive and restrictive policies, as the intake side’s inhumane practices undoubtedly serve as incentives for individuals to achieve “stability”
and psychotropic medication, as suggested by Hatch and Fabris, renders individuals more compliant with psychiatric and carceral policies (D.C. Department of Corrections: Correctional Treatment Facility & Central Detention Facility Inspection Report FY 2017 32; Hatch 11; Fabris). Nonetheless, I wish to examine the normalizing function of the unit independently to shed light on seemingly-less punitive forms of psychiatric treatment as exertions of carceral violence.

As this chapter has shown, processes of normalization and their attempted correction of pathologized individuals are inherently carceral. At the CDF and CTF, these processes assume a doubly-carceral function, molding individuals to the norm of the jail and, therefore, ensuring their compliance with carceral policies. This notion is clear, as one’s ability to “function” in the jail setting requires a certain level of compliance with this setting’s punitive practices and regulations. According to the DC jails’ “Inmate Handbook,” incarcerated individuals must comply with frequent cell searches, or “shakedowns,” daily sanitation inspections, being locked in one’s cell for the entirety of the night, and emergency lockdowns and follow arbitrary regulations that, for example, forbid them from sleeping “in the nude or on the floor” and require them to make their bed by 8 am and leave it made until 10 pm (Inmate Handbook 5-7). Therefore, individuals’ stabilization in the Acute Mental Health Unit, aimed at developing their ability to “function” in the jails’ general population by the above definition, clearly presents an exertion of carceral control through psychiatric treatment. It is important to note that, as suggested above, practices of normalization in the Acute Mental Health Unit and, thus, in the carceral setting are especially coercive, as DC DOC staff and clinicians can withhold basic life necessities from incarcerated individuals until they comply with criminal legal and medical notions of functionality and stability (District of Columbia Department of Corrections 2018)
Therefore, mentally ill, incarcerated individuals at the CDF and CTF do not only experience a distinct form of carceral violence from their non-mentally ill, incarcerated counterparts but also a distinct form of psychiatric violence from their non-incarcerated, mentally ill counterparts.

This section has thus shown that, legitimized by constructions of mentally ill, incarcerated individuals’ simultaneous need for “care” and incapacitation, DC DOC’s Acute Mental Health Unit subjects this group to a unique intersection of psychiatric and carceral violence. Manifesting in this group’s enhanced, inhumane confinement – in the form of physical and chemical restraints – and its members’ normalization through seemingly-therapeutic practices, these intersecting forms of violence grant carceral actors extended access to and control over mentally ill, incarcerated individuals. Importantly, the practices outlined above, as instances of psychiatric violence in the carceral setting and of doubly-carceral psychiatric services, harm mentally ill, incarcerated individuals in unique ways that non-mentally-ill, incarcerated individuals and non-incarcerated, mentally ill individuals do not experience.

II. Safe Cells

Safe cells in DC’s jails are a clear example of the most drastic and restraining jail-based psychiatric services. As suicide prevention measures, these cells rely on constructions of the danger that mentally ill (or, more specifically, suicidal), incarcerated individuals pose to themselves to subject them to extreme forms of surveillance and restraint. The acute mental health units at the CDF and CTF hold a number of these cells (six and two, respectively) for individuals on suicide watch (under 24-hour observation) or precaution (subject to frequent check-ups) (District of Columbia Department of Corrections 2018 Inspection Report 17). The
cells are “suicide resistant” in that they hold limited amenities and lack “physical structures that could be used in a suicide attempt (e.g. electrical switches or outlets, bunks with open bottoms, tower racks, [...]” (District of Columbia Department of Corrections 2018 Inspection Report 17; Suicide Prevention and Intervention 5). Before entering safe cells, incarcerated people – such as Dalke, mentioned in this chapter’s introduction – undergo a strip-search and receive a “safety smock or safety clothing” (Suicide Prevention and Intervention 21; Ryals). A psychiatrist or psychiatric nurse assesses all individuals on suicide watch or precaution on a daily basis, resulting in either discharge, a transition from suicide watch to precaution (or vice versa), or hospitalization in an outside facility (Suicide Prevention and Intervention 23). As of 2017, following advocacy efforts against these cells’ inhumane nature, DC DOC policies provide that individuals in safe calls should have access to the following: 30 minutes of out-of-cell time a day, phone calls, video visitation, family visits, running water, safety mattresses and blankets, safe eating utensils, showers, safety smocks, socks, and shoes, personal property, dimmed lights for at least eight hours each night, and “unrestricted view” from their cell doors (D.C. Department of Corrections Response to Washington Lawyers’ Committee White Paper 3; Suicide Prevention and Intervention 22). Crucially, individuals’ access to these necessities is dependent upon clinical assessments of whether they are “consistent with the safety of the inmate” and can be denied on the basis of “exigent circumstances of legitimate penological reasons” (Suicide Prevention and Intervention 21).

Despite these new policies, through these loopholes, safe cells continue to expose incarcerated individuals to inhumane practices. University Legal Services’ Natasha Walls Smith observed this continued abuse of incarcerated individuals in safe cells in her monitoring of these cells between September 2019 and March 2020. According to a Washington City Paper article,
Walls Smith’s observations revealed that the “two most glaring and consistent policy violations are restricted access to running water and the lack of out-of-cell time.” She noted that, if CDF and CTF staff cut off one individual’s access to running water for “exigent circumstances or legitimate penological reasons,” they will shut off running water for an entire block of safe cells, thereby depriving a large number of safe cell occupants of this necessity. Similarly, Walls Smith found that most officers were completely unaware of safe cell occupants’ right to out-of-cell and recreation time (Ryals). Importantly, her observations also revealed that officers often changed individuals’ treatment plans in retaliation to “disciplinary infractions,” which, Walls Smith noted, often consist of safe cell occupants protesting inhumane treatment and conditions. For example, she reported that officers often discipline safe cell occupants by depriving them of phone calls, reading materials, running water, showers, and other necessities (Ryals).

These cells clearly point to the extended access that claims of mentally ill, incarcerated individuals’ dangerousness grant carceral actors over this group. On the basis of the supposed threat that these individuals pose to themselves and of DC DOC’s stated effort “to provide a safe and secure environment, to preserve life, [and] to prevent injury,” the Department legitimizes its complete supervision of their bodies and behaviors, subjecting them to violating strip searches, constant officer surveillance, and repeated mental health assessments (Suicide Prevention and Intervention 2, 21; District of Columbia Department of Corrections 2018 Inspection Report 17). Strikingly, according to a 2017 Corrections Information Council report on the CTF and CDF, safe cells in the CDF’s Acute Mental Health Unit are equipped with a camera that displays incarcerated individuals inside the cell on a monitor in the unit’s nurse’s office, allowing for their “24-hour observation” (D.C. Department of Corrections: Correctional Treatment Facility & Central Detention Facility Inspection Report FY 2017 35). The role that mentally ill,
incarcerated individuals’ supposed dangerousness plays in legitimizing their constant restraint and supervision is especially clear in the loopholes to incarcerated individuals’ required necessities mentioned above. On the basis of an individual’s “acuity of risk,” mental health clinicians can deprive them of basic life necessities like family visitation and running water for their own “safety” (Suicide Prevention and Intervention 21). In a 2014 DC Council hearing, Jail and Prison Advocacy Project (JPAP) Director Tammy Seltzer reported two especially striking instances of incarcerated individuals’ deprivation of life necessities in these cells. She shared the stories of a client who was left “naked and shivering” in a safe cell without a blanket, mattress, clothing, or a safety smock and resorted to laying pieces of toilet paper on the cell’s floor to make himself more comfortable and of a client who was denied another ULS client phone calls, recreation, or visitors following a “presumed suicide attempt” (District of Columbia, Council, Committee on the Judiciary [2014] 02:54:31-02:55:17).

Safe cells thereby shed light on the distinctions that claims of pathology construct between mentally ill, incarcerated individuals and non-mentally-ill, incarcerated individuals, legitimizing inhumane forms of “treatment-as-punishment” over the latter on the basis of their need for protection (Opton 605). This distinction is especially evident in the differences between solitary confinement and individuals’ isolation in safe cells. Non-mentally ill, incarcerated individuals in solitary confinement face fewer restrictions than individuals in safe cells, as they are allowed to keep their clothing and have access to books, visitation, phone calls, and running water (Walls Smith; Inmate Orientation 18). Activist efforts against solitary confinement at the CDF and CTF legitimize this distinction, identifying safe cells as medically necessary practices that are, thus, distinct from the strictly punitive practice of solitary confinement. As mentioned in the introduction, in the summer of 2022, DC Councilmember Mary Cheh introduced a bill that
would prohibit the use of solitary confinement in DC’s jails for “any purpose, including discipline, safety, security, and administrative convenience,” with the exception of medical isolation in the case of one’s contraction of an airborne disease (District of Columbia, Council [2022] 4-5). Nonetheless, the bill continues to allow for DC DOC’s use of safe cells, albeit in a restricted manner. In fact, the bill’s text provides that DC DOC may still place individuals in a safe cell if such placement is “immediately necessary to prevent death or serious bodily injury” and if “[t]he penal institution provides the incarcerated person appropriate medical and mental health care” (District of Columbia, Council [2022] 5). These caveats for the continued use of safe cells clearly reflect the role that constructions of mentally ill, incarcerated individuals’ need for incapacitation, protection, and care play in DC DOC’s justifications for their inhumane confinement. Even through a lens that is fundamentally critical of practices of solitary confinement, claims of the inherent threat that mentally ill individuals pose to themselves, as well as their need for mental health care justify their confinement.

III. Mental Health Step-Down Unit

Another crucial DC DOC psychiatric service consists of the CTF’s Mental Health Step-Down Unit (MHSDU). As explained in previous chapters, this unit serves “as a therapeutic environment” that, through extensive programming and less restrictive confinement conditions, works to “prepare inmates to enter back into the general population of the jail and the larger, outside community” (D.C. Department of Corrections: Correctional Treatment Facility & Central Detention Facility Inspection Report FY 2017 32-33). This unit thus presents as a gentler form of psychiatric treatment than, for example, the Acute Mental Health Unit and safe cells, rendering its exertion of psychiatric and carceral violence less clear. I consider this unit as a more
explicit embodiment of the Acute Mental Health Unit’s normalizing function, as its stated purpose is that of ensuring individuals’ transition “to the general population and the community” following their confinement in the latter, more restrictive setting (Mental Health Step-Down Unit 4). I therefore examine the MHSDU as a site of surveillance and correction to shed light on its role in extending carceral actors’ access to and control over incarcerated individuals.

Due to its normalizing function, the MHSDU is predicated on developing individuals’ “independent functioning” before their transition into the jail’s general population and DC’s community at large (Mental Health Step-Down Unit 4). Before examining the intersecting forms of psychiatric and carceral violence that the MHSDU subjects individuals to on this basis, I will briefly show that notions of mentally ill, incarcerated individuals' functionality largely reflect their construction as simultaneously invulnerable and invulnerable subjects. On one hand, as Hatch and Galanek make clear, determinations of one’s “functionality” in the carceral setting are closely tied to their ability to exist within jails and prisons without disrupting their day-to-day activities (Hatch 11; Galanek 218-219). Therefore, as my analysis of the Acute Mental Health Unit’s practices shows, aims of securitization drive jail policies aimed at the identification, incapacitation, and normalization of mentally ill, incarcerated individuals, which work to “[i]nmates with unstable mental health status who are suspected of being a danger to themselves or others” (Mental Health Step-Down Unit 10).

On the other hand, constructions of mentally ill, incarcerated individuals’ unique need for “care” in the carceral setting also drive efforts to improve their functionality in the carceral setting. As mentioned above, DC DOC justifies its confinement of mentally ill, incarcerated people in its acute mental health units as an effort to prevent these individuals’ “acute decompensation due to suicidality” and facilitate their reintegration into the jail’s general
population (Performance Oversight Responses [2021] 178). These policies reflect the sanist and ableist notions that mentally ill, incarcerated individuals are incapable of independently caring for themselves and, thus, require psychiatric treatment (refer to chapter two’s discussion of sanism, ableism, and carceral ableism; Ben-Moshe, Decarcerating 16-17). This stated effort echoes claims promoting the implementation of the community-oriented health care model in jails and prisons, discussed in chapter one, which constructed mentally ill, incarcerated individuals as helpless victims of repeated incarceration by virtue of their pathology and, thus, as requiring care and correction through jail-and-prison based mental health services (Gordon). Similarly, justifications for the Acute Mental Health Unit and MHSDU frame mentally ill, incarcerated individuals as requiring stabilization for their successful re-entry into the jail’s general population and, thus, for their own good.

I thereby established that the MHSDU’s normalizing functions – which, as I will show below, expose mentally, incarcerated individuals to unique forms of psychiatric and carceral violence – draw legitimacy from this group's constructed need for simultaneous incapacitation and care. As my analysis of DC DOC’s Acute Mental Health Unit makes clear, the development of individuals’ functionality in the carceral setting implies their growing compliance with jail and prison policies and conditions. The practices described below should thus be understood as holding doubly-carceral functions that, adapting psychiatric processes of normalization to carceral efforts aimed at ensuring individuals’ compliance with the carceral setting, expose mentally ill, incarcerated individuals to unique forms of psychiatric and carceral violence.

The MHSDU’s policies clearly reflect its normalizing function. DOC assigns individuals admitted to the unit a treatment team and an “Individualized Treatment Plan” (ITP) that health care providers on the unit review and revise every four weeks (Mental Health Step-Down 4, 6).
Based on their behavior, participants can progress through the MHSDU’s program phases and access increasing “[p]rivileges and rewards,” which include more unstructured time, extended access to commissary items, and “late night privileges” (Mental Health Step-Down Unit 9-10). Notably, individuals’ progression through these phases largely depends on their compliance with the MHSDU’s operations. MHSDU clinicians and officers allow individuals to move from levels one through three if they exhibit “three (3) consecutive weeks of positive cooperation and participation” (emphasis added; Mental Health Step-Down 9). Further, correctional officers are often part of individuals’ treatment teams, which suggests that security and restraint concerns likely play a role in their Individualized Treatment Programs (Mental Health Step-Down 5). After individuals reach level three, MHSDU clinicians and staff may transition them to the general population – again, based on individuals’ progress (Mental Health Step-Down Unit 10). This structure thus demonstrates the MHSDU’s reliance on techniques of constant supervision, as well as coercive practices that render individuals’ access to “[p]rivileges and rewards” dependant on their behavior, to integrate mentally ill, incarcerated individuals into the jail environment (Mental Health Step-Down 9-10). The next paragraphs examine this dynamic further to shed light on the extended access that the MHSDU allows carceral actors over its residents on the basis of this group’s need for normalization and, thus, for simultaneous “care” and incapacitation.

First, the unit’s assignment of ITPs and treatment teams to individuals displays the heightened surveillance that mentally ill, incarcerated people are subject to at the CTF. Such procedures scrutinize all parts of an individual, from their behavioral and physical health to their “transition goals” and “strengths, skills, and interests” (Mental Health Step-Down 4). To this point, treatment teams are interdisciplinary – involving one or more mental health clinicians, a
primary care provider, DC DOC case managers and officers, and a social worker – and treatment plans include mental health assessments, a “nursing care plan,” and “[t]ransition and aftercare plans,” thereby exerting what Shildrick and Price refer to as a field of “total visibility” onto mentally ill, incarcerated individuals (Mental Health Step-Down 9; Shildrick and Price 102). Although all incarcerated people are subject to intense scrutiny, mentally ill, incarcerated individuals’ continuous assessment by mental health clinicians and DC DOC officers in their treatment teams, as well as the breadth of these assignments, distinguishes their experience with surveillance from that of their non-mentally-ill, incarcerated counterparts (Mental Health Step-Down Unit 8). Therefore, drawing legitimacy from mentally ill, incarcerated individuals’ constructed need for normalization and, thus, incapacitation, correction, and “care,” the MHSDU subjects this group to unique forms of surveillance. This surveillance clearly signifies an extension of carceral control over mentally ill, incarcerated individuals in the form of psychiatric screenings and treatment. With the aim of, as established above, developing individuals’ compliance with the carceral setting, these practices render every aspect of an individual subject to scrutiny and, thus, correction, granting carceral actors greater control over this group and its members’ behaviors.

Second, to this latter point, the MHSDU subjects mentally ill, incarcerated individuals to treatment programs that, relying on carceral and psychiatric actors’ extended access over this group’s thoughts and behaviors, work towards their correction and, thus, integration into the jail population and DC’s larger community (Mental Health Step-Down Unit 4, 7). In this section, I will largely focus on seemingly-less restrictive and therapeutic programs in an effort to problematize notions that, compared to explicitly-punitive practices (consider, for instance, safe cells), these services are inherently beneficial to incarcerated individuals. It is important to note,
however, that the MHSDU also subjects individuals to restraining practices like chemical incarceration – as individuals must be “[s]table on medications and treatment” upon their transfer to the unit (Fabris 4; Mental Health Step-Down Unit 8). The unit’s therapeutic programming includes “Cognitive Behavioral Therapy,” “Anger/Stress Management” courses, “Trauma Informed Care Therapy,” and “Psychodynamic Therapy,” among others (Mental Health Step-Down Unit 7). As this chapter has suggested, psychiatric treatment aimed at altering individuals’ thought patterns and behaviors is inherently carceral, as it relies on notions of pathology to surveil and correct individuals, thereby working to fit them to societal norms of acceptable and unacceptable behaviors (Drinkwater; Yates). Cognitive Behavioral Therapy (CBT) clearly reflects this goal, as, according to the American Psychological Association (APA), it works to “change [individuals’] thinking patterns,” allowing them to, for example, “recognize one’s distortions in thinking that are creating problems, and then to reevaluate them in light of reality.” Similarly, according to the APA, anger management works “to reduce both [...] [one’s] emotional feelings and the physiological arousal that anger causes” (“What is Cognitive Behavioral Therapy?”).

In jails and prisons, these services hold doubly-carceral aims. Consider, for example, CBT’s efforts to adjust individuals’ thinking to “reality” and challenge their “distortions in thinking” (“What is Cognitive Behavioral Therapy?”). As this chapter has established, in the carceral setting, one’s pathology and, thus, one’s “distortions in thinking” are associated with one’s disruption of jail and prison logics and policies (Galanek 218-219). Thus, efforts aimed at correcting individuals’ thinking in this context are likely influenced by carceral actors’ interest in rendering incarcerated individuals compliant with this setting. “Thinking for a Change” (T4C) is an important example of CBT’s adaptation in the criminal legal context. Offered at the CTF’s
Young Men Emerging Unit, this program employs CBT to change “the criminogenic thinking” of incarcerated individuals (“Program Profile: Thinking for a Change”; District of Columbia Department of Corrections 2020 Inspection Report 12). The program prompts incarcerated individuals to identify their “antisocial thoughts, feelings, attitudes, and beliefs,” trains them “to engage in prosocial interactions,” and supports them in developing a plan to implement the thinking patterns and behaviors that they learned (“Program Profile: Thinking for a Change”).

Operating on constructed notions of criminality as pathological, this program thus works to modify individuals’ behavior to fit widespread notions of what constitutes safe and orderly behavior. The implications of similar programs in the carceral context are clear, as they may pathologize and, thus, correct individuals’ resistance to the jail or prison setting – as well as their natural responses to conditions that, as established in this thesis, are inherently dehumanizing and disabling (Ben-Moshe, Decarcerating 137, 147; Stewart and Russel). These programs thus extend carceral control over incarcerated individuals in the form of psychiatric treatment, providing an invasive and seemingly-therapeutic venue through which to ensure individuals’ compliance with the carceral setting. Although T4C is not reserved for mentally ill, incarcerated individuals, the latter’s subjection to similar doubly-carceral therapeutic services aimed at developing their functionality and stability and, thus, their compliance with the carceral setting clearly points to the unique psychiatric and carceral control that these individuals experience compared to non-mentally-ill, incarcerated individuals.

Third, the coercive nature of the MHSDU’s normalization efforts is important to consider. As mentioned above, during their time in the MHSDU, individuals progress through three levels that afford them increasing “[p]rivileges and rewards” based on their “positive cooperation and participation” (Mental Health Step-Down Unit 9). Although DC DOC does not specify what
individuals’ “positive cooperation and participation” are in relation to, one can reasonably assume that this policy refers to their compliance with MHSDU policies and programming and, thus, their progression toward functionality and stabilization (Mental Health Step-Down 9). This system not only signals the intensified restrictions that mentally ill, incarcerated individuals are subject to by virtue of their pathology but also elucidates the carceral nature of the MHSDU’s normalization efforts as coercive practices aimed at ensuring mentally ill, incarcerated individuals’ compliance with the carceral setting. Importantly, these practices clearly distinguish mentally ill, incarcerated individuals’ treatment from that of their non-mentally-ill, incarcerated and non-incarcerated, mentally ill counterparts. As I suggest above, these services render mentally ill, incarcerated individuals uniquely vulnerable to carceral control in the jail and prison setting, granting carceral actors access to and control over their thought patterns and behaviors in an effort to ensure their compliance with jail and prison policies. Further, although, as this chapter’s opening section has made clear, non-incarcerated, mentally ill individuals are also subject to coercive psychiatric services, the distinct limitations that mentally ill, incarcerated individuals face to their agency by virtue of their incarceration render them especially vulnerable to psychiatric violence.

*Psychiatric Treatment in Re-Entry*

Mental health diagnoses play an important role in reentry planning for individuals incarcerated in the CTF or CDF (Performance Oversight Responses [2021] 180). This section examines the unique position that mentally ill returning citizens occupy in reentry services. I will consider discharge policies and procedures for individuals at the DC DOC who are and are not assigned community-based supervision upon their release.
I will first consider the experiences of mentally ill returning citizens who are not placed under community supervision. DC DOC collaborates with DC’s Department of Behavioral Health (DBH) to identify individuals who received mental health services in their communities prior to incarceration and who may, therefore, benefit from mental health services following their release (Moser et al. 72). For individuals who received mental health assistance from a community-based, DBH Core Service Agency (CSA) prior to their incarceration, DBH liaisons working at DC DOC inform their CSAs of their arrest and, thirty days prior to their release, work to connect them to the same CSA for follow-up appointments in the community (Moser et al. 72; Performance Oversight Responses [2022] “61. Please describe DOC’s current release and reentry planning procedures relating to residents with mental or behavioral health needs”). Prior to DBH-imposed limitations on CSA spending in 2017, the collaboration between the DBH, CSAs, and DC DOC was even more extensive, with CSAs visiting their incarcerated clients and maintaining contact with them throughout their incarceration and reentry planning (Moser et al. 72). For those who had no involvement with the DBH prior to their incarceration, DBH liaisons identify available CSAs or DBH services to connect them with prior to their release, scheduling them for a post-release appointment and following up with their assigned CSA to determine whether they attended the appointment or not. Although DC DOC and the DBH liaisons do not take further action if an individual does not attend this post-release meeting, they record the individual’s attendance in the individual’s file (Moser et al. 72-73).

The procedures described above do not explicitly intensify individuals’ reentry as a result of their mental health diagnoses, as they do not enhance carceral supervision over this group. As this chapter has established, however, psychiatric services hold clear carceral functions independently of the criminal legal system, suggesting that these practices play an important role
in introducing individuals to or preserving their participation in another carceral network: that of public, community-based mental health services. As psychiatric providers, community-based services continue to subject pathologized individuals to dehumanizing power dynamics, stripping them of their individuality to normalize their behavior and, thus, successfully integrate them into their communities (Drinkwater; Yates). DC DOC’s work to connect mentally ill, incarcerated individuals to such services following their release thus exemplifies individuals’ transfer from one carceral system to another. The implications of this phenomenon are especially troubling for individuals who had no contact with the DBH or CSAs prior to their incarceration. In such cases, jails and prisons serve as mentally ill, incarcerated individuals’ entry point into a carceral system that extends beyond their incarceration, thereby subjecting individuals to another form of supervision that will follow them regardless of their incarceration status.

Some incarcerated individuals are released on parole, supervised release, or probation under the supervision of DC’s Court Services and Offender Supervision Agency (CSOSA). CSOSA places great emphasis on identifying and responding to individuals’ mental illness, employing specialized “Mental Health teams” for the supervision of mentally ill returning citizens. The agency identifies individuals with mental health diagnoses as requiring “a highly structured program, consisting of heightened monitoring and coordination with treatment services” (Community Supervision Services Operations Manual “B. Mental Health Supervision”). CSOSA explicitly legitimizes this group’s need for enhanced supervision through claims of its members’ simultaneous need for “care” and incapacitation, noting that its mental health monitoring program “takes into account the offender’s therapeutic needs, while ensuring the safety of the community by addressing the risks that each offender presents on an individual basis” (emphasis added; Community Supervision Services Operations Manual “B. Mental Health
Supervision”). This section examines the extended access that these constructions of mentally ill, incarcerated individuals as simultaneously vulnerable and invulnerable subjects grant CSOSA’s Community Supervision Officers (CSOs) and, thus, carceral actors over this group (Strategic Plan 14).

CSOSA’s Offender Processing Unit (OPU) assigns all “mental health” cases under the agency’s supervision, or cases of individuals requiring mental health screenings or treatment, to a mental health team. CSOs can also refer individuals under CSOSA’s “general supervision” to a mental health team if they are “exhibiting mental health issues.” In this latter case, following referral by a CSO, individuals receive a psychiatric screening that determines their need for mental health supervision before their assignment to a mental health team (Community Supervision Services Operations Manual “B. Mental Health Supervision”). CSOs on these teams are responsible for assigning individuals to further mental health evaluations and consulting with clinicians to ensure individuals’ compliance with their “treatment performance contract” or “behavior contract” (Community Supervision Services Operations Manual “B. Mental Health Supervision). The latter are contracts that outline individuals’ treatment trajectories and ask that individuals recognize the steps they are to take to comply with their treatment and supervision requirements – I will discuss these further below. CSOs are required to monitor individuals’ treatment progress for at least six months of their supervision, after which, “if the offender is stable with his or her mental health requirements and is in basic compliance with all other supervision standards,” they may transfer the individual to CSOSA’s general supervision unit (Community Supervision Services Operations Manual “B. Mental Health Supervision”). Importantly, in CSOSA’s mental health teams, individuals’ “[s]atisfactory participation in all
treatment programs” is a requirement for their assignment to a lower level of supervision

(Community Supervision Services Operations Manual “B. Mental Health Supervision”).

These practices clearly exemplify the enhanced carceral control that mentally ill, returning citizens are subject to by virtue of their pathology. Similarly to individuals in the CDF and CTF’s Acute Mental Health Unit and MHSDU, mentally ill, returning citizens under CSOSA supervision experience a greater level of surveillance compared to their non-mentally-ill counterparts. Drawing legitimacy from this group’s constructed pathology, CSOs exert a field of “total visibility” over its members through extensive mental health screenings and communication with individuals’ mental health care providers (Shildrick and Price 102; Community Supervision Services Operations Manual “B. Mental Health Supervision”). Relying on this field of visibility, CSOSA renders individuals’ compliance with their supervision dependent on their compliance with psychiatric treatment, which is problematic on two fronts. First, this practice exemplifies the increased carceral control that claims of mentally ill, incarcerated individuals’ simultaneous need for “care” and incapacitation can subject them to. CSOSA forces mentally ill returning citizens to comply with practices that their non-mentally-ill, incarcerated individuals are not subject to, adding an additional means by which they may be reincarcerated following their release. Second, this practice evidences the coercive nature of mentally ill returning citizens’ psychiatric treatment, which, mirroring the Acute Mental Health Unit and MHSDU’s level systems, renders individuals’ access to increased independence dependent on their treatment compliance and, importantly, on their adoption of “stable” behaviors (Community Supervision Services Operations Manual “B. Mental Health Supervision”).
Mentally ill returning citizens under CSOSA supervision can face further detention in the form of halfway houses or residential treatment. For example, individuals who exhibit a high level of risk according to CSOSA’s Auto Screener, have at least six months left in their supervision, and exhibit “[a]n extensive and chronic history of mental health issues” can be referred to the Re-Entry and Sanctions Center (RSC). The RSC is a residential re-entry center that provides returning citizens with “holistic and multi-disciplinary interventions designed to address one or more criminogenic risks and needs that pose challenges to the residents’ successful reentry into the community” (Guidance Statement “Re-Entry and Sanctions Center: Overview”). The facility implements three different programs: a 28-day program for male returning citizens and defendants diagnosed with a substance use issue, a 42-day program for female returning citizens and defendants diagnosed with a substance use issue (both including individuals with co-occurring mental health diagnoses), and a 60-day “Extended Stay” program for “high risk male offenders and defendants for whom substance use is not the primary risk factor” (Guidance Statement “Re-Entry and Sanctions Center: Overview”). Upon arrival at the facility, individuals receive extensive medical and psychiatric screening to ensure their “suitability for RSC placement,” after which they can participate in counseling groups, cognitive behavioral therapies, psycho-educational groups, and other activities aimed at providing “intensive assessment and reintegration programming for high-risk offenders” (Guidance Statement “Intake and Orientation”).

The RSC is a clear example of the increased confinement and loss of agency that mentally ill, returning citizens face compared to non-mentally ill, returning citizens, as well as this group’s subjection to doubly-carceral corrective treatment. First, the RSC’s practices closely resemble those of jails and prisons, with extensive facility rules dictating every aspect of
individuals’ routines. For example, the facility’s regulations require that individuals wake up at 6 am every day, forbid individuals from lying in their beds until 9 pm, and place significant restrictions on the personal property that individuals are allowed to own at the facility (Guidance Statement “Daily Schedule and Other Information”). If individuals fail to follow these policies, as well as rules dictating their behavior in group therapeutic settings, their dress code, movement, and telephone use, they face consequences spanning from a warning to an extension of their stay or a meeting with their CSO (Guidance Statement “Daily Schedule and Other Information” and “RSC Rules”). Therefore, by virtue of mentally ill returning citizens’ pathology and, thus, of their constructed, unique dangerousness, the RSC subjects this group to jail-like conditions of confinement that non-mentally-ill returning citizens are not subject to.

Second, similarly to the Acute Mental Health Unit and the MHSDU, the RSC employs doubly-carceral normalization practices to ensure mentally ill returning citizens’ compliance with carceral policies. Upon their admission to the facility, mentally ill returning citizens undergo psychiatric and medical screenings and participate in extensive mental health programming aimed at helping them to, for example, “[r]e-frain from engaging in criminal activities,” “[s]ucceed in vocational/educational undertakings,” and “[i]nitiate productive community reintegration.” RSC programs include “[p]sycho-educational groups,” counseling, CBT programming, and “[v]iolence reduction group[s]” (Guidance Statement “Re-Entry and Sanctions Center: Overview”). These programs’ stated goals, as well as the RSC’s function as a facility for individuals on community supervision, clearly suggest these services’ role in promoting individuals’ compliance with the terms of their conditions through processes of psychiatric normalization. Importantly, the punitive policies described in the paragraph above, as well as CSOs’ significant involvement in individuals’ progression within the RSC, point to these
practices' coercive nature. In fact, CSOs greatly supervise individuals’ compliance with the RSC’s programming, documenting individuals’ expected trajectory within the facility in an “Offender Behavioral Contract” that mentally ill returning citizens must comply with, monitoring individuals’ compliance with assessment and treatment processes alongside RSC staff and reviewing their behavioral contract when necessary, and developing individuals’ discharge plan for the individual (Community Supervision Services Operations Manual “7. Referral of Appropriate Mental Health Offenders to the Re-Entry and Sanctions Center”).

CSOSA’s treatment of mentally ill returning citizens is thus a clear example of the extended access that mental health diagnoses grant carceral actors to mentally ill, incarcerated individuals. The implications of this phenomenon are especially troubling in the case of individuals who did not have a history of mental health diagnoses prior to their incarceration, as it exemplifies the direct impact that individuals’ construction as mentally ill, incarcerated subjects within DC’s jails (which I have outlined in chapter one) can have on their further carceral supervision and confinement in the community. This section has thus shown that these mental health diagnoses allow CSOSA, through constructions of pathologized individuals as fundamentally vulnerable and invulnerable individuals requiring incapacitation and “care,” to justify the increased supervision and incapacitation of mentally ill returning citizens, as well as their forced compliance with the agency’s carceral policies in the form of doubly-carceral, corrective psychiatric treatment.

Conclusion

This chapter has shown that mental health services in jails and prisons not only better the image of carceral actors as mental health care providers but also grant correctional facilities
greater access to and control over mentally ill, incarcerated individuals. In the context of
disability studies and abolitionist theory, I showed that psychiatric services are fundamentally
carceral outside of the correctional setting and, thus, adopt doubly-carceral aims in jails and
prisons. I argued that these services rely on constructions of mentally ill, incarcerated
individuals’ simultaneous need for “care” and incapacitation to subject this group to unique
intersections of psychiatric and carceral control and violence. I showed that explicitly-restrictive
and punitive psychiatric services subject mentally ill, incarcerated individuals to enhanced forms
of supervision and confinement that non-mentally-ill, incarcerated individuals do not experience.
I also considered the carceral aims of seemingly-therapeutic, normalizing treatments in the
carceral setting, which align their aims with those of carceral actors in an effort to ensure
mentally ill, incarcerated individuals’ compliance with carceral policies through psychiatric
treatment.

I then placed mental health screenings and services in DC’s jails in this context to
examine the unique carceral violence that DC DOC’s mental health initiatives have exerted on
mentally ill, incarcerated individuals at the CDF and CTF. For example, I showed that
competency assessments and restoration programs, Acute Mental Health Units, and safe cells at
the CTF and CDF, as well as DC DOC’s mental-health-focused re-entry processes, allow for the
enhanced and extended confinement of mentally ill, incarcerated individuals in DC DOC custody
in the name of “protection” and “care.” I also suggested that less-restrictive programs, such as
the CTF’s MHSDU and its therapeutic treatments largely serve as carceral tools to integrate
incarcerated individuals in the jail environment, using standards of mentally ill, incarcerated
individuals’ “stability” to ensure their compliance with carceral practices.
Despite the clear detrimental impact that jail-based psychiatric services have on mentally ill, incarcerated individuals, it is important to acknowledge that a number of incarcerated or formerly incarcerated individuals seek psychiatric support in the carceral setting. For example, in a 2011 hearing before the DC Council, Wallace Kirby, a self-identified “survivor of incarceration” and community organizer with University Legal Services’ DC Jail and Prison Advocacy Project, called on DC DOC to increase its mental health programming. Kirby specifically demanded that the Department provide individuals in its facilities’ mental health units with equal access to programming and mental health support groups and ensure “comprehensive mental health discharge planning” for this group (District of Columbia, Council, Committee on the Judiciary [Mar. 2011] 02:06:10-02:08:27). At another 2011 DC Council hearing, Franklin Gregg, also a survivor of incarceration, stressed the importance of treatment and medication continuation at the CTF and CDF and critiqued the lack of mental health programming in the jails’ re-entry unit (District of Columbia, Council, Committee on the Judiciary [Nov. 2011] 01:37:00-01:38:36).

These demands reflect calls for the greater support of incarcerated individuals, especially of those with mental health diagnoses, that mental health services supposedly deliver. It is important to remember that jails and prisons subject individuals to an innately punitive and dehumanizing environment and that, in this context, “therapeutic” mental health services may promise a less violent and inhumane space for this group. This chapter has shown that, despite their stated purpose, jail-and-prison-based mental health services fail to accomplish this goal, instead carving out more violent spaces for mentally ill, incarcerated individuals. Through this claim, I do not seek to dismiss calls for the much-needed support of incarcerated individuals; rather, I wish to shed light on life-affirming services that may be implemented in this setting.
This thesis’ conclusion will provide an overview of such services in the hopes of beginning and centering efforts on the provision of anti-carceral and anti-ableist healing services in jails and prisons.
Conclusion

When I started my research, my aim was to problematize mental health screenings and treatment services in jails and prisons as extensions of carceral control over incarcerated individuals with mental health diagnoses. I sought to contextualize these services in theory on the shared role of psychiatry and the criminal legal system in the carceral state to examine their pathologization and forced normalization of incarcerated individuals as mentally ill subjects. In other words, my initial scope was limited to what now exists as chapter three of this thesis—except that, rather than consider mentally ill, incarcerated individuals’ unique vulnerability to psychiatric and carceral violence, I sought to apply existing literature on the carcerality of psychiatric services outside of the prison context to this group’s experience. As I undertook this project, however, two things became apparent to me and significantly broadened my research. First, neoliberal and carceral notions of pathology played a fundamental role in the emergence of mental health services in jails and prisons, rendering the latter part of a larger project of pathologization and organized abandonment. Second, psychiatry’s role in the criminal legal system cannot be reduced to the implementation of these services in the carceral setting.

My research on jail-and-prison-based mental health initiatives quickly revealed that these services exist within a wider context of pathologization that individualizes structural issues to legitimize the neoliberal state’s organized abandonment of large sectors of its population. Through Ben-Moshe’s critique of the “new asylum” thesis, as well as Gilmore, Willse, and others’ writing on the role that abandoned subject identities play in sustaining present political and economic systems, I realized that these services emerged from established, neoliberal framings of incarceration and housing insecurity as individual conditions (Ben-Moshe,
Additionally, I found that these efforts drew legitimacy from widespread processes of racial criminal pathologization that frame racialized, pathologized individuals as inherently criminal and, conversely, racialized, criminalized individuals as pathological, thus calling for psychiatric interventions in the criminal legal field (Ben-Moshe, Decarcerating 25-27; Iliopoulos). My research thus revealed that the pathologization of incarcerated individuals begins long before their exposure to jail-and-prison-based mental health services, which themselves result from efforts to address the needs of constructed, abandoned, pathologized subject identities – namely, the “homeless,” the “mentally ill,” the “criminal,” and the criminalized “homeless mentally ill” (Ben-Moshe, Decarcerating 33).

These findings significantly broadened my research question. I decided to contextualize emerging jail-and-prison-based services in the psychiatric and criminal legal discourses that surrounded them – including, for example, prisoners’ rights and mental health activist efforts – to examine their reliance on and reinforcement of neoliberal and carceral constructions of housing insecurity, disability, and incarceration. I thus framed these services as individual, pathology-focused solutions to structural problems and set out to investigate their own role in constructing the politically and economically valuable subject identity of the mentally ill, incarcerated subject. This perspective thus extended my analysis beyond the impact that jail-and-prison-based mental health services have on incarcerated individuals, albeit this element remained central to my research, to their role in reinforcing widespread processes of organized abandonment and carceral control through pathologization.

To this latter point, Ben-Moshe’s critique of the “new asylum” thesis and Kilgore’s analysis of mental health discourses as the “cutting edge of carceral humanism” suggest that the
introduction of psychiatry as a way of knowing in the criminal legal system fundamentally reshapes conceptions of incarcerated individuals and, thus, carceral practices aimed at their control and correction (Ben-Moshe, Decarcerating 137; Kilgore). As this thesis has shown, resulting from and strengthening constructions of “criminal,” “homeless,” and “mentally ill” subjects, efforts based on the “new asylum” thesis redefine some incarcerated individuals’ criminality as a direct result of their pathology. This causal association does not merely introduce mental health services in jails and prisons, but also constructs a distinct sector of the incarcerated population – mentally ill, incarcerated subjects – that, in turn, reshapes the stated function of carceral facilities. I restructured my research to examine jail-and-prison-based mental health services as unique tools of carceral expansion and control, as opposed to mere exertions of psychiatric power in the carceral setting.

My research questions thus became: how do these services, operating within neoliberal and carceral frameworks of pathology and at a unique intersection of psychiatric and criminal legal knowledge, produce unique subject identities in the carceral setting? And what social, political, and economic functions do these subject identities perform in the carceral setting? In other words, how do these subject identities sustain and expand carceral systems and their power over incarcerated individuals?

In this thesis, I argued that jail-and-prison-based mental health services employ criminal legal and psychiatric knowledge to construct their recipients into the unique subject identity of the mentally ill, incarcerated individual. Through a case study of DC’s jails, I showed that discourses surrounding these services, advanced by prisoners’ rights activists as well as carceral actors, and their practical implementations depict this subject identity as fundamentally distinct from non-mentally-ill, incarcerated individuals and non-incarcerated, mentally ill individuals by
virtue of their need for extensive “care” and incapacitation in the form of psychiatric treatment. I then posited that this subject identity expands carceral systems in two distinct but related ways. First, through a framework of carceral humanism, I suggested that this subject identity reshapes notions of criminality and, thus, of incarcerated individuals’ vulnerability and invulnerability in the carceral setting, allowing for depictions of carceral actors as mental health providers that legitimize carceral expansion in the face of increasingly-abolitionist politics. Second, I showed that mentally ill, incarcerated individuals’ constructed need for “care” and incapacitation renders them vulnerable to a unique intersection of psychiatric and carceral violence that ultimately expands carceral control over this group. I thus problematized portrayals of jail-and-prison-based mental health services as forms of care for incarcerated individuals, framing them, instead, as unique tools of carceral control and violence.

It is crucial to note that this thesis leaves half of the story on constructions of mentally ill, incarcerated subjects in the carceral setting untold: that is, the first-hand accounts and experiences of incarcerated individuals receiving jail-and-prison-based mental health services. As Foucault suggests, subject formation relies on individuals’ acceptance of the truth imposed on them by disciplinary and biopolitical systems of power – or the process by which one “turns him- or herself into a subject” (Foucault, “Afterword” 208). This is where pathologized individuals’ resistance to medical, psychiatric, and criminal legal processes of subject formation emerges. Both Yates and Sullivan show that individuals in medical and psychiatric facilities actively resist standardized processes of diagnosis and treatment in an effort to preserve their agency and individuality. For example, one individual interviewed by Yates refused to comply with medical protocols for people with spinal cord injuries, drawing on her understanding of her needs to demand treatments that would work for her (Sullivan; Yates 39). Future research on
jail-and-prison-based services should thus consider incarcerated individuals’ struggle against their construction into mentally ill, incarcerated subjects and claims on their supposed need for extended “care” and incapacitation to gain a more complete sense of this subject identity’s role in and out of the carceral setting.

First-hand testimonies shed light on another aspect of jail-and-prison-based mental health initiatives that this thesis left largely unexplored: incarcerated individuals’ desire for psychiatric services and mental health programming. For example, self-identified “survivor of incarceration” Wallace Kirby, whose activism I discussed in chapters two and three, called for extensive mental-health-focused programming, support groups, and discharge planning in DC’s jails at a 2011 hearing before the DC Council (District of Columbia, Council, Committee on the Judiciary [Mar. 2011] 02:07:20-02:08:57). That same year, Franklin Gregg, who holds a mental health diagnoses and faced incarcerated at the DC jail, critiqued DC DOC’s failure to ensure treatment continuity for individuals on psychotropic medication and provide individuals in its re-entry unit with needed mental health programming (District of Columbia, Council, Committee on the Judiciary [Nov. 2011] 1:37:30-1:38:30). Existing services have also received support from incarcerated individuals. For instance, in the City Paper article discussed in chapter two, one Mental Health Step-Down Unit (MHSDU) resident praised the unit’s yoga classes: “[the class] is the first time I’ve kind of enjoyed being here – having this makes the day go by” (Laura Hayes). How can we reconcile this demand for programming with the findings in this thesis? And, most importantly, how can incarcerated people and their allies, guided by abolitionist and disability rights principles, go about instituting life-affirming support services in the carceral setting?
Beyond the “New Asylum”: Re-Imagining Care for Incarcerated People

This thesis has presented two principal issues underlying jail-and-prison-based mental health services’ treatment of incarcerated individuals. First, I have shown that these services individualize the structural issues of housing insecurity and incarceration through their pathologization of incarcerated individuals, and, second, that, drawing legitimacy from this pathologization, these services subject incarcerated people to violent practices of correction and incapacitation. Providing meaningful support services to incarcerated individuals thus requires the adoption of a framework grounded in abolitionist and disability rights politics that abandons these two underlying functions of jail-and-prison-based mental health services. As Ben-Moshe makes clear, for abolitionist work to be truly anti-carceral, it must center disability rights and the experiences of those most impacted by carceral, psychiatric, and medical violence (Ben-Moshe, Decarcerating 1). I thus conclude my thesis with an overview of possible approaches to healing and support in the carceral setting that, I suggest, successfully accomplish this task.

The healing justice framework is one such approach. Rather than individualize structural issues as pathologies, this framework understands trauma as directly tied to systems of racial, economic, gender, and disability oppression (“Our Framework”; “What is Healing Justice?”). Cara Page and the Kindred: Southern Healing Justice Collective developed healing justice as an effort to address harm and trauma in liberatory movements, conceptualizing healing, in the words of “queer, sick, and disabled nonbinary femme writer and cultural worker” Leah Lakshmi Piepzna-Samarasinha, “as a form of liberation and social justice” (Piepzna-Samarasinha). By this framework, then, healing requires and allows for the dismantlement of systems of oppression. Healing justice is fundamentally anti-ableist, as it centers disabled individuals’ experiences, disrupts normative distinctions between able and disabled bodies, and challenges medical,
hierarchical relationships between doctors and patients. Unlike psychiatric services that construct pathologized individuals as requiring correction and subject them to standardized and normalizing treatments on this basis, healing justice depends on the leadership of people with disabilities and their understanding of their bodies and needs (Piepzna-Samarasinha). This framework centers individuals with disabilities as healers in a collective approach to healing that disrupts “the illusion that our struggles and [...] private and separate” and embraces non-western, ancestral healing practices (Midnight; Piepzna-Samarasinha).

Healing justice can take a number of forms. The Kindred: Southern Healing Justice Collective, for example, works directly with community organizers and implements healing justice practice spaces – defined by Piepzna-Samarasinha as “free, community-based spaces where many forms of healing are offered” – in times of movement building and crisis (“What is Healing Justice?”; Piepzna-Samarasinha). The Fireweed Collective, an organization committed to offering “mental health education and mutual aid through a Healing Justice lens,” exemplifies this framework’s implementation in a context specifically focused on mental health. Fireweed views altered states of mind as a result of oppressive systems and recognizes that the mental health system plays a fundamental role in reinforcing them (“Mission and Vision”). For this reason, the organizations’ healing efforts center discussions of oppression and delegitimize normative notions of pathology that push medication and other forms of psychiatric treatment on pathologized individuals.

For example, Fireweed, formerly known as the Icarus Project, published a workbook that helps its readers develop “Mad Maps” – “documents that we create for ourselves as reminders of our goals, what is important to us, our personal signs of struggle, and our strategies for self-determined well-being” (Madness & Oppression: Paths to Personal Transformation and
The workbook asks individuals to reflect on how they experience oppression, the impact that oppression has on their well-being, and the ways in which they cope with oppression (*Madness & Oppression: Paths to Personal Transformation and Collective Liberation*). The organization also published a “Harm Reduction Guide to Coming Off Psychiatric Drugs” that, acknowledging the benefits and harms that psychotropic medications hold for different people, educates individuals on these treatments to enable them to make informed, independent decisions on whether to make use of them or not (Hall 6). Additionally, Fireweed holds four weekly support groups that make space for individuals experiencing intersecting forms of oppression – for instance, the organization offers a “QTPOC [queer, trans, people of color] Support Space” and a group titled “Healing Verses: A Healing Justice Approach to Collective Poetry Crafting for POC Folks” (“Groups”). These resources, although difficult to replicate in the carceral setting due to censorship policies, restrictions on incarcerated individuals’ interactions, and the latter’s vulnerability to sudden transfers (Wilson, “Study”), present possibilities for humanizing healing practices in jails and prisons.

The most prevalent forms of non-psychiatric support and healing work inside jails and prisons are largely undocumented and led by incarcerated individuals themselves (Alexander). For example, study groups and, especially, abolitionist study groups can carve out necessary spaces for humanity and healing in the carceral setting. “Dreaming Freedom, Practicing Abolition,” a network of prison-based abolitionist study groups in Pennsylvania led by “inside facilitator” Stephen Wilson, encompasses a number of such groups (“Contact”). The network’s “Circle Up” study group, for instance, teaches its members about “restorative justice, transformative justice, conflict resolution, and mediation,” engaging them in “healing and peace circles.” The “Smithfield Abolition Study Squad” involves individuals participating in
Smithfield’s – the Pennsylvania-based prison – LGBTQ support groups and engages with “penal abolition theory and practice that centers the lived experiences of queer/trans folk with policing, imprisonment and parole/probation” (“The Study Groups”). Another group, “Black August,” facilitated by Wilson, initially started as an effort to learn about the history of incarcerated people’s resistance movements, and, instead, became a collective endeavor to discuss and heal the violence that the group’s members experienced inside and outside of the carceral setting. People in “Black August” worked to connect with outside organizations engaging in healing work in an effort to extend healing justice services to incarcerated people. In an article on “Black August,” Wilson notes: “People inside need healing. [...] Everyone in this group has experienced and witnessed violence. They are closest to the problem. They are also closest to the solution. They want to heal” (Wilson, “Black”).

Although not explicitly framed as healing justice initiatives and not directly engaging with questions of disability and mental health, these study groups serve as healing spaces for incarcerated individuals. Incarcerated individuals and prison educators have long recognized education inside as a means of carving out a humanizing, life-affirming space in the carceral setting (Ginsburg). In “An Open Letter to Prison Educators,” incarcerated scholar Malakki writes:

Your role as a facilitator is key. For when you appear, a special place comes into existence that allows us to be a different us than the cell, chow hall, yard, and day-room us. And what’s beyond your purview is that the place where you have your class becomes defined and sanctioned by the group as a sort of sacred space (Malakki 18).
These study groups thus grant incarcerated people breathing room from their dehumanization as criminalized individuals, serving as spaces of healing from the carceral and, perhaps, psychiatric violence that they experience on a daily basis. Further, these groups directly engage with questions of healing – in the cases discussed above, through questions of interpersonal and state-sanctioned violence – in an abolitionist and anti-racist context. This approach, which allows incarcerated people to engage with texts such as Keeanga-Yamahtta Taylor’s *From #BlackLivesMatter to Black Liberation* and Victoria Law’s *Resistance Behind Bars: The Struggles of Incarcerated Women*, centers struggles against white supremacist, patriarchal, carceral systems in healing efforts, thereby acknowledging and addressing the harm that these systems inflict on incarcerated people (Wilson, “A 9971”). Clearly recalling healing justice efforts, these groups, led by incarcerated people, serve as sources of support and healing that do not pathologize, dehumanize, and exert violence on this group.

Healing justice and abolitionist study groups thus present important venues for supporting incarcerated people’s emotional well-being. In his piece on “Black August,” Wilson critiques the fact that “[t]here are no programs inside that are trauma-informed […] [and] no programs that focus on healing justice” (Wilson, “Black”). Introducing and expanding healing justice practices in the carceral setting should thus be a priority of abolitionist- and disability-rights-focused efforts at supporting incarcerated individuals. This endeavor could look like increasing the access of organizations like Fireweed to jails and prisons, working towards the implementation of healing justice practice spaces and other support groups inside these facilities. These efforts could also focus on supporting existing jail-and-prison-based healing justice and study groups. “Dreaming Freedom, Practicing Abolition,” for example, receives
support from a number of outside organizations in the form of donations, texts, and organizing support (*Dreaming Freedom, Practicing Abolition*).

As Fireweed’s guide on psychotropic medication suggests, however, some people with mental health diagnoses desire access to psychiatric services (Hall). This thesis suggests that psychiatric services are innately carceral and that, jail-and-prison-based mental health services expose incarcerated individuals to unique, intersecting forms of psychiatric violence. Providing humanizing psychiatric services to this group would thus entail the introduction of outside therapists operating within an anti-racist, abolitionist framework. Initiatives such as the National Queer & Trans Therapists of Color Network – which works “to establish a network where therapists can deepen their analysis of healing justice and where QTPoC community can connect to care” – and the Black Emotional and Mental Health Collective (BEAM) – which operates within a healing justice framework to remove Black Americans’ barriers to mental health supports” – present opportunities for this work (“Our Origin Story”; “About Beam”). Importantly, to counter the coercive nature of present jail-and-prison-based mental health services, the provision of such psychiatric support should be completely voluntary and based on incarcerated individuals’ informed decision to receive care in this form.

Acknowledging the harm that existing services inflict on incarcerated people does not mean abandoning them to carceral violence. It means developing life-affirming, humanizing supports for people on the inside as we work towards the abolition of carceral spaces and the liberation of all incarcerated people. As Cara Page, one of the creators of the healing justice framework, puts it: “Our movements themselves have to be healing, or there's no point to them” (Piepzna-Samarasinha). Abolitionist movements must center incarcerated individuals’ need to heal from the harm and trauma that they experience on a regular basis, and they must do so
through a disability rights lens (Ben-Moshe, *Decarcerating*; Piepzna-Samarasinha). This looks like expanding healing justice practices spaces to the carceral setting, decentering ableist mental health discourse in prisoners’ rights efforts, supporting incarcerated people’s healing work, and centering those most impacted by carceral and psychiatric violence (Ben-Moshe, *Decarcerating*; Piepzna-Samarasinha). I hereby end this thesis with an invitation to its readers: make your abolitionist work anti-ableist, center the experiences of survivors of psychiatric and carceral violence, and go from there.
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