Resisting Carcerality:
A Case for Mad Liberation

Violet Stoudt

Honors Thesis

Department of Ethnic Studies

Primary Thesis Advisor:

Nishant Upadhyay, Ph.D., Department of Ethnic Studies

Honors Committee Members:

Jessica Ordaz, Ph.D., Department of Ethnic Studies

CheyOnna Sewell, Ph.D., Miramontes Arts & Sciences Program

University of Colorado, Boulder

29 March 2022

Table of Contents

Introduction

At fourteen I was diagnosed with Bipolar type two—a diagnosis of a life rife with instability. Ever since then I've struggled with truly accepting this diagnosis and what it means for my outlook on the rest of my life. Eleven years later, through the introduction of disability justice to my consciousness in 2021 and the learning I have done through the process of writing this thesis, I have come to realize just how deep our society's ideologies of ableism and sanism have become entangled with my self-perception. As an Ethnic Studies student, I have also come to recognize that these systemic oppressions are built by and within the carceral logics deeply ingrained in the U.S. society.

In this thesis, I explore how carcerality informs, reinforces, and creates ableism and sanism, and vice-versa. In this thesis, I argue that our response to mental illness is deeply entrenched in the United States society's carceral nature. Through this carcerality, I believe we other, disappear and punish those with mental illness from every level—from interpersonal to systemic levels leading to deep levels of internalized sanism for those with mental illness. I begin the thesis by explaining the theoretical connections I have found between carcerality, ableism, and sanism. In the next section, I continue by exploring the way these ideologies intersect with other systems of oppression, namely: capitalism, colonization, racism, and cis-heteropatriarchy. Then, I provide a historical explanation of the deinstitutionalization movement which set the stage for the violent contemporary structures in place for those with mental illness. In the following section, I elaborate on these contemporary structures that continue to fail those with mental illnesses. Following this examination of current systemic failures, I conclude with the analysis of resistance movements like the Mad liberation movement and how ex-patients can turn to frameworks of abolition and disability justice to further their movement's success in creating a more just future for all of us. I have also included a coda at the end in order to share the immense personal impact writing this thesis has had on me.

Theoretical Frameworks

Carcerality

Scholars and activists use the term carceral to describe the ways that the U.S. society imposes a punitive system of strict punishments for violations of socially enforced norms. The U.S. society is obsessed with this form of social control and has given nearly complete control of punishment over to the state. This has resulted in a state which routinely enforces laws in violent ways and more often than not by incarcerating people. In *We Do This Til We Free Us,* Mariame Kaba explains that “a carceral logic, or a punishment mindset, crept into nearly every government function, including those seemingly removed from prisons” (77). It is clear to see the carceral nature of the U.S. society when examining the police and prison industrial complex. When discussing the police one easily sees the normalization of the narrative that an individual is punished for acting outside of the prescribed norms. This gives police unprecedented power over the society, without any mechanisms to control and check their misuse and abuse of power. Since the advent of the War on Drugs, this power has further escalated with more financial funding given by the federal government to militarize the police through acts like the Byrne Grant and the Military Cooperation with Law Enforcement Act (Alexander 93, 97). In November of 2021, the Justice Department declared they would be providing over $139 million in grants to fund, “183 law enforcement agencies across the nation, allowing those agencies to hire 1,066 additional full-time law enforcement professionals” (U.S. Department of Justice). Ultimately, as of 2018, the United States spends over $118 billion on police forces, which puts it only behind the U.S. military and China in terms of spending on a military organization (Beschizza). The police have also gained immense power of discretion when it comes to who they target through rulings in the Supreme Court like *Terry v. Ohio* (Alexander 80). This has led to a severely disproportionate number of Black, Indigenous, and Latinx peoples ending up in jails and prisons or on parole for non-violent drug charges. According to a 2021 report from The Sentencing Project, "Black Americans are incarcerated in state prisons at nearly 5 times the rate of white Americans" and "Latinx individuals are incarcerated in state prisons at a rate that is 1.3 times the incarceration rate of whites" (Nellis 5). The magnitude of this situation is also felt by Indigenous communities. Although data is not available broken down based on gender, incarceration rates for Indigenous people are "more than double that of white Americans" (Daniel). Additionally, in states like North Dakota which have a higher population of Indigenous people, the "incarceration rates are up to seven times that of white people" (Daniel). The War on Drugs is also harming women, the Sentencing Project also found that "the proportion of imprisoned women convicted of a drug offense has increased from 12% in 1986 to 26% in 2018" ("Incarcerated Women and Girls."). The situation for Black, Indigenous, and Latina women is also disproportionate especially surrounding drug offenses. "In 2019, the imprisonment rate for African American women was over 1.7 times the rate of imprisonment for white women" and "Latinx women were imprisoned at 1.3 times the rate of white women" ("Incarcerated Women and Girls").

The War on Drugs also brought about the development of the school-to-prison pipeline. This refers to the numerous ways in which young children of color, especially Black children, and students with disabilities are targeted for punishment, which is then used to justify pushing them out of schools. Leaving school before graduating high school greatly increases the likelihood of these children later becoming incarcerated. A study done by the U.S. Department of

Education Office for Civil Rights found that African-American students were “3.5 times more likely than their white classmates to be suspended or expelled” (Elias). For Black children with disabilities, the problem is exacerbated. A report by Daniell J. Losen found that “[a]bout 1 in 4 black children with disabilities were suspended at least once, versus 1 in 11 white students” (Elias). This problem starts early. The NEA reported that “[b]lack children represent 18 percent of pre-school students, but account for 48 percent of pre-school suspensions” (Flannery). Upon the first suspension, a cycle develops. A study by Horace Duffy at the Houston Education Research Consortium found that “for every suspension a student faced, they were 7% more likely to have contact with the juvenile justice system. Once those students returned to school, they were 20% more likely to be suspended” (Rice University). The saga continues to develop as Aizer and Doyle reported, those students who were “incarcerated as a juvenile are 39 percentage points less likely to graduate from high school and are 41 percentage points more likely to have entered adult prison by age 25 compared with other public school students from the same neighborhood.” Through this system of preparing the next generation for incarceration, the system of mass incarceration maintains itself.

Due to this increasing number of people being incarcerated by the state following the advent of the War on Drugs, the opportunity arose for some to capitalize on it with privately run prisons. The Sentencing Project reports that “[f]rom 2000 to 2016 the number of people housed in private prisons increased five times faster than the total prison population. Over a similar timeframe, the proportion of people detained in private immigration facilities increased by 442 percent” (Gotsch). As of 2015, Core Civic and GEO Group, the largest private prison corporations, “manage over half of the private prison contracts in the United States with combined revenues of $3.5 billion” (Gotsch).

To maintain and boost profits private prisons and government-run prisons “employ” inmates in incredibly low-paying jobs to produce products to be sold at an astronomical price. As of 2017, the imprisoned population could make an average of 86 cents per day before other costs are subtracted which often cut their pay in half (Sawyer). The Federal Prison Industries program, UNICOR, “makes nearly half a billion dollars in net sales annually using prison labor” (“Profiting off of Prison”). The growth of private prisons has also created “lockup quotas” which require the states and counties to fill a certain amount of beds in a prison (“Private Prisons”). These quotas incentivize the government to push for further arrests. This development of strict policing, punishment, and incarceration is just one manifestation of the carcerality of U.S. society.

This control is implemented throughout the judicial system but also through the normalization of punishment in the general society. Most of us have been taught from a young age that policing one another is not only “normal” and expected but necessary. From childhood, we have been instructed through paternalistic narratives that those behaving outside of societal “norms” deserve punishment. Social control over those operating outside of societal “norms” has fallen into all of our hands. We have been deputized by the state to shame and isolate those who behave “abnormally.” For instance, a classmate who cannot seem to sit still or stay quiet is punished rather than being supported. The behavior seen as abnormal begins to be associated with the innate nature of a person. Not only is the behavior “bad” but so is the person. We are conditioned to believe that it is not just the behavior that needs to be punished but rather that the person requires control from an outside source.

This carceral logic is reproduced in interpersonal relationships as well. It becomes internalized and we begin to police ourselves and each other. This has created a society in which we have been taught to be ashamed of any aspect of ourselves that falls outside of those sacrosanct norms, based on race, gender, sexuality, disability, class, religion, ethnicity, nationality, age, etc. We are taught to control and hide our authentic selves to survive. This is a problem for everyone in the society but is especially detrimental to the well-being of those with a mental illness. The society makes having a mental illness seem abnormal and therefore worthy of punishment. When taken to the next level those of us who are labeled mentally ill, begin to see it is not just the abnormality that is a problem, but rather ourselves on a fundamental level. Perhaps we have an understanding that we are more than our abnormality, but we can begin to feel that in the eyes of society this abnormality defines us. This creates a sense of isolation as we fear anyone knowing this deep secret of our true selves. We can feel trapped by factors outside of our control yet we know how this is innately connected to us, a deep part of ourselves. When everyone around us seems to do everything to avoid being like us or make light of our experience, how can we avoid wanting to change this part of ourselves? We will crawl through life wishing this part of us could disappear, wishing we could fit the norm. But this is not a real option. Instead, we will spend countless hours trying to control this part of ourselves, trying to invisiblize it. Hopelessly hoping if we try hard enough we can be freed from our illness and society will look at us as human beings, not an innately flawed being worthy of punishment, segregation, incarceration, and destruction.

The impact on the mentally ill or Mad is less often addressed and acknowledged as a systemic problem. Upon examination of the carceral state's impact on this community, it becomes apparent how this carceral logic is routinely used to further legitimize ableism and sanism which serves to impede the ability of the mentally ill to be part of the society. Part of this comes from the development of a carceral society's obsession with not only the social control of citizens but also through the physical control of bodies. All carceral systems operate under this structure of violence and instill fear into the general public, but the focus of the state and its citizens is particularly on marginalized communities. The carceral nature of the U.S. society results in increased violence upon the mentally ill, both on interpersonal levels as well as through the implementation of the power of the state. In this thesis, I explore this carceral treatment of the mentally ill in our society.

Ableism

Ableism refers to the inherently violent, dehumanizing societal assumption that people with disabilities are inferior to able-bodied/minded people and that they do not fit within societal norms. Disabled people are viewed not only as disobeying societal norms, but also as people who consistently break rules—through their existence. When your existence inherently defies the rules of our society you are opened up to constant policing. Ableism brings with it the ideologies that disabled people would like to be and need to be “healed” and “fixed” of their perceived abnormalities (Eisenmenger & LeFrancois, Brenda A., et al.). This is the result of a society so obsessed with everyone conforming to the norm that they shame someone for something they have no control over. This also attempts to negate the embracing of these disabled identities by society or by disabled people themselves. Campbell explains that because of ableism, disability, “is cast as a diminished state of being human” (44). An ableist society is permeated with “harmful stereotypes, misconceptions, and generalizations of people with disabilities” (Eisenmenger). Sayings like being “blindsided,” “the blind leading the blind,” and the use of the r-word are all examples of ableist language that has permeated our society. The normalization of these phrases and terms speaks to the degree to which the society refuses to even attempt to understand, let alone sympathize with the disabled community, or build relations with us.

Ableism also erases invisible disabilities from the conversation. Most often in our society when the term disabled is used, it is in regards to someone with a visible physical disability. It is not that this is not a true disability that needs to be thought of, but it also seeks to negate the realities of oppression of those with intellectual or developmental disabilities or mental illnesses. Mental illness along with the people afflicted with it has been disregarded throughout modern times. A simple example of this is the horrendous environments of psychiatric hospitals that the mentally ill were for over a century and continue to be relegated to for "treatment."

Sanism

The specific systemic violence against those with a "mental illness" is called sanism. Morton Birnbaum coined the term sanism and explained it as "the systematic subjugation of people who have received mental health diagnoses or treatment" (Le Francois, 339). For this thesis, I will at times refer to those with a "mental illness" as "Mad". The use of Mad is a form of reclamation and resistance to the judgment of someone's experiences and life. Poole and Ward explain, "we are referring to a term reclaimed by those who have been pathologized, psychiatrized as 'mentally ill,' and a way of taking back language that has been used to oppress" (10). Diamond expands that Mad is used "to mean the group of us considered crazy or deemed ill by sanists" (11). Sanism is rooted in the state's need to control everyone. To those in positions of power's dismay, those with mental illnesses are inherently difficult, if not impossible, to control. They Mad think in ways that have not existed before. The Mad act in ways that are not easily predictable. The Mad are resistant to conforming to traditional oppressive systems. Because of this, *the Mad are inherently revolutionary*. This is terrifying to the state which knows that its power is rooted in the ability to control the society. So the state will allow for the perpetuation of narratives of ableism and sanism to deeply shame the Mad into submission. Sanism intertwined with a carceral society enables this shame to blossom.

The manifestations of one's madness is immediately seen as a flaw in not only their actions but them as a person as well. It is not just the manic spending or depressed self-harm that is the abnormality needing to be "fixed", but one's intrinsic self. Even though many factors leading to self detrimental behaviors are externally triggered, it is the Mad person who must change themselves. Without these changes, they will be punished by remaining on the outskirts of society. Because of our carceral society, one's perceived abnormalities become their identity. One's illness becomes their identity; "you are bipolar," rather than "you have a bipolar diagnosis." For many, this leads to fear of ourselves and the possibility of others seeing our perceived differences from the "norm." The socially imposed fear drives many to such an extent of shame that we deny the impact of our illnesses and because of this may deny ourselves the care we need. Even with the thought of asking for support, we begin to question the validity of our experiences because we have been taught to fear and conceal our "abnormalities" on such a deep level. This level of concealment leads to the deaths of thousands of people each year. In the U.S., in 2019 alone, 12 million adults seriously contemplated suicide, 1.4 million adults attempted suicide, and ultimately 47,511 people killed themselves. Among people from 10-34, suicide was the second most prominent cause of death in 2019, and across all age ranges tenth most common cause of death ("Suicide"). As of 2020 someone kills themselves every eleven minutes in the U.S. ("Facts About Suicide"). Our society has created such a punishing, violent space where people are so commonly in distress and suffering, and have so little support and care that it is no wonder that so many are lost to suicide.

These deep-seated notions of fearing the mentally ill are perpetuated in numerous ways. It is not just the state but also the society that fears those with mental illness. We see this narrative of the mental illness being violent perpetuated with every mass shooting, something that has become routine. Every white or white-passing shooter is immediately labeled as mentally ill and their actions are attributed to their illness. Headlines like, "Investigators believe Las Vegas gunman had severe undiagnosed mental illness" "A look inside the 'broken' mind of James Holmes," and "Very Anti-Social': Suspect in Boulder Supermarket Massacre Was Paranoid, Brother Says" pepper the media following shootings (Thomas, P.; O'Neill et. al.; Melendez, et al.,). This connection between mental illness and mass shootings is largely exaggerated. A 2015 article by Michael Stone found in his database of mass shootings, "only 52 out of the 235 killers in the database, or about 22 percent, were mentally ill" (Matthews). Another study which compiled "shooters who killed four or more people since 1966" by Fox and Fridel found: "of the 88 shooters who met that criteria, only 14.8 percent had been diagnosed with a psychotic disorder. And even for them, it's hard to say with any certainty that mental illness "caused or contributed to their shooting" (Matthews). Additionally, according to the National Center for Health Statistics, "fewer than 5% of the 120,000 gun-related killings in the United States between 2001 and 2010 were perpetrated by people diagnosed with mental illness" (Metzl, 241). Most importantly, the fact remains that people with mental illness are "over 10 times more likely to be victims of violent crime than the general population" ("Mental Health"). But the media continues to perpetuate the narrative, and government officials from both parties back it up. In 2016 President Obama said, "We're going to do more to help those suffering from mental illness get the help that they need" (Rosenwald). In 2019, Trump echoed this sentiment saying, "Mental illness and hatred pull the trigger. Not the gun." He continued: "I want guns to be in the hands of people that are mentally stable. People that are insane, people that are sick up here,", pointing to his head, "I don't want them to get a gun" (Thomas, E.). He also mentioned the necessity of involuntary commitment for the Mad (Panetta). It should be noted that men of color are excluded from the label of “mentally ill.” They are instead immediately labeled as a terrorist (Mercier; Williams). This narrative connecting mental illness to mass shootings completely negates the necessary conversations that should arise after these atrocities, like the direct tie between domestic violence, white supremacy, and gun deaths; or the extreme accessibility of firearms; or the encouragement and normalization of violence in white men. This narrative only serves to harm all of society. The deeper roots of the issue are glossed over and the same violence will only continue and the mentally ill will continue to be feared, leaving them further isolated.

All these examples of ableism and sanism are a result of a society that is so concerned with controlling one another that they will provide a cycle of violence from involuntary committal to psychiatric hospitals, incarceration in jails and prisons, violent police interactions, and being unhoused, over and over again. This is all done on a root level because of the violences our state not only normalizes but celebrates. The U.S. is a country built on centuries of settler-colonial, antiblack, white supremacist, cis-heteropatriarchal, and capitalist violences. This white supremacist model also requires neurotypicality. For one to be a functioning cog in the violence of capitalism, one must be willing to sacrifice any semblance of self-care, something a Mad person requires to survive. Additionally, someone’s madness immediately makes them flawed, which is in direct contrast with perfectionism, a key tenant of white supremacy (Jones). As a result, we see the majority of the ways our society handles the Mad are attempts to violently disappear them. This can be seen in the systemic ways in which the Mad’s experiences are systemically silenced and erased. This leaves 52.9 million in the U.S. people feeling isolated and without the community support of those with shared experiences ("Mental Illness"). This also serves to hinder the organizing efforts of the Mad.

When the country has been built on violence it is no wonder that the people of this country act in violent ways toward one another. Its citizens have been brainwashed into thinking that dehumanization of one another is not only acceptable but the inherently "right" thing to do, as it brings a false sense of security. But a true sense of security is only accessible to the privileged. Marginalized communities in the U.S. struggle to attain any semblance of security in a country built on the foundation of violence against the people who do not share their identities because their existence is seen as violating the supposed norms of white supremacy. And, our social structures back all of the violences of the state. There is always a justification and it will always be at the expense of the disabled, the Mad, and all of those marginalized by a white supremacist capitalist cis-heteropatriarchal society. In the following section, I expand upon the impact of sanism's intersection with other systems of oppression.

Systemic Intersections

When examining ableism and sanism it is important to note their intersections with other systems of oppression. Mia Mingus explains: "[a]bleism is connected to all of our struggles because it undergirds notions of whose bodies are considered valuable, desirable and disposable" ("Changing the Framework"). Sandy Berne underscores: "[w]e cannot comprehend ableism without grasping its interrelations with cis-heteropatriarchy, white supremacy, colonialism, and capitalism. Each system benefits from extracting profits and status from the subjugated 'other'"

(Piepzna-Samarasinha 21). In this section, I provide examples of how ableism and sanism work in tandem with systems of oppression rooted in capitalism, colonialism, white supremacy, and cis-heteropatriarchy. I acknowledge that this section cannot possibly incorporate all aspects to this coalescing of power structures, but I hope that it can begin to explain them through the framework of disability justice that Piepzna-Samarasinha tells us “asserts that ableism helps make racism, christian supremacy, sexism, and queer- and transphobia possible, and that all those systems of oppression are locked up tight” (22).

It is important to note that the awareness of these intersecting structures is grounded in Black feminist theory. Kimberlé Crenshaw’s coined the term “intersectionality” in 1989. This was grounded in the historical work of Black feminists, dating back to Sojourner Truth and the Combahee River Collective. All of these Black women recognized that aspects of one's identity are not easily broken down simply into separate categories like race or gender but rather these identities come together to create different identities and experiences. This is built upon by Patricia Hill Collins who named the importance of “co-formation”, a theoretical framework that centers on the distinctive perspectives and life experiences of individuals/communities within the structures of oppression and power. She tells us that these structures are “perpetually co-forming” to sculpt how one will be able to maneuver and experience this world (245). She describes intersectionality as a framework to explore the “in-between, dynamic, liminal space on the borders of entities” to understand the variety of these life experiences (251). The framework of intersectionality illustrates how ableism and sanism are interlocking with other systems of oppression. This thinking can be further developed through the frameworks provided by feminists-of-color disability studies that encourage us to be aware that the common denominator amongst systems of oppression from ableism to white supremacy to the cis-heteropatriarchy as they all seek to “assign value or lack thereof to certain bodyminds” (Schalk and Kim). (When using the terminology of “bodyminds” I am working off of Sami Schalk’s definition which notes that the term “is particularly useful in discussing the toll racism takes on people of color” (5).)

To begin, the narrative that devalues the lives of the disabled can be directly tied to the capitalist agenda. Mia Mingus explains in a tweet: “ableism and capitalism are bound up together” (@mia.mingus). Our society values a person by their labor, the labor that allows for them to make more money for the already wealthy. It also means that unpaid labor is continuously disregarded by the mainstream. Shi puts it simply: “your value and worth lie in how much you can produce for profit.” Under the eyes of capitalism, many disabled and mentally ill people are seen as less productive because many are not employable. In 2018, only 19.1% of people with disabilities were employed, compared to 65.9% of people without disabilities (“Employment of People with a Disability”). Even those who are employed face pay discrimination in the workplace. As of 2019, one study of around 420,000 disabled employees were being paid an average of $2.15 an hour (West). This mass underpaying is legal because of a section in the Fair Labor Standards Act that specifies that employers can pay disabled workers less. For those who are unemployed, the immense amount of labor many disabled people must do to simply survive is unpaid. This labor being unpaid feeds into the narrative that disabled and Mad lives are not worth preserving. The mentally ill are seen as lazy despite a deeper examination which would show that their labor is simply undervalued, underpaid, and disregarded. One might assume that society would be advocating for better economic support for those with disabilities, but this is stunted by the individualization perpetuated by capitalism and the myth of the “American Dream.” The individualization that has permeated U.S. society is motivated by the idea that one must work on their own to succeed and the myth that if someone works hard enough, they will be successful, regardless of their positionality in society. This serves to stigmatize those who need more support, as broader society believes they should figure out their problems on their own. However, there are numerous structures in place that prevent those with disabilities from building wealth that might allow them to “succeed” under traditional standards, like asset limits. These limits come into play when someone is seeking Social Security Income (SSI) which is supposed to aid those with low income (Laurence). In order to attain this benefit, one must have their assets verified to ensure they are eligible. An individual cannot have more than $2,000 in assets this includes any “cash, money in checking or savings accounts, household goods and personal effects,” and even restricts one from having more than $1,500 in life insurance policies (Laurence). Even if someone is married, their assets cannot exceed $3,000 (Laurence). This asset limit prevents many people from getting married and even causes some people to get divorced to preserve or gain benefits. The toll is especially felt among couples that are both disabled because of the regulations they “are allowed to have fewer assets” and “receive about 25 percent less in benefits than they did as two unmarried individuals” (Kim). As a result, “marriage rates among Supplemental Security Income (SSI) recipients are half that of the general public” (Kim). One of the most important aspects to this is that those with SSI are eligible for Medicaid, in most states (“SSI Overview”). This is significant because many people with disabled people rely on personal care assistants (PCA) and Medicaid “is the only health insurance that covers PCAs and similar long-term services and supports” (Powell). So people with disabilities already receiving legally yet ethically criminally low wages are forced into lower socioeconomic status in order to survive.

Ultimately it is coercion between capitalism and ableism that perpetuates the current system where one study found, “[p]eople in the lowest stratum of income, education, and occupation are about two to three times more likely than those in the highest stratum to have a mental disorder" (Office of the Surgeon General et al.). And capitalism is not there to solve the problems of the Mad that they have created, as Spade said, "[c]apitalism makes us think about short-term gains, not building the long-term capacity for all of our well-being" (66). I will explore the impacts of this further in the section regarding the current situation for those with disabilities and mental illnesses.

Berne points out that "500+ years of violence against black and brown communities includes 500+ years of bodies and minds deemed 'dangerous' by being non-normative." (Piepzna-Samarasinha 21). The intersection between carceral sanism and colonization can be seen both theoretically and materially. I have noted the theoretical collusion of white supremacist culture stemming from colonialism with ableism and sanism previously. But more concrete examples can be found especially when examining the initial and ongoing colonization of Indigenous communities. One exemplification of the violence of colonization through the lens of psychiatry is found in the 1899 creation of the "Hiawatha Insane Asylum for Indians." This institution was built at the direction of the U.S. Congress. This institution came to hold individuals from thirty to fifty different tribal nations from across the country (Yellow Bird 4). The basis for these incarcerations varied from physical disabilities across all ages, as well as disagreeing with a white person in a position of authority who was demanding they end traditional religious practices. More were incarcerated because they would not allow the government to take their children to boarding schools (5). This psychiatric institution served as a way to further colonization through ableism and sanism. Yellow Bird tells us that this institution labeled the incarcerated "defectives" which justified sterilization. Yet nobody in the facility knew how to sterilize someone, so they decided to simply hold the incarcerated until they died. The result was that “of the average ten discharges per year at Canton, nine were due to death” (5). This institution's existence and processes speak to how ableism and sanism were used to justify the expansion of colonization. This incarceration and murder of Indigenous people ultimately served as a weapon of further dispossession of land, resources, and culture, and a new way to commit genocide. This is a clear example of how sanism has been used to justify a carceral response to Indigenous communities.

The intersection of the carceral nature of ableism and sanism and systemic anti-Black racism is also significant. Dating back to the Antebellum period, enslaved African Americans had psychiatric labels attached to them if they behaved in any ways deviating from the subservient roles enslavers had normalized. Dr. Samuel A. Cartwright was one of the founding writers on these “diagnoses” and had them published in the “New Orleans Medical and Surgical Journal” in 1851. He believed in “drapetomania” which he claimed was the reason an enslaved African Americans would attempt to escape their enslavement. He wrote of “rascality,” which explained enslaved people to “commit petty offenses.” As well as “dysesthesia ethiopica”, which he said led enslaved peoples to be “insensible and indifferent to punishment” (Willoughby 579). These psychiatric diagnoses allowed for further dehumanization and stripping of autonomy through sanist notions, therefore adding to the (un)justification for their enslavement. Once again one sees the connection between a mental illness being used to justify a carceral response, in this case, enslavement.

When examining the treatment of those with mental illness it is critical to include the differing impact of ableism and sanism on women. We see an increasing societal policing of women in relation to their mental stability which is complicated by sexist notions. One aspect of this is the sexist notion that masculinity is associated with rationality. This can be seen in the simplest ways like the consistent calling women “crazy” for the simplest reason, or no reason at all. This logic inherently renders women as consistently acting irrationally, an attribute also associated with the mentally ill. Further, this is also linked to the logic that women are seen as emotionally unstable. This sanist-sexist logic can be traced back centuries with the proposition of “hysteria” as an explanation for women’s behavior and emotions. This diagnosis has almost always been exclusively used to pathologize women’s behavior. This theory dates as far back as 1900 BC in ancient Egypt and would surface again in ancient Greece (Tasca 110). Both cultures believed women’s “abnormal” behavior was caused by the uterus moving throughout the body. In ancient Greece, hysteria was attributed to a poor sex life with descriptions like a “melancholy of the uterus” and Plato believed “the uterus is sad and unfortunate when it does not join with the male and does not give rise to a new birth” (Tasca 110). During the Middle Ages in Europe, “hysteria” began to be attributed to moral defects and exorcisms became a treatment practice (112). Although the term hysteria fell out of medical diagnosis when it was left out of the *Diagnostic and Statistical Manual of Mental Disorders*, this did not stop the use of the term hysterical from being used to describe women (North). Along with “crazy”, it remains a common designation for a woman. This labeling serves as a way to disregard what women are saying and feeling while also continuing to preserve men’s position of authority over women and their supposed greater attachment to rationality (Harris O'Malley). The impact of sanism on women is even more severe when one looks at its impact on women of color. As Mia Mingus explained, “women of color are already understood as ‘mentally unstable,’ regardless of whether or not they are actually ‘disabled’” (Ritchie 91).

The imposition of sanism also plays a heavy hand in transphobia and the maintenance of the gender binary. The idea that one would live outside of their assigned binary sex goes in direct contradiction to the rules of U.S. society and therefore has been deemed a mental illness. Transphobia was officially written into psychologists' doctrine in 1980 with the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (Beemyn 12). At this time transgender individuals were labeled "transsexuals." Over the decades, this psychological diagnosis would shift but the underlying notion of one identifying as transgender or gender nonconforming would continue to be deemed a mental illness. In 1994, being transgender was categorized as a "gender identity disorder." Some saw progress with the change made in 2013 to the label of "gender dysphoria" (Beemyn 25). However many trans activists continue to fight back against this continuation of the pathologization of one's gender identity.

Ableism and sanism are also tied to queerphobia. These identities are seen as not fitting the societal norms of our society and therefore are inherently flawed. Not conforming to the cis-heteronormative structure of our society is seen as a direct affront to normalcy. A lot of this is grounded in the grounding of the United States in Christianity, of which most branches did and continue to deem any form of queerness as a sin. For gay men, the stigma lies in the ideology that they have departed from the cis-heteronormative norm of holding a position of power over a woman in a relationship, and into an inherently wrong relationship of supposed sexual submission to another man. The departure from cis-heteronormativity for lesbians is also seen as an affront to the standard role of women to live in constant control by a man in a romantic relationship. Without this role of a man, they are seen as being "out of control" which can clearly be tied as an affront to the carceral and sexist nature of our society and therefore related to sanism. Additionally, any sexual relationship that would not result in pregnancy was sinful (Baughey-Gill 6). Those with sexualities like bisexual or pansexual are seen as hyper-sexual as they cannot contain their sexual and romantic desires for any gender identity, therefore also deemed “out of control” of both their bodies and minds. For someone identifying as asexual or aromantic, there is a similar disdain for not conforming to cis-heteronormativity. U.S. society so values the nuclear family that someone who does not appear to go willingly into the structure is deemed deeply flawed and in need of serious alterations. As with transgender identities, homosexuality was encoded as a mental illness in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in 1952, when it was described as a “sociopathic personality disturbance” (Baughey-Gill 7). Following years of protest, homosexuality was eventually totally removed from the *DSM* in 1987 (Burton). This pathologization continues with practices like conversion therapy that assume ones’ innate self can be altered through medical treatment.

Today the lineages of all these intersecting forms of oppression continue to plague oppressed community members’ bodyminds (Schalk 5). The generational trauma, near erasure of traditional healing practices, and continuing systems of unfreedoms preventing accessible mental health care have created a situation where Indigenous people have a 20 percent higher death rate from suicide compared to white people (“Mental and Behavioral Health”). The incessant stream of police murdering Black people in the U.S. has had a significant impact on Black communities’ mental health. Just within the week following the release of the video of George Floyd’s murder, amongst Black people, “[t]he rate showing clinically significant signs of anxiety or depressive disorders jumped from 36 percent to 41 percent” which “represents roughly 1.4 million more people” (Fowers). Additionally, LGBTQIA+ youth are “four times more likely to attempt suicide than their peers” and it is estimated that within the community there is “at least one attempts suicide every 45 seconds” (“Facts About LGBTQ”). Also “more than half of transgender and nonbinary youth have considered attempting suicide in the past year” It is important to note the intersection of racial identities when discussing the mental health of LGBTQ youth. The Trevor

Project found that among Two-Spirit/LGBTQ Indigenous young people—33% reported a suicide attempt in the past year compared to 14% of other LGBTQ adolescents. This intersection is especially stark for Black transgender and nonbinary youth of whom “59% seriously consider suicide” and over one in four attempted suicide in the last year (“Facts About LGBTQ”). These situations are worsened and sometimes explained by the lack of accessibility of high-quality mental health care to communities of color, which I will explore in the “Lack of Resources” section.

Ultimately, all of these intersecting systems of oppression are built to strip the power away from marginalized people through the lenses of ableism and sanism. It is through these processes that society can justify the horrid carceral conditions the mentally ill are subjected to in contemporary society. In the following section, I further explore the concrete forms that carceral sanism takes in society. First through an examination of the deinstitutionalization movement to provide historical context to the current situation.

Deinstitutionalization

The roots of the deinstitutionalization in the U.S. were crafted by the protesting hands of ex-patients dating back to the 1800s. Elizabeth Packard was a notable woman imprisoned in an asylum in this period. She was initially committed in 1860 because she questioned her husband’s strict Calvinist beliefs (40). Packard spent three years in the institution until her children successfully got her released. She went on to publish several books and helped pass thirty-four bills that helped prevent women from unfounded commitment (42). She was also the founding member of the Anti-Insane Asylum Society, which although not successful, was a meaningful step toward the modern psychiatric survivor movement (Chamberlin 324). In 1883, Mary Huestis Pengilly was also placed in a psychiatric institution (Le Francois, 43). While there she wrote secretly about the experiences she experienced and the treatment she saw others going through. She detailed the way her fellow patients were being handled in extremely detrimental ways, as though they were less than human. Through her journaling she exposed the systemic violence going on inside institutions and when released shared them with as many as would listen in an attempt to improve the situations occurring inside, but little progress was made on a systemic level (45).

The deinstitutionalization movement refers to the massive shift of those incarcerated in psychiatric hospitals into the public. The timeline of this movement is debated by many but since 1955 the numbers of those incarcerated in psychiatric hospitals have been decreasing. The number of those incarcerated who had been deemed mentally ill peaked in 1955 with 559,000 people incarcerated in state hospitals and this number continued to fall for the following decades (Ben-Moshe). There are several factors for this progression, these include: the advent of psychiatric medication, the changes in federal and state funding and policies, changes to legal precedent through civil rights lawsuits, and activism by ex-patients as key features. I discuss these below. It is important to note these changes made by the government in how they provided or failed to provide care for those with a mental illness. Before deinstitutionalization, the solution for someone who was seen as mentally ill was purely and obviously seen to be incarceration in a psychiatric hospital. This movement speaks to the transition from more obvious carceral state reactions to mental illness to the less obvious and more insidious ones we see in the present day.

The advent of psychiatric medication certainly brought about major changes in the lives of those deemed mentally ill. Inklings of this movement started with scientific work in the late

1800s and would begin showing themselves at full force starting in the 1950s. It all started in 1948, with the discovery that lithium salts could be used as a treatment for bipolar disorder (Ruffalo). It was soon followed by the 1947 development of chlorpromazine**.** Later released by the U.S. Federal Drug Administration in 1954, under the brand name Thorazine (Braslow and Marder 28). It was the first antipsychotic, then called a major tranquilizer, a medication that was extremely helpful for treating schizophrenia and psychotic manic stages of bipolar (Braslow and Marder 29). It boasted in advertising that the drug "reduces or eliminates the need for restraint and seclusion; improves ward morale; speeds release of hospitalized patients; reduces destruction of personal and hospital property" (Groopman). The medication was a huge success for the producers, "[b]y 1964, some fifty million prescriptions had been filled" (Groopman). Thorazine made massive waves throughout psychiatric hospitals and justified the release of countless patients into communities. Then, in the early 50s, the first antidepressants were released: Imipramine, the first tricyclic antidepressant, and Iproniazid, the first MAIO (monoamine oxidase inhibitor) (Braslow and Marder 32). Anti-anxiety medications came next. In 1955, meprobamate, called Miltown, was released. It was soon followed by the first benzheptoxdiazines named Librium in 1960 (Braslow and Marder 33).

While some scholars, activists, and patients saw the widespread use of psychiatric medication as a sign of progressiveness when it came to the normalization of mental illnesses, others heavily disagreed. The progression of more stringent diagnoses and medicinal treatment aided in the development of the burgeoning ex-patient/psychiatric survivor movement. These communities thought these "medical advances" were further measures to other those with mental illness. In his seminal work, *Madness and Civilization (1961),* Michel Foucault posed that the mentally ill were an oppressed group and the psychiatric field was using the pathologization of mental illness to subdue “resistance” (Groopman). Even people within the field were skeptical. Thomas Szasz, a psychiatrist argued in his book *The Myth of Mental Illness:* “psychiatric diagnoses were too vague to meet scientific medical standards and that it was a mistake to label people as being ill when they were really, as he termed it, “‘disabled by living’—dealing with vicissitudes that were a natural part of life” (Groopman).

Many of these new medications, especially Thorazine were touted as revolutionary tools that could liberate the mentally ill from psychiatric hospitals. Some see a causal relationship between the introduction of Thorazine in 1954 with the drop-off in the number of those incarcerated in psychiatric hospitals starting in 1956. What was not taken into account when “liberating” all these patients from facilities through medication, was who would ensure these patients stayed on the medication that was supposed to “normalize” them enough to be integrated into communities. Who was going to ensure they were in secure enough environments for medication to be their only form of treatment? This is where we begin to see the issue of federal or state level support becoming an issue.

While not initially having an impact on the lowering number of mentally ill incarcerated in psychiatric hospitals, federal and state governments quickly jumped in to worsen the conditions for those leaving psychiatric hospitals. Prior to the passage of The Community Mental Health Act in 1963, the care for those deemed mentally ill fell solely on the shoulders of state governments. But with the passage of this bill, the federal government involved itself in a situation that some would argue was beginning to heal itself. The federal government at this point was led by President John F. Kennedy who had made reforms to institutions a personal objective. He created an Interagency Committee together to create a solution to the violent state-run psychiatric hospitals (Torrey 41). The situation in these institutions at the time had been deemed “bankrupt beyond remedy” by the Joint Commission on Mental illness and Health and was called to be “liquidated” in 1958 by the then president of the American Psychiatric Association (Torrey 44). The Interagency Committee only had one mental health professional on it and none of them had any direct involvement with a psychiatric institution (Torrey 42, 44). So the Interagency Committee began its work and proposed the creation of “Community Mental Health Care Centers (CMHCs).” They believed these facilities could serve as both alternatives to the hospitals and provide preventative care for the mentally ill (Torrey 46). Despite these grand ideas, the committee was missing out on a key aspect: the progress already being made at the state and local levels. By 1962, states across the country had already begun crafting and enacting their own versions of community care projects (52). But instead of working together on these solutions, they each continued their own work on essentially the same solution to the same problem. What ultimately led to the disastrous impact of these policies was the influx of federal funding combined with little forethought on how federal and state programs would work together. While supporters of CMHCs conveyed that these centers would help to get patients out of the state-run hospitals there was never an established route of communication between the two. In fact, in some cases, they were purposefully avoiding sharing information with others (77). There was startling data showing how little the two were working in tandem: “between 1968 and 1978 patients who had been discharged from state mental hospitals who then were followed up in CMHCs made up only 3.6% to 6.5% of all CMHC patients” (77). In fact, most of the CMHCs were actually avoiding helping anyone who seemed too “difficult,” so really anyone with a serious mental illness like depression, schizophrenia, or a mood disorder. Instead of treating them, the CMHCs would refer them to a state psychiatric hospital (78). The situation only worsened with the creation of Medicaid and Medicare in 1965, despite both having been built to intentionally avoid supporting the mentally ill (72).

The federal government's plan to avoid taking on any more costs related to caring for the mentally ill failed, and they had quickly made themselves even more responsible for them. The states were now incentivized to move even more patients out of their hospitals and into the community care systems that Medicaid and Medicare were helping them fund. But these community-based solutions like CMHCs were not prepared for nor qualified for the care of those leaving hospitals. Regardlessly the states continued releasing patients for the next four decades. Some pressure to release patients came with the ruling in *Lake v. Cameron* in 1966. In this case, the D.C. Court of Appeals ruled that if a patient was well enough they would be transferred to what they deemed the "least restrictive setting" (Yohanna). This ruling was seen as a victory among many patient advocates, however, the lack of opportunities for good quality care outside of the state hospitals would continue to be the issue. This ruling also gave states further motivation to discharge patients in an attempt to avoid further lawsuits and it gave them another form of justification for their discharges. Another case came in the 1970s which would justify shutting down psychiatric hospitals. *O'Connor v. Donaldson* set standards for treatment in psychiatric hospitals. This 1975 decision, created the standard by which someone could be involuntarily committed. The U.S. Supreme Court ruled that someone could not be held if they were "capable of surviving safely in freedom" and were not posing a threat to their own or someone else's safety ("Dangerousness Standard"). Originally a right to treatment case in lower courts helped along in the ruling of *Wyatt v. Stickney* which served as an attempt to improve the conditions within psychiatric hospitals. Donaldson ruled that it was necessary for committal to meet the standard that "treatment as will give him a realistic opportunity to be cured or to improve his mental condition" ("Dangerousness Standard"). This helped solidify Wyatt's argument that conditions in psychiatric hospitals conditions were not conducive to treatment. In response to this ruling and others coming through the courts, states continued closing their state hospitals out of fear of further litigation because they were unwilling or financially unable to raise the standards of their facilities to those the court was ordering ("Right to Treatment"). As time went on they were discharging patients with more and more severe symptoms who most needed the support. These ex-patients entered communities ill-prepared to care for them. Some patients would be transferred into intermediate care facilities, which were created in an amendment to the Social Security Act in 1967. These facilities were originally meant to provide care to "elderly disabled individuals who did not need full-time care yet were not capable of living on their own" (Torrey 95). However, states quickly recognized these facilities as another institution into which they could place elderly state psychiatric hospital patients. This development not only brought a financial gift for states but also to those operating the facilities (96). These patients' right to survival was put at risk in this transition. One study of these transitions done in California found that there was a "nine-fold increase in deaths among patients who had been transferred from a state hospital to a nursing home" (96). It would later be discovered that nursing homes were "bidding" on state psychiatric patients through state hospital psychiatrists. They were on a mission to find the patients who would be more "easily managed" (100)

Another "solution" for the placement of ex-patients was board-and-care homes. A 1969 study of them said they were

> …in most respects like small long-term state hospital wards isolated from the community. One is overcome by the depressing atmosphere. . . . They maximize

> the state-hospital-like atmosphere. . . . The operator is being paid by the head, rather than being rewarded for rehabilitation efforts for her “guests”. (Torrey 96)

As with intermediate care facilities, board-and-care homes quickly became another opportunity for privatization and revenue production at the expense of the discharged patients. Across the country, a pattern of monetary association developed “between the governor, who was emptying state hospitals, and business persons who were profiting from the process” (97). The conditions within these facilities would also prove to widely be yet another inhumane environment for the mentally ill. The “homes” made more money when they spent less on patients’ conditions (101). As a result, many left on their own accord, while “others were evicted when the symptoms of their illness recurred because they were not receiving medication” (97). Regardless of the reasoning, people deemed mentally ill began to fill city streets, and became unhoused. This brought new public attention to the mentally ill, who had mostly been ignored for the decades that they were segregated into violent psychiatric hospitals. And it was not the poor treatment the mentally ill had been experimenting with in these transitions between violent facilities, it was their visibility in public spaces (101). This attention also brought new sanist narratives to light. In 1971, a San Jose newspaper referred to these victims of the state becoming visible in communities as a “mass invasion of mental patients” (97).

The sanist narratives would only grow as these newly unhoused ex-patients were criminalized by the very government that had abandoned them. These logics continue to this day with the book heavily cited in this section: Torrey’s *American Psychosis How the Federal Government Destroyed the Mental Illness Treatment System (2013).* Even in this book which describes in detail the mass abandonment of the mentally ill over the decades, Torrey turns to sanist narratives of the mentally ill being violent criminals as justification for their increasing rates of incarceration. Media of the time and this contemporary book, detail specific events of individuals previously hospitalized for being violent, whilst forgetting the driving force behind these individuals being on the streets, and without noting that this was not of their own accord. They had been left with no support system to aid their health. Instead of speaking to the true victims of the system, the police become the ones posited with a new struggle. Torrey writes that "police were beginning to feel the burden of the discharged, but often untreated, mentally ill individuals" (98). Regardless of narratives painted by Torrey or media from the 70s on, the fact remained that the mentally ill were now facing a different form of incarceration: jails and prisons. This remains the standard of care for the mentally ill, which I will explain further in the following section.

Some see the deinstitutionalization movement as a step in the right direction for those with mental illness. They see the steep decrease in the number of those in violent psychiatric hospitals as a net positive for the community. But in reality, the deinstitutionalization movement has all really just been a mass remodeling of the violent systems that those with mental illnesses in the United States have been facing for centuries. There have been progressive steps made through the judicial system in court cases that have attempted to protect the civil rights of those incarcerated in psychiatric hospitals. However, at every turn toward progress, the state and psychiatric institutions will maneuver a new way to pursue new forms of unfreedoms for the mentally ill. Ultimately how can we determine the better option between a life spent in the violence of a psychiatric hospital in 1950 versus a life spent experiencing the violence of being unhoused or spent in a prison cell? Both leave a person vulnerable to physical, emotional, and sexual violence. Both leave a person stripped of their agency. Both completely dehumanize a person. So are things really any different from where they were half a century or a century ago?

Or has the government just switched the design of the cell? In the subsequent section, I explore the current situation that remains in the wake of deinstitutionalization.

The Current Situation

While the period of blatantly incarcerating the mentally ill into asylums has passed, the situation has not improved. The current situations clearly exemplify the continuation of the carceral nature with which our society treats someone with a mental illness. There are now so few treatment options that society has turned the key workforce of the carceral state—the police— to handle the mentally ill. The asylum has gotten a fresh coat of paint but the violence remains within them. The asylum now has solitary confinement and jail bars. The asylum now means a life on the streets with a higher than ever risk of being killed directly by an officer of the state. Possibly more now than ever one can see society's carceral response directly interwoven with ableism and sanism. The purpose of this section is to expose how gravely dilapidated, insufficient, and carceral the current systems of care for the mentally ill are.

Lack of Resources

The lack of resources for Mad peoples exemplifies the systemic nature of sanism. The current mental health care system in our country is setting up the mentally ill to fail. A 2008 nationwide survey found that "25 percent of Americans do not have adequate access to mental health services and 44 percent either do not have mental health coverage or are not sure if they do" (Novotney). Despite numerous attempts by the federal government to increase the accessibility of care the problem remains nearly 60 years after JFK's Community Health Care Act. In the *2018 National Mental Health Services Survey*, there were only 11,682 mental health treatment facilities in the United States. This means that there were only approximately 4 facilities per

100,000 population and this number includes some outpatient facilities as well (37). In the entire country, there are only 109,241 beds in inpatient psychiatric hospitals (43). As I'll describe, in this section, these inpatient settings are extremely problematic, but due to the lack of outpatient treatment options often inpatient is the only choice. When examining access to outpatient care, one of the key components is access to a psychiatrist who can support stability through prescription medications. In 2018, "55 percent of counties in the continental U.S. do not have any psychiatrists" according to a study done by Bishop (National Council for Mental Wellbeing, 12). Another contributing factor to the inaccessibility of mental health care in the U.S. is the role of insurance companies. One study found in 2016 that "only 55 percent of office-based psychiatrists accept health insurance, which means that many patients who do get in to see a psychiatrist are faced with large out-of-pocket expenses" (Bishop, et al., "Population of US Practicing Psychiatrists" 2) This is especially true for those on Medicare and Medicaid. Bishop et al. found in their 2014 study that only 54% of psychiatrists accept Medicare and 43% of psychiatrists accept Medicaid ("Acceptance of Insurance by Psychiatrists" 176). Both of these rates are significantly lower than the acceptance of these insurances by physicians in other fields. This is significant because nearly one in four people on Medicare and about 29% of people on Medicaid have a mental illness or substance abuse disorder (McGinty and Maxwell, et al.). The issue continues if one is prescribed a medication for their mental illness. In a February 2019 poll, one in four U.S. adults reported having a difficult time paying for their prescribed medication (Kirzinger et al.). At the same time, one in four people in the U.S. is taking a psychiatric medication as of 2022 (VinZant). As a result of all of these systemic failings, "only 40 percent of patients with mental illnesses receive treatment." (Wang, et al.) These structures that leave so many with mental illness without care clearly show how the U.S.society not only disregards the lives of the mentally ill but believes they should suffer from their illnesses without support as a form of punishment for their "abnormalities." As mentioned previously, the problems of accessible quality mental health care disproportionately impacts BIPOC individuals and communities. This was proven by a 2005 study by the U.S. Department of Health and Human Services. The National Healthcare Quality and Disparities Reports found that "Blacks and Hispanics experience worse quality of care for approximately half of the quality measures reported" and "Hispanics and Asians experience worse access to care for approximately two thirds of access measures" (Kelley et al.). Some of this can be attributed to the lack of BIPOC mental heatlh care providers. The American Psychiatric Association (AMA) reported that "only two percent of psychiatrists" and "only 4 percent of psychologists are Black" (Lisa O'Malley). There is also a mass shortage of bilingual care providers. The APA reported that only, "approximately 10.8 percent of respondents reported being able to provide services in a language other than English, including Spanish (5.5 percent), French (1.1 percent), and other languages (3.7 percent)" (Hamp). The lack of BIPOC care providers closes the door to treatment and leaves many people vulnerable to care that is not culturally competent and therefore not effective in truly helping people in need. In the following section, I will examine the abhorrent impact of these structural deficiencies upon those with mental illness.

Calling Police

Often the carcerality of mental health care is first enacted when the police are called to respond to someone who is experiencing a crisis. Most often this can be attributed to the harsh stigma against those with a mental illness. Narratives of the mentally ill being dangerous have flooded the minds of people, even those who are mentally ill themselves. Of course, this narrative of fear can be easily disproved as previously mentioned. Nonetheless, the police are called, which can also be attributed to the perceived notion that with a police presence comes safety. This is not accurate as we already know through the experiences of Black and other communities of color who are systemically harassed by and incur violence from police. However, the state has neglected funding and providing alternative support systems to respond to someone in crisis, so, in most places, the police have become the only option. As a consequence, it is estimated that at least 20% of police calls are in regards to someone with a mental illness (Westervelt). The interactions between the mentally ill and police tend not to have positive outcomes and most of the time the situations are escalated. Partially this is due to the lack of de-escalation training of police and to the entirely carceral and violent training police receive, which I will expand on later. As a result, "one in four people with mental disorders have histories of police arrest" (Livingston). When encounters escalate the lives and livelihood of the mentally ill person are at risk. The mentally ill in these situations run the risk of being placed involuntarily in a psychiatric hospital, facing criminal charges, being incarcerated in a jail, or most devastatingly being murdered by the police. Ultimately all these forms of punishment are attempts to incarcerate and therefore invisiblize the Mad from the rest of society most of whom have come to accept this process as the best and/or only solution.

Psychiatric hospitals

This first option of someone being placed in psychiatric institutions can be argued to be the least dangerous, however, this does not take into account the detrimental impacts on one's mental and physical health after exposure to the conditions in these institutions. The conditions within psychiatric hospitals are especially harmful to those who lose their autonomy to be able to leave. This involuntary hospitalization often happens as a result of police interactions. This practice happens widely as can be seen in a report by the 2018 *National Mental Health Services Survey.*

Researchers found that on a given day in 2018, 57% of the patients were there against their will (29). These involuntary commitments made up the vast majority of hospitalizations in public hospitals compared to private facilities, which speaks to the steep disparities in the socioeconomic status of patients which also requires examination (89). Some of those who are involuntarily committed are there because they have been deemed "incompetent to stand trial," which I will explore further in the next section.

Once within the hospital, patients continue to be treated in a carceral manner. Part of this can be seen in the extreme violence they face while in "treatment." In the report *Trauma within the Psychiatric Setting: A Preliminary Empirical Report,* the reporters found a staggeringly large amount of ex-patients had experienced trauma while hospitalized. 86.0% of patients reported experiencing traumatic "institutional events and procedures" which the researchers categorized as events like "being handcuffed, put in restraints, and placed in seclusion." Researchers also found that 43.9% had experienced sexual or physical abuse. Additionally, 38.6% of those surveyed reported treatment by staff like, "being forced to take medications against one's will or being threatened with involuntary commitment." Lastly, 26.3% of ex-patients reported witnessing traumatic events, and 22.8% experienced verbal intimidation/abuse (Cusack, et al.). Along with the violence these patients are being subjected to, even the surroundings within the hospital look more like those in a prison. A 2019 article exposed that the changes that "aimed at limiting suicide risks" were making the spaces more like prisons (Associated Press) The article quoted Dr. Charles Herrick, chair of psychiatry for the Western Connecticut Health Network, "If you perceive the environment as a prison — and prisons are a place of punishment — then you can't help but think you are being punished, whether consciously or unconsciously." Another form of control under which patients are expected to conform, to avoid punishment is the strict schedule (Grohol, Lage, Heugel). While this is justified in terms of creating a more stable environment, it is also another way of stripping the autonomy and therefore the humanity of patients.

Lastly, and perhaps the most carceral aspect of psychiatric hospitals is that patients do not have the option to leave when they would like to, even those who have voluntarily admitted themselves. If they would like to leave voluntarily committed patients must fill out a "request for release" form. After filling out this form the hospital must either release the patient in a certain amount of time, depending on the state, or the hospital may file for a hearing which can result in the patient being classified as being treated involuntarily which could lead to committal for weeks ("I Am a Voluntary Patient," "Voluntary and Informal Admission"). All these conditions within psychiatric hospitals tend to only increase the instability of patients because of the violent treatment they are subjected to within the facilities. One study on patients after they were hospitalized found that 'at least half of these patients are rehospitalized or die by suicide in the long-term" (Loch). Part of this could be explained by the poor conditions those hospitalized have after release. This is largely true for unhoused populations. The *2017 Annual Homeless Assessment Report (AHAR),* found that in 2017, 19,268 people became unhoused after being released from psychiatric hospitals, and 29,548 people were left unhoused after substance abuse treatment. Being unhoused already has an impact on one's mental health Sovine LMSW-AP, executive director at Austin Recovery explained "[Being homeless is] isolating and disenfranchising, serving only to compound what might already be a pre-existing mental illness or substance use disorder" (Sheppard). Unsurprisingly, the conditions within psychiatric hospitals, as they stand today, have been recognized by the United Nations as psychological torture. This is regardless of them being named as a "'medical necessity of the 'best interests' of the patient" and note that they "generally involve highly discriminatory and coercive attempts at controlling or "correcting" the victim's personality, behaviour or choices and almost always inflict severe pain or suffering"(Human Rights Council 10). Despite the horrific level of "care" provided to those incarcerated in psychiatric hospitals, they have become U.S. society's main if not only resource for mental health care for someone in crisis, and for some they can be the only option to even beginning to get one's mental health on track. Yet they continue to perpetuate more trauma upon those who are incarcerated within them. Thus, continues the system of control and punishment for the mentally ill for things well beyond their control.

Incompetent to Stand Trial

The risk of arrest for people with a mental illness is staggering. It is reported that 383,000 of those incarcerated in prisons and jails have a mental illness ("Our Impact"). One of the responses to someone with a mental illness being arrested is them being deemed "incompetent to stand trial." This system was created with the ruling in a 1960 U.S. Supreme Court case, Dusky v. U.S (Tullis). This means that one will be forced into a psychiatric institution for an unspecified amount of time. It is only when a psychiatrist determines the patient is "well enough" that they will return to being held by the carceral judicial system. While this process may appear logical and beneficial to some it is not even functioning in this idealized version in most places in the U.S. Across the country we return to the issue of an insufficient number of treatment sites for the mentally ill. The reality of this situation is one where an unknown number of people deemed incompetent to stand trial are sitting in jail cells waiting for a bed in a psychiatric hospital to open up for them and as previously mentioned this is a serious issue due to the shortage of psychiatric institutions. Prior to 2002, there were no regulations as to how long someone deemed incompetent to stand trial could be held in jail before being transferred into a psychiatric facility.

Detainees were found to have been waiting in jail for years because there was no space in psychiatric hospitals. But in 2002, the Oregon Advocacy Center (OAC) raised a lawsuit against the Oregon State Hospital for preventing the admission of patients and forcing them to wait in jail (Tullis). The Ninth Circuit ruled in favor of the OAC and set the precedent that, "state psychiatric hospital[s] must accept within seven days people found to not have the mental capacity to stand trial" ("Lawsuit"). This was ruled based upon the "Fourteenth Amendment's ban on deprivation of liberty without due process" (Tullis).

Despite this landmark case psychiatric hospitals across the country continue to refuse admission of patients, the only difference was that now patients had the ability to sue the state for their mistreatment. But the problem continues. Researchers found in 2017 that the wait time to simply be evaluated averaged over 35 days in eight states. This study by the National Association of State Mental Health Program Directors, also found that "[w]hen it came to transferring people from jails after they are found incompetent to stand trial, 11 states reported average wait times exceeding 28 days" (Tullis). Some states stand out for their extreme failure. In Texas in 2018, the average time someone would be held in jail was 229 days. Tullis found that in Colorado "some defendants have waited for as long as eight months for alleged crimes that included stealing a bicycle or spitting on a police officer." It has been proven that time in a jail or prison cell is hugely detrimental to even a neurotypical person's mental stability, so it is not difficult to see how this time is incredibly problematic for someone deemed mentally ill. This can also lead to detainees being charged with additional charges after instances like altercations with guards or other inmates. These detainees can also face violence from other inmates and guards. Worst of all some of those being held in jails will commit suicide. In one case Jillian White, a 64-year-old killer herself in her jail cell "where she had been held for more than 60 days following an incompetency determination" (Tullis). It is incredibly important to note that all of this is happening before any of these people have been convicted of a crime, they are punished simply because of their mental illness. They are experiencing one of the most extreme iterations of carcerality through their imprisonment.

Police Murders

In some cases, there is not even the potential for treatment for those in crisis. Police routinely murder the disabled and mentally ill. Ableism is clear when examining police killings. One study found that "mentally ill/mad, Disabled, neurodivergent, and Deaf BIPOC account for over 50% of police deaths" (Kaufman-Mthimkhulu). When looking specifically at mental illness there is a significant relationship with police killings, studies have shown that "individuals with untreated severe mental illness are involved in at least 1 in 4 and as many as half of all fatal police shootings." Additionally, "[p]eople with untreated mental illness are 16 times more likely to be killed during a police encounter" ("People with Untreated Mental Illness"). This violence is impacting children too. In September of 2020, police shot and killed an unarmed thirteen-year-old autistic boy in Salt Lake City, Utah. (Treisman). In her book *Invisible No More: Police Violence against Black Women and Women of Color,* Ritchie speaks to the disproportional level of this violence against Black women and Indigenous women. She details cases like Kayla Morre, a Black trans woman, who had been deemed schizophrenic. The police continuously misgendered her and called her "it" throughout the interaction and wrongly said there was a warrant out for Kayla's arrest. When Kayla denied this, she was tackled to the ground and eight officers got on top of her, eventually suffocating her (Ritchie 94). There was no punishment for the officers involved. Another woman, Loreal Tsingine, was a Navajo mother, who was being treated for psychosis, was shot by an officer five times, killing her, within thirty seconds of going near her (Ritchie 98). Ritchie also shares the story of an eight-year-old Lakota girl who was suicidal being tasered with "fifty thousand volts of electricity." Again there was no punishment for the officer (98). A lot of this violence can be attributed to the flawed idea that the mentally ill are dangerous. The statistics on interactions with police show this is untrue. Research shows that at the bottom line police interactions with the mentally ill are statistically "less dangerous situations." The mentally ill "were less likely to be armed with a projectile weapon and were less likely to be attacking police" (Frankham, 72).

This constant stream of murders by the police brings up the familiar narrative touted by police departments that police officers just need de-escalation training or crisis intervention teams. This training simply means an expansion of police forces and their budgets, with questionable impacts. Even the experts on de-escalation admit that there is "no conclusive evidence that de-escalation training works… And the training has never been rigorously studied" (Schumaker). And the de-escalation training that exists in some states does not even include training regarding people with a mental illnesses (Pauly). The cities that have supposedly trained their officers, continue to see police violence. For example, the city of Minneapolis had already tried to make "reforms" before the murder of George Floyd (Schumaker). Yet some "advocates" for the mentally ill, like NAMI, will continue pushing for these reforms ("Crisis Intervention Team (CIT) Programs"). But these reforms do not change the fact that police are trained from the beginning to be violent and carceral in their approach to communities. As Karma explains, "Police are hired disproportionately from the military, trained in military-style academies that focus largely on the deployment of force and law, and equipped with lethal weapons at all times, and they operate within a culture that takes pride in warriorship, combat, and violence." This combined with a society obsessed with a carceral logic that is embedded in ableism, sanism, racism, sexism, transphobia, and classism it is no wonder we see so many murders by police. Ultimately all of the issues of police violence can be tied back to the gaps in access to mental health care that was left in the aftermath of deinstitutionalization.

It is because of these issues that result from a lack of resources that I argue our society must turn towards frameworks of abolition and disability justice in response to the mental health crisis that exists today. I contend that it is only through the dismantling of these oppressive and violent structures that we can begin to shape a safer and more equitable society for those with mental illnesses. It is through the practices of community care, ingrained in abolition and disability justice, that we can build new systems of care to take their place.

Towards Resistance: Mad Liberation, Abolition, and Disability Justice

Resistance to the aforementioned crisis of insufficient mental health care has been constant. This resistance has been codified as the "mental patient's liberation movement" and can be traced into the 1800s in the U.S. There is no doubt that the work of
\aforementioned ex-patients like Mary Huestis Pengilly and Elizabeth Packard helped to start national conversations about the conditions within psychiatric hospitals. The conversation continued into the 20th century. As deinstitutionalization was taking full effect, the U.S. began to see a mass community forming amongst those who had been institutionalized. In the 70s, a movement of people who had suffered the conditions of the psychiatric institution began to organize this "mental patients liberation" (Chamberlin 323). Between 1970 and 1972, four major organizations formed around the issues of ex-patients: the Insane Liberation Front in Portland, the Mental Patients' Liberation Project in New York, the Mental Patients' Liberation Front in Boston, and the Network Against Psychiatric Assault in San Francisco. At the same time,

national networks of communications between the Mad were being developed. The first was the Madness Network News which was the first major publication connecting Mad people from across the country. Local organizations were also aided by the development of the Annual Conference on Human Rights and Psychiatric Oppression which began in 1973 (Chamberlin 327). But perhaps the most powerful action that was happening was developments in smaller communities. These communities became linked together through two major modes of communication.

Through their organizing, ex-patients began to recognize the systemic nature of the carceral, sanist violence they had been experiencing. The power of being in a community with those who share your experiences can not be understated and that is what fueled this movement. The spaces for self-help they were sharing became "a means by which people become empowered and begin to think of themselves as competent individuals as they present themselves in new ways to the world" (Chamberlin 331). Chamberlain explained the importance of these spaces, "[b]y its very nature, self-help combats stigma, because the negative images of mental patients ultimately must give way to the reality of clients managing their own lives and their own programs" (331). This self-help motivates ex-patients to speak for themselves, no longer allowing others to speak "for" them" (323). This was a breakthrough idea for a community of people who had their autonomy of body and mind stripped from the moment their symptoms began. As established previously the Mad are constantly being pressured to conform and be controlled by existing at the intersection of a society ripe with carcerality and sanism. The idea that someone with a mental illness could control how they would handle this difference in their bodymind is life-changing. Although the threat of involuntary committal remains, this new cultural idea was spreading.

The ex-patient movement has often had to fight off co-optation and influence by those who did not share their experiences. As with many liberation movements centered around identity, Chamberlain explained that the liberatory model held by purely ex-patient organizations often shifted towards "reformist" goals, which did not hold on to the ideal of the abolition of psychiatric institutions (325). She notes that outsiders like families of ex-patients or those employed in psychiatric institutions held on deeply to their biases of sanism which made true liberatory spaces impossible (325). This can be seen in the leadership of the largest "advocacy" organization in the U.S., the National Alliance on Mental Illness (NAMI). In the 2021- 2022 Board of Directors, only three of the seventeen directors note having a mental illness in their biographies and all three of these directors are men ("Meet the Board"). Additionally, no person within their Senior Leadership says they have a mental illness. There is however a member, David Levy, who previously "held various executive financial management positions" at organizations like Fox Television ("Senior Leadership"). Chamberlin critiques systems like this saying NAMI is "a group primarily composed of relatives of patients, which enthusiastically embraces the medical model and promotes the expansion of involuntary commitment and the lifetime control of people labeled "mentally ill"" (334). One example of this can be found in NAMI's support of Crisis Intervention Teams, whom they tout on their website as it "improves communication, identifies mental health resources for those in crisis and ensures officer and community safety" ("Crisis Intervention Team"). The fact that an organization "advocating" for the mentally ill would suggest police reform over abolition and note the importance of "officer safety" is a sure sign they are not truly listening to voices of all of the Mad.

This is where one begins to see the powerful intersection between Mad liberation and the frameworks of abolition and disability justice. Both abolition and disability justice hold the ideology that those facing the most extreme iteration of oppression should be the ones leading the liberation movement. Piepzna-Samarasinha explains that "[disability justice] insists that we organize from our sick, disabled, 'brokenbeautiful' bodies' wisdom, need, and desire" (22). These three movements hold the opportunity for relief from these intersectional systemic harms.

One must dream big when fighting against such violent structures. One can and should ask for more than a "quilted cage" (Garcia, Jordan, et al.). Abolition refers to the removal of systems of oppression in our society and the creation of better solutions. Many will skip over the second part of this framework and critique abolitionists because they don't have solutions perfectly worked out and that the solutions that are proposed are not simple. However, this dismisses the fact that abolition requires a community to rebuild. Abolition means everyone coming together to create these alternatives, not a single abolitionist solving the issue of policing on their own. When examining the detrimental role both state and federal governments have had on the treatment of those with mental illnesses, it becomes clear that the Mad can not rely on the government to create the drastic and imperative changes current mental health care in the U.S. needs. In the 59 years since the Community Health Care Act was passed, the reality for the Mad in this country has not improved at the rate or to the quality that was and is now necessary. This emphasizes the necessity of abolition of the carceral state and its nefarious branches to create the changes required for the Mad to survive.

Mad survival also requires the creation of new systems of care. Disability justice holds this as a key component. Disability justice means the dismantling of ableist and sanist structures of oppression rooted in carcerality both from the state level down to interpersonal relationships. Disability justice notes that for this dismantling to occur it requires the elimination of the stigma and innate fear and judgment of the disabled and mentally ill. This is difficult work, especially for those with a mental illness themselves, it becomes second nature to fear the parts of one's illness that push past the supposed norms of society. This is where one must again turn to the frameworks of disability justice. Piepzna-Samarasinha reminds one: "[w]e say no to the medical-industrial complex's model of 'cure or be useless,' instead working from a place of belief in the wholeness of disability, interdependence, and disabled people as inherently good as we are" (102). And the mentally ill themselves along with society must learn to appreciate the innate knowledge from their experiences. Audre Lorde told us this, "it is necessary to teach by living and speaking those truths which we believe and know beyond understanding. Because in this way alone we can survive, by taking part in a process of life that is creative and continuing, that is growth" (13).

Additionally, disability justice and abolition note that there should continue to be a creation of community-based systems of care that have those most impacted by ableism and sanism at the center like those formed in early Mad organizing. These systems allow for the creation of knowledge from the standpoint of the most oppressed. This creation and new appreciation of the knowledge of lived experiences opens the doorway for the creation of more spaces for healing from the traditional violences faced by those who have a mental illness. This communal knowledge will also allow for the formation of resources that do not rely on traditional forms of social justice organizing like nonprofits. As Piepzna-Samarasinha spells out, "[d]isability justice, when it's really happening, is too messy and wild to really fit into traditional movement and nonprofit industrial complex structures, because our bodies and minds are too wild to fit into those structures" (124). These community creations could also be framed in terms of mutual aid which not only, "work to meet survival needs and build shared knowledge about why people do not have what they need," but also "mobilize people, expand solidarity, and build movements… [and] solve problems through collective action rather than waiting for saviors" (Spade 9, 16). Ultimately the key to attaining liberation for those with a mental illness will come from not just opening the locked doors keeping them in a psychiatric hospital or the jail cell, or keeping the police from interacting with them, but rather through a manifestation of communal care and support systems being in a place that allows them to see the beauty of their minds regardless of the pathologizing and dehumanizing that has been done to it. Lorde speaks to the importance of community saying, "[w]ithout community, there is no liberation, only the most vulnerable and temporary armistice between an individual and her oppression" (Moraga 95).

Conclusion

In this thesis, I have argued that carcerality is inextricably linked to ableism and sanism. Through the examination of these theories with other systems of oppression like capitalism, colonialism, white supremacy, and cis-heteropatriarchy I showed how these oppressive systems work together to enhance one another. I have also illustrated the historical impact that the deinstitutionalization movement had in continuing to serve carceral institutions for the Mad. This was followed by an analysis of the failings of the current structures that are in place for the Mad like the police being called when someone is in crisis, incarceration in psychiatric hospitals, the problems stemming from the incompetent to stand trial system, and the violence perpetrated by the police upon the Mad. Finally, I explained the crucial role that the Mad liberation movement has had on the systems of oppression that have been in place for over a century and the necessity of listening to the voices of the Mad to solve these issues. As well as explaining the necessity of using the frameworks of abolition and disability justice in order to dismantle current systems of oppression and create new safer and healthier systems of care for the Mad. Throughout the thesis, I have shown the importance and necessity of Mad liberation.

These concepts for liberation are crucial and viable more than ever now. The violences against the mentally ill have been present for centuries, but the recent years since 2020 have shed light on more of the systemic failings of our society. Conversations of disproportionate experiences of police brutality and murder facing Black communities have returned to a brighter spotlight and abolition has finally become a more widely understood theory and is no longer reserved to the most radical settings. We can begin to bring the intersection of disability and mental illness into these conversations when examining their experiential similarities. Additionally in 2020, with the advent of the COVID-19 pandemic, we have seen broader conversations around access and quality of public health care. We have also seen the disabled community standing up loudly about their disproportionate struggles within medical systems. A study out of the UK found that six out of ten of the lives lost to the virus were disabled (UK Statistics Authority 4). And the U.S. federal government has been normalizing the death of the disabled from COVID. On the 8th of January 2022, Doctor Walensky, the director of the U.S. CDC said, “The overwhelming number of deaths, over 75 percent, occurred in people who had at least four comorbidities…So really these are people who were unwell, to begin with, and yes, really encouraging news in the context of Omicron” (Spocchia). We also saw the triaging of care begin when hospitals were filling beyond capacity. Studies have shown that this left many people with disabilities at the bottom of the list for medical care like access to ventilators. Some of this was attributed to care providers internalized stigma while other instances can be tied to state emergency orders (University of Georgia). The case of Michael Hickson illustrated the situation facing those with disabilities combined with the racism of health care providers. Hickson was disabled and contracted COVID. Doctors decided to deny him access to life-saving treatment because they presumed he had a “low quality of life” because of his disability (Shapiro). Situations like Hickson’s and the systemic nature of these harms have led to disability activists calling the government’s handling of the pandemic modern-day eugenics. At the same time, we see the true carceral and ableist nature of our society shining as the government and a large proportion of the U.S. population refuse to take the smallest steps to prevent needless deaths. Refusal to wear masks and get a vaccine have been politicized as issues of personal liberty while completely disregarding people with disabilities' right to life. In both of these national conversations, we can see connections to the carcerality and ableist and sanist nature of our society, from an interpersonal to a governmental level. This is again where bringing theories of abolition and disability justice to life are crucial steps. These liberatory structures hold the power to help not only the Mad and the disabled but all of those who are being held under the oppression of the carceral state. And while we see the current situation as a crisis, it is important to remember that Grace Lee Boggs saw “every crisis is an opportunity” (brown 44)

Ultimately the fate of our collective liberation from these oppressive systems relies upon us keying into this opportunity to be liberated internally first. We must learn the true and deep impact of these systemic violences upon our psyches. Our communities hold the power to develop these awarenesses if given the opportunity and resources. But the first progression we must make is to dismantle the sanist oppression that has been deeply embedded into our bodyminds (Schalk 5). This is a process of healing that adrienne maree brown describes as happening, “when a place of trauma or pain is given full attention, really listened to. Healing is the resilience instinct of our bodies, a skill we unlearn as we are taught to pay for and rely on data and medicine outside of our own awareness to be well” (34). Through this healing, we can begin to reimagine new futures. As Gloria Anzaldúa tells us, "[n]othing happens in the 'real' world unless it first happens in the images in our heads" (109). If we are being held back by our fears of our own supposed limitations we will not be able to recognize our power to make deep change. These fears that prevent us from making a change are the exact ones our society has purposefully embedded in us for exactly that reason—if we don't see ourselves as capable of revolution it will not happen. The wisdom Boggs left us with speaks to this, "[t]ransform yourself to transform the world" (brown 53). A key aspect to having these self actualizations is the support of a community that will support us in our journey. This community must accept the differences of the mentally ill and learn to appreciate and love them. As Audre Lorde tells us: "[i]t is learning how to take our differences and make them strengths. For the master's tools will never dismantle the master's house. They may allow us temporarily to beat him at this own game, but they will never enable us to bring about genuine change." (Moraga 95).

Coda

The thesis thus far has examined sanism through an academic lens but in the process of writing this thesis. I have experienced immense changes to myself. I wanted to share that experience as I feel it is a critical aspect considering the theoretical approaches I choose. Perhaps some of it is "too" personal but I think in reality the deeply personal aspect is the most powerful aspect to movements of liberation.

I have had to black out parts of my experiences because of university rules that make those reading this on my committee mandatory reporters on issues of self-harm. I am unsure of what repercussions I would face if I were entirely open despite my ongoing treatment. I believe this university policy speaks to the desire from educational institutions to silence the voices of those who are struggling in a carceral, punishing manner. This only serves to show the university's connection to other violent institutions from which the Mad need to be liberated. It also shows that the university is not concerned with personal growth or working to ensure the Mad succeed; it is only invested in the transactional nature of learning from which they profit. This goes in direct contradiction to accepting and honoring the power of knowledge that comes with lived experiences. This knowledge is precious. Its disregard speaks to our society's unwillingness to address the harsh truths of existence in our violent world. But we must acknowledge what power we are missing out on by dismissing these uncomfortable truths. As Audre Lorde told us, "my silences had not protected me. Your silence will not protect you. But for every real word spoken, for every attempt I had ever made to speak to those truths for which I am still seeking, I had made contact… which gave me strength and enabled me to scrutinize the essentials of my living" (10). So regardless of the self-censorship, here is just a piece of my experience…

I have spent the majority of the last ten years in therapy. Ever since my mental illness arose with clarity. Only today, March 10, 2022, did I realize the depth to which our society's sanism has embedded itself in my mind and body. Today I truly faced the part of me that hates me, that wants me to hate myself deeply, that wants me to hurt, that wants me gone. This part is glad when I fail. It is glad when I [redacted] myself. It is glad when I give in to the eating disorder and [redacted] myself when I make myself [redacted]. Initially, and for the next few hours, I was terrified. I was terrified that this part had become an entity within my body and mind, my bodymind (Schalk 5). I was terrified of the idea that it might win one day. Then I talked with my mom. She reminded me that you have to know the power of your enemy to defeat it. Today, I have truly looked this enemy in the eye. I have heard its' true desires and goals. And I realize now that I have spent the last eleven years in a constant battle with it. So far, I have won every battle.

Recently, I have been doubting myself. Thinking that before this point my work towards normalizing mental illness was naive because I did not fully understand the scope of sanism, I had only called it a stigma. But today I recognize that those were battles that were not always easily fought. It did not matter that I did not fully understand sanism when I decided to be honest about where I had been upon returning after being hospitalized. It does not diminish the fact that that was a turning point in my life. It has not mattered every time I have openly discussed a therapy session or pulled out my pill bottles. Those were all steps in the progression towards today.

I have started writing this coda four times in the last four days. I have been writing reflections for the last five months. I have recorded the milestones of self-actualization. I have recorded the many different states of mind that have hurt. Those moments have had me questioning my ability to complete this thesis. I have questioned if what I write will fit the mold of other people's theses. But I don't think mine needs to do that. My bodymind is different. And through the last months, I have come to realize that that does not mean that it is bad, wrong, or inherently flawed. It has been society's voice embedded within my bodymind that has been telling me these lies day after day, month after month, year after year. Perhaps these differences in my bodymind have made others fearful, I cannot blame them as I have been afraid of my bodymind too. I know my self-hatred has scared the people who love me, again I cannot blame them because it has scared me too.

Because of this fear, I have spent years trying to gain control over my bodymind. Always attempting to stabilize the unstable moods. To stay stable like so many can do without a second thought. In truth, wishing away this difference in my bodymind. And I have always failed. Today I realized it has been this hateful part trying to gain this control. Because if I had control I would be like everyone else. Then I would be able to do things like everyone else. I had convinced myself that if I attained control over my mind's differences, then I could do what I wanted with my life. If I stayed crazy I could not accomplish anything. Every accomplishment I have had has always been tainted by the idea that I had only barely made it, I had only made it because people took pity on me—I had not really done it. The part of myself ruled by society had convinced me that the people I love only said kind things to me out of their compassion for someone so clearly flawed. I had just gotten lucky to have people in my life who took pity on me.

But now I see it has been this community of people who have gotten me to this point. It has been a coordinated effort between my mom bringing me food and always being there to talk; my dad talking with me for hours on these issues; my sister inspiring me to make the world better; my family believing in me; my friends sitting with me and supporting me while I was in pain; my therapists guiding me; and all my professors who have given me the space and time I needed, actively working outside of and in resistance to the confines of educational institutions. My community has helped me grow from my pain, they have saved my life—no institution has.

Only on September 11th, 2022—twenty-five years old—did I realize that my experience being hospitalized for suicidal ideations was not life-saving because of some medical treatment. It was life-saving because I found people who had bodyminds like mine for the first time.

Only on October 9th, 2022, did I realize that I had been forced to stay "functioning" in order to get to the place I was at now. I had spent the last eleven years of my life forcing my pain deeper into my bodymind so that I could "succeed" but really it was just to survive our world.

Only on November 29th, 2022, did I realize that if I was happy with where I was in life then I owed some of that placement to my bipolar. Perhaps I should be grateful, even love my bipolar for where she had gotten me. Only on that day did I realize that if I had an episode my life would not fall apart and I would not die.

In December and January, I was just trying to survive depression. I had no mental capacity for paradigm shifts. But December 29th was the last time I [redacted]. I am now 71 days free of that [redacted].

Only on February 10th, 2022, did I see that I was more than my mental illness I saw that there were parts of myself that were admirable and worthy of love.

Only on February 21st, 2022—nearing twenty-six years old—did I have my first episode that I didn't spend hating myself.

This honors thesis has been a life-changing experience. I have the urge to say it was the most progress I have ever made in my life in relation to my self-hatred. But I have to acknowledge that if I hadn't spent hours with other therapists processing PTSD, anxiety, and my bipolar, I would not have been able to get here. And I'm not being hyperbolic in saying I probably would not have survived long enough to get here. But these six months have been the most life-changing. They have been the most empowering. The most liberating. The most revolutionary.

"Hurt" by Johnny Cash, just came on shuffle. The first song I listened to on repeat during my first major depressive episode. I know every note, every chord, every word, every breath he takes between the words. For years I could not listen to this song without instantaneously crying. Tonight I am crying for an entirely different reason. Tonight I am crying because I can see more clearly why that fourteen-year-old me was in so much pain. Tonight I am crying because I am freer from that pain than ever before.

Bibliography

Aizer, Anna, and Joseph Doyle. “What Is the Long-Term Impact of Incarcerating Juveniles?” *VOX CEPR*, 16 July 2013, https://voxeu.org/article/what-long-term-impact-incarcerating-juveniles#:~:text=In%20regressions%20with%20minimal%20controls,students%20from%20the%20same%20neighbourhood.

Alexander, Michelle. *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. The New Press, 2020.

Angelou, Maya. *On the Pulse of Morning: The Inaugural Poem,* Random House, New York, NY, 1993.

Anzaldúa Gloria. “By Your True Faces We Will Know You.” *Borderlands = La Frontera*, Aunt Lute Books, San Francisco, CA, 1999, pp. 108–109.

Associated Press. “Hospital Psychiatric Wards Now Feel like Prisons, Some Say.” *Modern Healthcare*, 19 Nov. 2019, https://www.modernhealthcare.com/behavioral-health-hospitals/hospital-psychiatric-wards-now-feel-prisons-some-say.

Baughey-Gill, Sarah. “When Gay Was Not Okay with the APA: A Historical Overview of Homosexuality and Its Status as Mental Disorder.” *Occam's Razor*, vol. 1, no. 2, 2011, pp. 5–16.

Beemyn, Genny, and Laura Erickson-Schroth. “Transgender History in the United States.” *Trans Bodies, Trans Selves a Resource by and for Transgender Communities*, Oxford University Press, New York, NY, 2014.

Ben-Moshe, Liat. *Decarcerating Disability: Deinstitutionalization and Prison Abolition*. University of Minnesota Press, 2020.

Beschizza , Rob. “U.S. Policing Budgets Would Rank as the World's Third-Highest Military Expenditure.” Boing Boing, 20 Apr. 2021, https://stephensemler.substack.com/p/world-military-budgets-vs-us-expenditures?s=r.

Bishop, Tara F., et al. “Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care.” *JAMA Psychiatry*, vol. 71, no. 2, Feb. 2014, pp. 176–181., https://doi.org/10.1001/jamapsychiatry.2013.2862.

Bishop, Tara F., et al. “Population of US Practicing Psychiatrists Declined, 2003–13, Which May Help Explain Poor Access to Mental Health Care.” *Health Affairs*, vol. 35, no. 7, July 2016, pp. 1271–1277., https://doi.org/10.1377/hlthaff.2015.1643.

Braslow, Joel T., and Stephen R. Marder. “History of Psychopharmacology.” *Annual Review of Clinical Psychology*, vol. 15, no. 1, 20 Feb. 2019, pp. 25–50., https://doi.org/10.1146/annurev-clinpsy-050718-095514.

brown, adrienne maree. *Emergent Strategy: Shaping Change, Changing Worlds*. AK Press, 2017.

Burton, Neel. “When Homosexuality Stopped Being a Mental Disorder.” *Psychology Today*, Sussex Publishers, 18 Sept. 2015, https://www.psychologytoday.com/us/blog/hide-and-seek/201509/when-homosexuality-stopped-being-mental-disorder.

Campbell, Fiona Kumari. “Inciting Legal Fictions: 'Disability's' Date with Ontology and the Ableist Body of Law.” *Griffith Law Review*, vol. 10, no. 1, 2001, pp. 42–62.

Chamberlin, Judi. “The Ex-Patients' Movement: Where We've Been and Where We're Going.” *The Journal of Mind and Behavior SPECIAL ISSUE: Challenging the Therapeutic State: Critical Perspectives on Psychiatry and the Mental Health System*, vol. 11, no. 3/4, 1990, pp. 323–336.

Christidis, Peggy, et al. “An Unmet Need for Mental Health Services.” *Monitor on Psychology*, vol. 49, no. 4, Apr. 2018, p. 19.

Collins, Patricia Hill. *Intersectionality as Critical Social Theory*. Duke University Press, 2019.

“Competency of Mentally Ill - Rogers v. Okin, Etc. Case Summaries.” *Mental Illness Policy Org*, https://mentalillnesspolicy.org/legal/competency-rogers-okin.html.

“Crisis Intervention Team (CIT) Programs.” *NAMI*, https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs.

Cusack, Karen J., et al. “Trauma Within The Psychiatric Setting: A Preliminary Empirical Report.” *Administration and Policy in Mental Health*, vol. 30, no. 5, May 2003, pp. 453–460.

“Dangerousness Standard: O'Connor v. Donaldson Case Summary.” *Mental Illness Policy Org*, https://mentalillnesspolicy.org/legal/survive-safely-oconnor-donaldson.html.

Daniel, Roxanne. “Since You Asked: What Data Exists about Native American People in the Criminal Justice System?” *Prison Policy Initiative*, 22 Apr. 2020, https://www.prisonpolicy.org/blog/2020/04/22/native/.

Eisenmenger, Ashley. “Ableism 101 - What Is Ableism? What Does It Look like?” *Access Living*, 12 Dec. 2019, https://www.accessliving.org/newsroom/blog/ableism-101/.

Elias, Marilyn. “The School-to-Prison Pipeline.” *Learning for Justice*, Southern Poverty Law Center, 2013, https://www.learningforjustice.org/magazine/spring-2013/the-school-to-prison-pipeline.

“Employment of People with a Disability in 2018.” *U.S. Bureau of Labor Statistics*, 1 Mar. 2019, https://www.bls.gov/opub/ted/2019/employment-of-people-with-a-disability-in-2018.htm.

“Facts about LGBTQ Youth Suicide.” *The Trevor Project*, 15 Dec. 2021, https://www.thetrevorproject.org/resources/article/facts-about-lgbtq-youth-suicide/.

“Facts about Suicide.” Centers for Disease Control and Prevention, 24 Feb. 2022, https://www.cdc.gov/suicide/facts/index.html.

Flannery, Mary Ellen. “The School-to-Prison Pipeline: Time to Shut It Down.” *National Education Association*, 5 Jan. 2015, https://www.nea.org/advocating-for-change/new-from-nea/school-prison-pipeline-time-shut-it-down.

Fowers, Alyssa, and William Wan. “Depression and Anxiety Spiked among Black Americans after George Floyd's Death.” *The Washington Post*, 12 June 2020, https://www.washingtonpost.com/health/2020/06/12/mental-health-george-floyd-census/?arc404=true.

Frankham, Emma. “Mental Illness Affects Police Fatal Shootings.” *Contexts*, vol. 17, no. 2, 7 June 2018, pp. 70–72., https://doi.org/10.1177/1536504218776970.

Gotsch, Kara, and Vinay Basti. “Capitalizing on Mass Incarceration: U.S. Growth in Private Prisons.” *The Sentencing Project*, 2 Aug. 2018, https://www.sentencingproject.org/publications/capitalizing-on-mass-incarceration-u-s-growth-in-private-prisons/.

Grohol, John M. “A Day in the Life of a Mental Hospital Patient.” *Psych Central*, 7 Sept. 2011, https://psychcentral.com/blog/a-day-in-the-life-of-a-mental-hospital-patient#1.

Groopman, Jerome. “The Troubled History of Psychiatry.” *The New Yorker*, 20 May 2019, https://www.newyorker.com/magazine/2019/05/27/the-troubled-history-of-psychiatry.

Hamp, Auntré, et al. *2015 APA Survey of Psychology Health Service Providers*. American Psychological Association, Center for Workforce Studies. Sept 2016, https://www.apa.org/workforce/publications/15-health-service-providers/report.pdf

Heugel, Abby. “4 Things Nobody Tells You About Being Admitted to a Psych Ward.” *YourTango*, 1 June 2020, https://www.yourtango.com/2014244161/self-love-five-things-nobody-tells-you-about-being-in-a-psych-ward.

Human Rights Council. *Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment.* A/HRC/43/49, 2020.

“I Am a Voluntary Patient at a Psychiatric Hospital Who Wants to Leave.” *Disability Rights Ohio*, 2021, https://www.disabilityrightsohio.org/voluntary-patient-wants-to-leave-psych-hospital.

"Incarcerated Women and Girls." *The Sentencing Project*, 24 Nov. 2020, https://www.sentencingproject.org/publications/incarcerated-women-and-girls/.

Jones, Kenneth, et al. *Dismantling Racism.*

Karma, Roge. "We Train Police to Be Warriors - and Then Send Them out to Be Social Workers." *Vox*, 31 July 2020, https://www.vox.com/2020/7/31/21334190/what-police-do-defund-abolish-police-reform-training.

Kaufman-Mthimkhulu, Stefanie Lyn. "We Don't Need Cops to Become Social Workers: We Need Peer Support + Community Response Networks." *Medium*, 6 June 2020, https://medium.com/@stefkaufman/we-dont-need-cops-to-become-social-workers-we-need-peer-support-b8e6c4ffe87a.

Kelley, Ed, et al. "The National Healthcare Quality and Disparities Reports." *Medical Care*, vol. 43, no. 3, Mar. 2005, https://doi.org/10.1097/00005650-200503001-00002.

Kim, Sarah. "Marriage Penalty Prevents Marriage Equity for People with Disabilities." *World Institute on Disability*, https://wid.org/2021/09/22/marriage-penalty-prevents-marriage-equity-for-people-with-disabilities/#:~:text=The%20disability%20marriage%20penalty%20punishes,thousands%20of%20people%20with%20disabilities.

Kirzinger, Ashley, et al. "KFF Health Tracking Poll – February 2019: Prescription Drugs." *KFF*, Kaiser Family Foundation, 1 Mar. 2019, https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/.

Lage, Ayana. “What Is It Like in a Psychiatric Hospital? 7 Things No One Tells You about a Psych Hospitalization.” *Bustle*, 27 Oct. 2017, https://www.bustle.com/p/what-is-it-like-in-a-psychiatric-hospital-7-things-no-one-tells-you-about-a-psych-hospitalization-2934067.

Laurence, Bethany K. “How Much Can I Have in Assets and Still Be Eligible for Disability Benefits?” *Disability Secrets*, Nolo, https://www.disabilitysecrets.com/how-much-can-i-have-in-assets-and-get-disability.html.

“Lawsuit: Providing Restorative Treatment When Unable to Aid and Assist in Defense.” *Disability Rights Oregon*, 15 May 2002, https://www.droregon.org/litigation-resources/oregon-advocacy-center-v-mink.

LeFrancois, Brenda A., et al., editors. *Mad Matters: A Critical Reader in Canadian Mad Studies*. Canadian Scholars' Press Inc., 2013.

Livingston, James D. “Contact between Police and People with Mental Disorders: A Review of Rates.” *Psychiatric Services*, vol. 67, no. 8, 2016, pp. 850–857., https://doi.org/10.1176/appi.ps.201500312.

Loch, Alexandre Andrade. “Discharged from a Mental Health Admission Ward: Is It Safe to Go Home? A Review on the Negative Outcomes of Psychiatric Hospitalization.” *Psychology Research and Behavior Management*, vol. 7, 28 Apr. 2014, pp. 137–145., https://doi.org/10.2147/prbm.s35061.

Lorde, Audre. *The Selected Works of Audre Lorde*. Edited by Roxane Gay, W. W. Norton & Company, 2020.

Massachusetts. Supreme Judicial Court, Suffolk. “Rogers v. Commissioner of Department of Mental Health.” *Massachusetts reports: cases argued and determined in the Supreme Judicial Court of Massachusetts. Massachusetts. Supreme Judicial Court* vol. 390 (1983): 489-513.

Matthews, Dylan. “Stop Blaming Mental Illness for Mass Shootings.” *Vox*, 5 Aug. 2019, https://www.vox.com/policy-and-politics/2017/11/9/16618472/mental-illness-gun-homicide-mass-shootings.

Maxwell, James, et al. “Battling the Mental Health Crisis among the Underserved through State Medicaid Reforms: Health Affairs Forefront.” *Health Affairs*, 10 Feb. 2020, https://www.healthaffairs.org/do/10.1377/forefront.20200205.346125/full/#:~:text=Approximately%2029%20percent%20of%20persons,substance%20use%20disorder%2C%20or%20both.

McGinty, Beth. “Medicare's Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement.” *Commonwealth Fund*, 9 July 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities#:~:text=additional%20future%20research.-,Mental%20Illness%20in%20the%20Medicare%20Population,Medicare%20beneficiaries%20have%20mental%20illness.

“Meet the Board.” *NAMI*, https://www.nami.org/About-NAMI/Who-We-Are/Meet-the-Board.

Melendez, Pilar, et al. “'Very Anti-Social': Suspect in Boulder Supermarket Massacre Was Paranoid, Brother Says.” *The Daily Beast*, 23 Mar. 2021, https://www.thedailybeast.com/boulder-colorado-cops-identify-king-soopers-supermarket-massacre-suspect-as-ahmad-alissa?ref=scroll.

"Mental and Behavioral Health - American Indians/Alaska Natives." *Office of Minority Health*, U.S. Department of Health and Human Services, 19 May 2021, https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=39.

"Mental Health Myths and Facts." *Mental Health.gov*, 29 Aug. 2017, https://www.mentalhealth.gov/basics/mental-health-myths-facts.

"Mental Illness." *National Institute of Mental Health*, U.S. Department of Health and Human Services, https://www.nimh.nih.gov/health/statistics/mental-illness.

Mercier, Brett. Irvine, CA, pp. 1–33, *Muslim Mass Shooters Are Perceived as Less Mentally Ill and More Motivated by Religion.*

Metzl, Jonathan M., and Kenneth T. MacLeish. "Mental Illness, Mass Shootings, and the Politics of American Firearms." *American Journal of Public Health*, vol. 105, no. 2, Feb. 2015, pp. 240–249., https://doi.org/10.2105/ajph.2014.302242.

Mingus, Mia. "Changing the Framework: Disability Justice." *Leaving Evidence*, 12 Feb. 2011, https://leavingevidence.wordpress.com/2011/02/12/changing-the-framework-disability-justice/.

@mia.mingus. *Instagram,* 16 March 2020, https://www.instagram.com/p/B90ByJVA-Mk/. 11 February 2022.

Moraga Cherríe, et al. "The Master's Tools Will Never Dismantle The Master's House." *This Bridge Called My Back: Writings by Radical Women of Color*, 4th ed., State University of New York Press, Albany, NY, 2021, pp. 94–97.

National Council for Mental Wellbeing. *The Psychiatric Shortage: Causes and Solutions.* 1 Mar. 2018.

Nellis, Ashley. *The Color of Justice: Racial and Ethnic Disparity in State Prisons.* The Sentencing Project, 2021, https://www.sentencingproject.org/wp-content/uploads/2016/06/The-Color-of-Justice-Racial-and-Ethnic-Disparity-in-State-Prisons.pdf

North, Carol S. "The Classification of Hysteria and Related Disorders: Historical and Phenomenological Considerations." *Behavioral Sciences*, vol. 5, no. 4, 5 Dec. 2015, pp. 496–517., https://doi.org/10.3390/bs5040496.

Novotney, Amy. "Landmark Victory: Mental Health Parity Is Now Law." *American Psychological Association*, vol. 39, no. 10, 2008, p. 26.

O'Malley, Harris. "Men Really Need to Stop Calling Women Crazy." *The Washington Post*, 9 July 2014, https://www.washingtonpost.com/posteverything/wp/2014/07/09/men-really-need-to-stop-calling-women-crazy/.

O'Malley, Lisa. "Addressing the Lack of Black Mental Health Professionals." *INSIGHT Into Diversity*, 17 Nov. 2021, https://www.insightintodiversity.com/addressing-the-lack-of-black-mental-health-professionals/.

O'Neill, Ann, and Ana Cabrera. "A Look Inside the 'Broken' Mind of James Holmes." *CNN*, 10 June 2015, https://www.cnn.com/2015/06/05/us/james-holmes-theater-shooting-trial/index.html.

"Our Impact: By the Numbers." *Treatment Advocacy Center*, 2015, https://www.treatmentadvocacycenter.org/evidence-and-research/fast-facts.

Panetta, Grace. “Trump Said People with Mental Illness Should Be 'Involuntarily Confined' If Necessary to Prevent Mass Shootings, despite Research Showing a Lack of Connection between Mental Illness and Gun Violence.” *Business Insider*, 5 Aug. 2019, https://www.businessinsider.com/trump-says-mentally-ill-people-should-be-involuntarily-confined-2019-8.

Pauly, Megan. “How Police Officers Are (or Aren't) Trained in Mental Health.” *The Atlantic*, Atlantic Media Company, 11 Oct. 2013, https://www.theatlantic.com/health/archive/2013/10/how-police-officers-are-or-aren-t-trained-in-mental-health/280485/.

“People with Untreated Mental Illness 16 Times More Likely to Be Killed by Law Enforcement.” *Treatment Advocacy Center*, 2018, https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness/2976-people-with-untreated-mental-illness-16-times-more-likely-to-be-killed-by-law-enforcement-.

Piepzna-Samarasinha, Leah Lakshmi. *Care Work: Dreaming Disability Justice*. Arsenal Pulp Press, 2018.

Placzek, Jessica. “Did the Emptying of Mental Hospitals Contribute to Homelessness?” *KQED*, 8 Dec. 2016, https://www.kqed.org/news/11209729/did-the-emptying-of-mental-hospitals-contribute-to-homelessness-here.

Powell, Robyn. “For People with Disabilities, Earning Pennies per Hour Is Only Part of the Problem.” *Rewire News Group*, 17 May 2018, https://rewirenewsgroup.com/article/2018/05/17/people-disabilities-earning-pennies-per-hour-problem/.

"Private Prison Quotas Drive Mass Incarceration and Deter Reform, Study Finds." *Equal Justice Initiative*, 26 Aug. 2013, https://eji.org/news/private-prison-quotas-drive-mass-incarceration/.

"Profiting off of Prison Labor." *Business Review at Berkeley*, 6 July 2020, https://businessreview.berkeley.edu/tag/profiting-off/.

Rice University. "Suspended Students More Likely to Get Caught up in Juvenile Justice System, and Vice Versa." *Phys.org*, 27 Oct. 2021, https://phys.org/news/2021-10-students-caught-juvenile-justice-vice.html.

"Right to Treatment: Wyatt v. Stickney - Case Summary." *Mental Illness Policy Org*, https://mentalillnesspolicy.org/legal/wyatt-stickney-right-treatment.html.

Ritchie, Andrea J. *Invisible No More: Police Violence against Black Women and Women of Color*. Beacon Press, 2017.

Rosenwald, Michael S. "Most Mass Shooters Aren't Mentally Ill. so Why Push Better Treatment as the Answer?" *The Washington Post*, 18 May 2016, https://www.washingtonpost.com/local/most-mass-shooters-arent-mentally-ill-so-why-push-better-treatment-as-the-answer/2016/05/17/70034918-1308-11e6-8967-7ac733c56f12_story.html?utm_term=.9f68631e9894.

Ruffalo, Mark L. "The Five Most Influential Psychiatric Drugs of All Time." *Psychology Today*, Sussex Publishers, 15 Nov. 2019, https://www.psychologytoday.com/us/blog/freud-fluoxetine/201911/the-five-most-influential-psychiatric-drugs-all-time.

Sawyer, Wendy. “How Much Do Incarcerated People Earn in Each State?” *Prison Policy Initiative*, 10 Apr. 2017, https://www.prisonpolicy.org/blog/2017/04/10/wages/.

Schalk, Sami. *Bodyminds Reimagined: (Dis)Ability, Race, and Gender in Black Women's Speculative Fiction*. Duke University Press, 2018.

Schalk, Sami, and Jina B. Kim. “Integrating Race, Transforming Feminist Disability Studies.” *Signs: Journal of Women in Culture and Society*, vol. 46, no. 1, 2020, pp. 31–55., https://doi.org/10.1086/709213.

Schumaker, Erin. “Police Reformers Push for De-Escalation Training, but the Jury Is out on Its Effectiveness.” *ABC News*, 5 July 2020, https://abcnews.go.com/Health/police-reformers-push-de-escalation-training-jury-effectiveness/story?id=71262003.

“Senior Leadership.” *NAMI*, https://www.nami.org/About-NAMI/Who-We-Are/Meet-Our-Leadership/Senior-Leadership.

Shapiro, Joseph. “One Man's Covid-19 Death Raises the Worst Fears of Many People with Disabilities.” *NPR*, 31 July 2020, https://www.npr.org/2020/07/31/896882268/one-mans-covid-19-death-raises-the-worst-fears-of-many-people-with-disabilities.

Sheppard, Sarah. “The Correlation between Homelessness and Mental Health.” *Verywell Mind*, 16 Apr. 2021, https://www.verywellmind.com/homelessness-impacts-mental-health-4783106.

Shi, Abbigale. “Mind Your Business: Ableism Is Rooted in Capitalism.” *The Daily Free Press*, Boston University, 19 Nov. 2020, https://dailyfreepress.com/2020/11/19/mind-your-business-ableism-is-rooted-in-capitalism/.

“6 Out of 10 People Who Have Died from Covid-19 Are Disabled.” *The Health Foundation*, 11 Feb. 2021, https://www.health.org.uk/news-and-comment/news/6-out-of-10-people-who-have-died-from-covid-19-are-disabled.

Spade, Dean. *Mutual Aid: Building Solidarity during This Crisis (and the next)*. Verso, 2020.

Spocchia, Gino. “'My Disabled Life Is Worthy': CDC Prompts Backlash for Comments on Omicron Deaths.” *The Independent*, 11 Jan. 2022, https://www.independent.co.uk/news/world/americas/cdc-omicron-covid-disabilities-deaths-b1989524.html.

Substance Abuse and Mental Health Services Administration, *National Mental Health Services Survey (N-MHSS): 2018. Data on Mental Health Treatment Facilities*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.

“Suicide.” National Institute of Mental Health, U.S. Department of Health and Human Services, https://www.nimh.nih.gov/health/statistics/suicide.

“Supplemental Security Income (SSI) Overview.” Understanding Supplemental Security Income SSI Overview– 2022 Edition, Social Security Administration, 2022, https://www.ssa.gov/ssi/text-over-ussi.htm#:~:text=Unlike%20Social%20Security%20benefits%2C%20SSI,taxes%2C%20corporate%20and%20other%20taxes.

Tasca, Cecilia, et al. “Women and Hysteria in the History of Mental Health.” *Clinical Practice & Epidemiology in Mental Health*, vol. 8, no. 1, 19 Oct. 2012, pp. 110–119., https://doi.org/10.2174/1745017901208010110.

Thomas, Elizabeth. “Trump's Claims and What Experts Say about Mental Illness and Mass Shootings.” *ABC News*, 23 Aug. 2019, https://abcnews.go.com/Politics/trumps-claims-experts-mental-illness-mass-shootings/story?id=65101823.

Thomas, Pierre. “Investigators Believe Las Vegas Gunman Had Severe Undiagnosed Mental Illness: Sources.” *ABC News*, 7 Oct. 2017, https://abcnews.go.com/US/investigators-las-vegas-gunman-severe-undiagnosed-mental-illness/story?id=50346433.

Torrey, E. Fuller. *American Psychosis How the Federal Government Destroyed the Mental Illness Treatment System*. Oxford University Press, 2014.

Treisman, Rachel. “13-Year-Old Boy with Autism Disorder Shot by Salt Lake City Police.” *NPR*, 9 Sept. 2020, https://www.npr.org/2020/09/09/910975499/autistic-13-year-old-boy-shot-by-salt-lake-city-police.

Tullis, Paul. “When Mental Illness Becomes a Jail Sentence.” *The Atlantic*, 9 Dec. 2019, https://www.theatlantic.com/politics/archive/2019/12/when-mental-illness-becomes-jail-sentence/603154/.

United Kingdom Statistics Authority; Office for National Statistics. *Updated estimates of coronavirus (COVID-19) related deaths by disability status, England: 24 January to 20 November 2020.* 11 Feb. 2021, file:///Users/violetstoudt/Downloads/Updated%20estimates%20of%20coronavirus%20(COVID-19)%20related%20deaths%20by%20disability%20status,%20England%2024%20January%20to%2020%20November%202020.pdf

The United States. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services*, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

The United States. Department of Housing and Urban Development, Office of Community Planning and Development, et al. *The 2017 Annual Homeless Assessment Report to Congress*.

The United States. Department of Justice, Office of Public Affairs. *Justice Department Announces $139 Million for Law Enforcement Hiring to Advance Community Policing*. 18 Nov. 2021, https://www.justice.gov/opa/pr/justice-department-announces-139-million-law-enforcement-hiring-advance-community-policing

The United States. Office of the Surgeon General; Center for Mental Health Services; National Institute of Mental Health. *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General.* Substance Abuse and Mental Health Services Administration, August 2001.

The University of Georgia. “People with Disabilities Faced Pandemic Triage Biases.” *ScienceDaily*, 4 May 2021, https://www.sciencedaily.com/releases/2021/05/210504112633.htm.

VinZant, Nick. “Pandemic Fuels Rise in Mental Health Prescriptions.” *QuoteWizard*, Lendingtree, 6 Jan. 2022, https://quotewizard.com/news/posts/mental-health-prescriptions.

“Voluntary and Informal Admission to a Mental Health Facility.” *Illinois Legal Aid Online*, 2021, https://www.illinoislegalaid.org/legal-information/voluntary-and-informal-admission-mental-health-facility.

Wang, Philip S., et al. “Twelve-Month Use of Mental Health Services in the United States.” *Archives of General Psychiatry*, vol. 62, no. 6, June 2005, pp. 629–640., https://doi.org/10.1001/archpsyc.62.6.629.

Westervelt, Eric. “Mental Health and Police Violence: How Crisis Intervention Teams Are Failing.” *NPR*, 18 Sept. 2020, https://www.npr.org/2020/09/18/913229469/mental-health-and-police-violence-how-crisis-intervention-teams-are-failing.

West, Rachel. “Everyone Is Overlooking a Key Part of the New $15 Minimum Wage Bill.” *Talk Poverty*, 19 June 2019, https://talkpoverty.org/2019/06/27/states-trump-overtime-pay/.

Williams, Jennifer. “White American Men Are a Bigger Domestic Terrorist Threat than Muslim Foreigners.” *Vox*, 2 Oct. 2017, https://www.vox.com/world/2017/10/2/16396612/las-vegas-mass-shooting-terrorism-islam.

Willoughby, Christopher D. E. “Running Away from Drapetomania: Samuel A. Cartwright, Medicine, and Race in the Antebellum South.” *Journal of Southern History*, vol. 84, no. 3, 1 Aug. 2018, pp. 579–614., https://doi.org/10.1353/soh.2018.0164.

Yellow Bird, Pemina, “Wild Indians: Native Perspectives on the Hiawatha Asylum for Insane Indians,” *National Empowerment Center,* https://power2u.org/wp-content/uploads/2017/01/NativePerspectivesPeminaYellowBird.pdf

Yohanna, Daniel. “Deinstitutionalization of People with Mental Illness: Causes and Consequences.” *AMA Journal of Ethics,* American Medical Association, Oct. 2013, https://journalofethics.ama-assn.org/article/deinstitutionalization-people-mental-illness-causes-and-consequences/2013-10.