

Working Note for the International Workshop on the Criminalization, Segregation and Control of People
Living in Poverty

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I. Introduction

This Working Note is submitted by the Urban Justice Center's Mental Health Project (MHP).¹ MHP is a team of attorneys, social workers and advocates dedicated to enforcing the rights of low-income New Yorkers with mental illness. We represent individual clients, bring class action lawsuits and engage in community education and outreach with the belief that low-income people with mental illness are entitled to live stable and full lives, free from discrimination.

In this paper, we begin by laying out three major realities of American society which must inform any discussion of poverty: the absence of a constitutional or other right to housing or healthcare; the history of slavery and on-going racial discrimination; and the phenomenon of mass incarceration. We then address four areas which exemplify government policies that criminalize, segregate and control indigent people with mental illness in the United States, with a focus on the city and state of New York. The four areas are: mental health treatment; criminal justice; social welfare; and child welfare practices.

II. Background Issues

To understand the ways in which the United States has criminalized poverty, one must first understand three basic realities. First, neither the U.S. Constitution nor any nation-wide laws establish a right to housing, health care or subsistence. In addition, although the U.S. Constitution and various federal laws prohibit discrimination on grounds including race, national origin, religion, disability and gender, the indigent are not a protected class, and discrimination against the poor is generally permissible.

Second, although slavery was formally abolished in 1865, and the rights of African-Americans and other racial minorities to live free from discrimination has been further codified by a series of Civil Rights Acts, racial bias is evident in every program designed to criminalize, segregate and control people living in poverty. Nowhere is this more apparent than in our criminal justice system. Although African-Americans account for only twelve percent of the U.S. population, an estimated 38.9 percent of all prisoners in the United States are black (Allen).

Third, the United States has the highest documented incarceration rate in the world. More than 1 in 100 adults in the United States are in prison. The United States has less than 5% of the world's population and 25% of the world's prison population (Pew Center). Reasons for the United State's astronomical rates of incarceration include: an insistence on viewing drug use as a criminal matter, rather than as a public health concern; economic reliance on both public and private prisons as employers in many rural communities; and the failure of our mental health systems to provide adequate care for low-income people with mental illness.

Having established this landscape, the paper now turns to the specific ways that U.S. policies and practices criminalize, segregate and control low-income people with mental illness, beginning with mental health treatment.

¹ For more information on the Urban Justice Center's Mental Health Project, see www.urbanjustice.org/project/mental. I would like to thank my staff, and our intern Faith Barksdale, for their contributions to this paper.

Mental Health Treatment

Stigma against people with mental illness is strong in the United States, and there is no right to treatment for those who cannot afford it. As a result, treatment is frequently tied to segregation and control. Below, we focus on two examples: first, the failure to provide non-institutional access to care, and second, the use of coercive treatment.

A. De-Institutionalization and the Absence of Services

Historically, people with mental illness whose families could not afford private care were involuntarily confined to state asylums. In the 1950s, a push began to shut down state mental hospitals, known as “deinstitutionalization.” In 1955, there were 558,239 patients in state psychiatric hospitals; in 2009, there were roughly 44,000 in state and county facilities (Torrey 3). Unfortunately, while states across the country closed asylums and psychiatric hospitals, they failed to create alternate systems to serve people in the community.

Thus, in New York, thousands of people were funneled from state hospitals to “adult homes,” “nursing homes,” or “boarding houses.” In these institutions, people with mental illness are housed but remain segregated from the general population. They generally receive minimal mental health treatment and suffer under intense control and surveillance. Thousands of others who left state hospitals became homeless. And, in recent years, community mental health services have been cut in tandem with hospitals.

Lacking housing, adequate treatment and community ties, people with severe mental illness often wind up in the criminal justice system. In fact, Americans with severe mental illness are now three times as likely to be in jail as they are to be in a hospital. In New York, although the total number of prisoners has declined in recent years, the percentage of prisoners with mental illness has increased. In 2008, approximately 8,500 prisoners, or more than thirteen percent of the total prison population, receive mental health services (MHCJP 14). Jails and prisons have become the new mental hospitals for the poor.

B. Coercive Treatment

Many low-income people with severe mental illness desire proper treatment for their illnesses. All too often, the public response is to deny treatment until a person becomes a threat or commits a crime. Then, poor people are not offered treatment, but mandated to receive it on an involuntary basis. The story of “Kendra’s Law,” which was passed in New York State in 1999, exemplifies this approach. Kendra Webdale died in January 1999 after being pushed in front of a New York City subway train by Andrew Goldstein who was living in the community at the time, but was not receiving treatment for his mental illness (Winerip).

In response, the legislature passed a law—commonly referred to as Kendra’s Law—empowering courts to mandate treatment, under penalty of confinement, for persons deemed to be “unlikely to survive safely in the community without supervision.” Courts can order outpatient treatment if non-adherence to past treatment regimes contributed to a person’s previous hospitalizations or acts of violence against himself or others. If the court-ordered treatment is not followed, the person can be involuntarily hospitalized—even if he is not currently a threat to anyone. New York allocated special resources to serve this population, and people who are court-ordered to receive treatment receive preferential access to scarce services including Assertive Community Treatment teams, intensive case management and supported housing (Swartz 5).

The terrible irony is that Andrew Goldstein himself desperately sought treatment—including hospitalization—in the months prior to pushing Kendra Webdale, and was turned away from hospitals, supportive living programs, and other providers. Andrew needed treatment, not a court mandate. But, under Kendra’s Law, New Yorkers have no right to outpatient treatment unless it is ordered by the courts.

Not surprisingly, Kendra's law has been applied in a discriminatory manner (Cooper). It is primarily applied to those served by the state's public health system—that is, people who cannot afford private care. This population is also disproportionately African-American. Thus, from 1999 to 2009, about thirty-four percent of those who have been ordered into treatment have been African American, although African-Americans make up only seventeen percent of New York's population. Conversely, thirty-four percent of those who have been ordered into treatment are white, while whites comprise sixty-one percent of the population (Swartz 13). This bias remains even when the disproportionate use of the public mental health system by African-Americans is taken into account (14).

IV. Criminal Justice

Intentionally or not, the failure of the American health system to care for poor people with mental illness has left a vacuum that has been filled by the criminal justice system. Neither law enforcement nor the correctional system was designed with needs of people with mental illness in mind. Below, we highlight three areas in which the criminal justice system has contributed to the plight of poor people with mental illness: law enforcement responses in mental health crisis, the use of solitary confinement in prisons and jails, and the continued use of capital punishment.

It is important to note that people with mental illness are no more likely to be violent than people without mental illness. Studies have found that the association of violence with mental illness does increase when individuals have co-occurring addiction disorders and/or are not receiving appropriate treatment (MHCJP 1). Nonetheless, the policies outlined below simply cannot be justified on the grounds that people with mental illness require a higher level of surveillance or incarceration than the general population.

A. Policing

As discussed above, the availability of both community and institutional mental health care for low-income people has eroded over the past century. In the absence of these services, many cities and counties have come to rely on local police as the first responders in mental health crises (Reuland). For example, when a person with mental illness has a crisis or becomes violent, family members have no one to call but law enforcement. Similarly, when teachers or schools witness a student with acute symptoms of mental illness, they will frequently respond by calling local law enforcement. Police are also called on to intervene when people with mental illness commit low-level, misdemeanor crimes or engage in "nuisance behaviors," such as making loud noises, blocking the sidewalk, or urinating in public (5).

Unfortunately, the police in the United State are generally not trained in working with people with severe mental illness (IACP). Too frequently, police called on to assist with a mental health crisis shoot or Taser the person, leading to his or her death. In just one example, New York City police arrived at the home of Iman Morales, a 35-year old man with a psychiatric diagnosis. Distraught and naked, Morales had climbed out the apartment window and onto a storefront ledge. The encounter ended when one of the officers aimed his Taser at Morales, who then plummeted onto the concrete 10 feet below and suffered a fatal head injury. Later that week, the police lieutenant who gave the order took his own life (Smith).

As a result of incident such as this, a growing number of localities have created special programs to improve police responses to people with mental illness. Often, it takes a local tragedy to prompt the adoption of a new response model. One study of 28 police departments with specialized responses methods found that nearly half had adopted the new methods following a tragic incident involving a person with mental illness. The New York Police Department has thus far declined to adopt a new model, although they have instituted enhanced training for new officers.

B. Incarceration and Solitary Confinement

While incarceration is difficult for most people, individuals with serious mental illness suffer particular hardships when imprisoned. Many are denied the psychiatric care they need and in addition, may be seen as easy targets for abuse by fellow prisoners and guards alike (Torrey 11). Most important, any inability

to follow institutional protocol, whether due to mental illness or not, is treated as an intentional infraction of the rules. For this reason, people with severe mental illness spend more time in prison or jail than others convicted of the same crimes, and are more likely to suffer various forms of discipline, including lack of privileges, solitary confinement and restricted diet (10-11).

Not only are people with mental illness disproportionately placed in solitary confinement, but such confinement is particularly detrimental to their health and well-being (Gawande). Indeed, it is a form of torture. In New York State prisons, cell blocks used for solitary confinement are officially and misleadingly termed “Special Housing Unit,” or SHU. They are also referred to more accurately as “the box” or “the hole.” People placed in the SHU are locked alone in their cells 23 hours a day. Most cells measure fifty-six square feet and have a small peephole and a slot for a food tray; generally, both are kept closed. Talking is not allowed. If people in the SHU break the rules, for example by screaming for help, they may be put on a restricted diet called “the loaf”—a rectangle of yeast, flour and potatoes, and a side portion of cabbage, three times a day.

People with mental illness are disproportionately represented in disciplinary segregation. While eleven percent of New York’s prisoners are on the mental health caseload, twenty-three percent of the population in disciplinary segregation is on the mental health caseload. The actual percentage of people with mental illness who are placed in disciplinary segregation is significantly higher. Not surprisingly, there is a high rate of self-injury and suicide in such segregation units. In New York, advocates have challenged the placement of people with mental illness in solitary confinement through litigation and legislation. With both new laws and a settlement agreement in place, we hope to see a reduction in the use of the SHU in coming months and years (*Disability Advocates Inc v. NYS Office of Mental Health*).

C. Capital Punishment

No overview of the criminalization of poverty in the United States would be complete without a discussion of the death penalty.² As applied, the death penalty is blatantly racist. Blacks make up less than thirteen percent of the general population, yet they comprise fifty-six percent of the population on death row (DPIC). The vast majority of those convicted are so poor that they cannot afford private counsel, but must rely on court-appointed attorneys who are under-resourced and at times incompetent.

While the United States Supreme Court has held that it is unconstitutional to execute defendants with “mental retardation,” no similar prohibition exists for defendants with severe mental illness. Although precise numbers are not available, it is estimated that five to ten percent of people on death row have a serious mental illness (NAMI). The United States Supreme Court has held that it is unconstitutional to execute a person who does not have “a rational understanding of the reason for the execution” (*Panettie v. Quarterman*). But our courts are split as to whether it is permissible to forcibly medicate a defendant to “make” him competent to be executed, and many states currently do so (ACLU).

V. Social Welfare

As discussed above, in the United States there is no constitutional or national right to housing or medical care. Instead, there is a patchwork of federal (national) and state (local) programs that provide varying levels of cash assistance, housing, medical care and nutrition to people living in extreme poverty. Because they are not universal, these programs can be selective in whom they help. In general, these programs strive to separate the deserving from the undeserving, and to police that moral line through surveillance. A large percentage of those in need of public benefits have mental illness, and little or no accommodations are made to assist them in navigating the programs (Kasdan & Youdelman). By design, the welfare system is onerous and punitive, with the objective of reducing the number of people receiving benefits.

² Although the State of New York no longer has the death penalty, the United States has executed 1242 people since 1976, and currently has over 3,000 people on death row (that is, awaiting execution).

For example, in New York, single people who are indigent are eligible for Safety Net Assistance.³ The aid provided by the program is nominal, in that it does not provide enough financial assistance to allow a person or family to survive in New York.⁴ To apply for benefits, a person must report to a “Job Center,” where he or she may be required to wait for over eight hours for an initial screening. The applicant will be required to present identification, proof of immigration status, a birth certificate for each person living in the household, proof of school enrollment for any children, and the lease for his or her residence. At various points in the process, the applicant will be fingerprinted. Often, an investigator will be sent to the applicant’s home; the applicant must be present and allow the investigator to enter and inspect the residence.

Applicants must disclose physical and mental health conditions including substance abuse, and provide access to their medical records. They may be required to be examined by a city doctor. Persons suspected of using controlled substances are often required to participate in “treatment programs” that provide little, if any, treatment, and to submit to weekly drug tests. If they fail the drug tests, they are sent to inpatient drug treatment programs outside of New York City. After a waiting-period of forty-five days, the applicant will finally receive an initial disbursement of benefits.

In order to maintain benefits, recipients must participate in “work activities” for thirty-five hours per week unless found to be medically exempt. If they are fifteen minutes late to work, they may lose their benefits for up to six months. Understandably, it is nearly impossible for most people to maintain their benefits, and they are regularly cut off. People with severe mental illness find this system impossible to navigate on their own, and thousands of technically eligible people go without food, clothing, shelter, transportation and hygiene because the system has locked them out.

Not only do our safety net programs treat people like criminals but they are increasingly unavailable to people who have a criminal record, no matter how old. Public benefits programs that are unavailable to people with certain criminal histories, such as non-violent drug crimes, include the nation’s primary cash assistance program for poor families; public housing; disability benefits; student loans; and benefits for veterans of the armed forces.

VI. Child Welfare

The United States Constitution guarantees the reciprocal rights of parents and children to live as a family unit. Parents have a right to raise their children, and children have a corresponding right to be raised by their parents (*Stanley v. Illinois*, *Santosky v. Kramer*). In every state, that right can be abrogated where the state alleges, and a court finds, that a parent has abused or neglected his or her children, and that it would be in the best interests of the child to be removed from the parent’s care.

There is a long and sordid history in the United States of denying people with psychiatric disabilities the right to have and raise their own children. Between 1907 and 1963, at least 60,000 persons were sterilized pursuant to laws permitting the involuntary sterilization of persons in state institutions (Kelves). Today, the same prejudice is exercised not through sterilization but through the child welfare system. Adults with psychiatric disabilities lose custody of their children at rates as high as 70% (Nicholson). In New York City, in over half of the cases in which children were removed from their homes, a parent with a mental illness was the caregiver (Child Welfare Watch, Winter 2009).

³ The rules governing the Safety Net Assistance Program are codified at Title 18 of the New York Code of Rules and Regulations.

⁴ A single person on Safety Net Assistance generally receives \$166 in cash, \$215 for shelter and an additional \$200 in Food Stamps, for a total of \$581 per month.

In New York, mental illness is a specific legal ground under which the state may terminate parental rights. To permanently sever a parent's relationship with her child, the state must establish that the parent is "presently and for the foreseeable future unable, by reason of mental illness or mental retardation, to provide proper and adequate care for a child" who has been in foster care for one year (Margolin 183). The state need not show that it made diligent efforts to reunify the family or even that the parent was offered appropriate mental health care (152). The parent's unfitness due to mental illness is established by the testimony of a court-appointed psychologist or psychiatrist, who generally bases his or her opinion on a single interview with the parent (155). Not surprisingly, the majority of the state's efforts to terminate parental rights on the grounds of mental disability are successful (152).

Even where the state refrains from removing children from the home, investigations by child protective officials prompt high levels of control and surveillance in poor parents' lives. Parents who are not currently mentally ill, or whose illness is well-controlled, are ordered to engage in inappropriate or duplicative treatment, release confidential medical records, submit to drug testing and open their home to child protective workers, all under the threat of losing their children. The vast majority of parents who come under the surveillance of the child protection system are poor, and they are disproportionately black, Hispanic, and Native American. Thus, the child protective system is responsible for the criminalization, control and surveillance of some of the most vulnerable people in our county—poor women of color with mental illness.

Works Cited

- Beck, Allen J, Ph.D. and Paige M. Harrison. *Prison and Jail Inmates at Midyear 2005*. Bureau of Justice Statistics, 21 May 2006.
- “Hard Choices: Caring for the Children of Mentally Ill Parents.” *Child Welfare Watch* 17 (Winter 2009). Center for New York City Affairs.
- Cooper, Michael. "Racial Disproportion Seen in Applying 'Kendra's Law'" *New York Times* 7 April 2005.
- Disability Advocates, Inc. v. New York State Office of Mental Health, et al.*, Private Settlement Agreement, April 2007.
- Death Penalty Information Center (DPIC). *Facts About the Death Penalty*. Washington: Death Penalty Information Center, 20 Sept. 2010.
- Gawande, Atul. “Hellhole.” *The New Yorker*. 30 Mar. 2009.
- Grissom, Brandi. "As Mental Health Cuts Mount, Psychiatric Cases Fill Jails." *New York Times* 24 Feb. 2011.
- International Association of Chiefs of Police (IACP). *Recommendations from the IACP National Policy Summit*. June 2010.
- Kevles, Daniel J. *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (Harvard University Press 1985).
- Margolin, Dale. "No Chance to Prove Themselves: The Rights of Mentally Disabled Parents Under the Americans With Disabilities Act and State Law." *Virginia Journal of Social Policy and the Law* (Fall 2007): 112-87.
- McLarin, Kimberly J. "Welfare Fingerprinting Finds Most People Are Telling the Truth." *New York Times* 29 Sept. 1995.
- McNeil, Lori. Urban Justice Center. *Effects of the Recession on the Public Assistance Caseload and the Barriers Public Assistance Applicants Face*. Testimony before the New York City Council Committee on General Welfare, 13 Sept. 2010.
- Mental Health Alternatives to Solitary Confinement. *Faces of the SHU; Family Members and Mental Health Consumers Speak Out About the Horrors of Solitary Confinement for People with Psychiatric Disabilities in New York State*. 2009.
- Mental Illness and the Death Penalty*. American Civil Liberties Union, 5 May 2009.
- National Coalition for Child Protection Reform. *Child Welfare and Race*. 3 Jan. 2011.
- National Coalition for Child Protection Reform. *Child Abuse and Poverty*. 3 Jan. 2011.
- New York Senate 333A/Assembly 4870, signed into law 28 Jan. 2008.
- New York State/ New York City Mental Health-Criminal Justice Panel (MHCJP). *Report and Recommendations*. June 2008.
- "Race, Bias & Power in Child Welfare." *Child Welfare Watch* 3 (Spring/Summer 1998). Center for New York City Affairs.

Panettie v. Quarterman, 549 U.S. 1146 (2007).

Reuland, Melissa, Matthew Schwarzfeld and Laura Draper. MacArthur Foundation, and The Council of State Governments Justice Center. *Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice*. New York, 2009.

"Parenting with Mental Illness." *Rise* Summer 2010.

Pew Center on the States. *One in 31: The Long Reach of American Corrections*. Pew Charitable Trusts, 26 Mar. 2009.

Santosky v. Kramer, 455 U.S. 745 (1982).

Smith, Alexandra. "Police Need New Approach to Deal with the Mentally Ill." Editorial. *Gotham Gazette*. Citizens Union Foundation, 6 Apr. 2010.

Stanley v. Illinois, 405 U.S. 645 (1972).

Swartz, MS, Swanson, JW, Steadman, HJ, Robbins, PC and Monahan J. New York State Assisted Outpatient Treatment Program Evaluation. Duke University School of Medicine, Durham, NC, June, 2009.

Stories From the SHU. 4th ed. New York: Mental Health Alternatives to Solitary Confinement, 2005.

Torrey, M.D., E Fuller, Sheriff Aaron D. Kennard, Sheriff Don Eslinger, Richard Lamb, M.D., and James Pavle. *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*. Treatment Advocacy Center, May 2010.

Winerip, Michael. "Bedlam on the Streets." *New York Times* 23 May 1999.