**“The institution yet to come”: analyzing incarceration through a disability lens**

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Grandmother lost her mother in the early 1900's to what was considered progressive policy. To protect society from the insane, feebleminded and physically defective, states invested enormous public capital in institutions, often scattered in remote areas. Into this state-created disability gulag people disappeared, one by one. Today, more than 1.7 million mothers and fathers, daughters and sons, are lost in America's disability gulag. Today's gulag characterizes isolation and control as care and protection, and the disappearances are often called voluntary placements. However, you don't vanish because that's what you want or need. You vanish because that's what the state offers. You make your choice from an array of one.

--Harriet McBryde Johnson, 2003

Institutional life, whether in a prison, hospital, mental institution, nursing home, group home, or segregated “school,” has been the reality, not the exception, for disabled people throughout North American history (and globally). In this paper I suggest analyzing the reality of incarceration through the critical prism of disability, by showcasing the connections between institutions and prisons and the populations that inhabit them, including disabled prisoners and those institutionalized. I will also highlight the strategy of resisting incarceration by calling for the abolition of repressive carceral spaces such as institutions for those with labels of psychiatric and intellectual/developmental/cognitive disabilities, as well as prisons.

McBryde Johnson (2003) describes in the opening paragraph her experiences and fear of the “disability gulag,” the warehouse for disabled people that is often called “the institution.” As she describes in her narrative, many people with significant disabilities fear that one day they will be sent there and lose their independence, if they are not living there already. In *Crip Theory*, Robert McRuer (2006) discusses what he calls “the disability yet to come,” describing both the fear that non-disabled people have of becoming disabled and the notion that if anyone lives long enough, they will eventually become disabled in some way. Intersecting McBride Johnson with McRuer, we can conceptualize “the institution yet to come” as a looming presence in the lives of all people with disabilities, even those who don’t reside in them (for the time being). The ghost of forced confinement haunts us all, but does so much more materially and immediately for marginalized populations, especially poor people, people of color, disabled people and any amalgamation of these groups (Chapman, Ben-Moshe and Carey, forthcoming).

This call for connecting analysis of incarceration with disability, is also a call to pay attention to the lives of mostly poor people of color who are incarcerated worldwide in nursing homes, institutions for those with labels of mental illness and/or intellectual/developmental disabilities and prisons, and bring their perspective to bear on what Chris Bell (2006) characterized as “white Disability Studies.” I want to add that the field of Disability Studies had historically not only privileged the experiences of white bodies, but in fact focused on bodies in general, at times to its detriment. Feminist and critical analysis of disability brought to the forefront a new conceptualization of disability, not just as a socially excluded category, but as an embodied identity (Thomson, 1997; Wendell, 1996). This focus on embodiment challenges the medical model of disability which conceives of disability as a lack and deficiency inherent in non normative bodies. It also challenges the social model of disability which encourages us to focus solely on processes of disablement as a critical framework that will end the oppression of people with disabilities (Morris, 2001; Tremain, 2002).

Not discounting such achievements, the (often unintended) consequence of such an enterprise is the effect of overrepresentation of the body and visible disabilities in the field of Disability Studies. Such focus obscures the myriad disabilities and impairments that could and should be analyzed under the purview of Disability Studies. I am not trying to suggest that the experiences and analysis of various impairments and forms of oppression should be conflated into one meta-field, called Disability Studies or anything else. I am also not suggesting that being psychiatrized, or being labeled intellectually disabled or having a physical or sensory disability are all the same. As expanded elsewhere (Ben-Moshe, 2012), what I am trying to push for is the understanding that the logic of compulsory ablebodiedness (McRuer, 2002), handicapism (Bogdan & Biklen, 1977), ableism, normalcy (Davis, 1995) and disablement (Oliver, 1990), are not just similar but related to forces of sanism or mentalism (Chamberlin, 1977; Perlin, 2000). I thus argue that Disability Studies could benefit immensely by actively taking up the theorizations and lived experiences in the field of Developmental Disability and Mad Studies. What such expansive formulations achieve is an understanding of incarceration in its broadest way in relation to hospitalization, institutionalization and imprisonment and a fuller understanding of the forces that construct medicalization and criminalization. This analysis is especially pressing because of the immense spread of the forces of incarceration in the US.

**Some background on imprisonment and (de)institutionalization**

For the first time in US history, in 2008, more than one in 100 American adults is behind bars. In 2009, the adult incarcerated population in prisons and jails in the US had reached 2,284,900 (BJS, 2010). Another whopping 5,018,900 people are under “community corrections,” which include parole and probation (BJS, 2010). Race, gender and disability play a significant role in incarceration rates. By 2006, one in fifteen black men over the age of eighteen and one in nine black men age twenty to thirty-four were incarcerated. The overall incarceration rate for women increased 832 percent from 1997 to 2007 (Human Rights Index, 2009-2010). The imprisonment rate for African-American women was almost double that of Hispanic women and three times the rate of white women. If these seem like mere numbers, consider the reality that today more African-Americans find themselves in penal institutions than in institutions of higher learning (Thompson, 2010).

Although several attempts have been made to estimate the number of prisoners who have psychiatric diagnosis, it is impossible to quantify their number with any degree of precision, even if taking the label of “mental illness” as a viable construct. The American Psychiatric Association reports in 2000 that up to 5 percent of prisoners are actively psychotic and that as many as one in five prisoners were “seriously mentally ill” (APA, 2000). Other attempts to estimate the prevalence appear to have used a substantially more expansive definition of mental illness. Bureau of Justice Statistics reports that in 2005 more than half of all prison and jail inmates were reported as having a mental health problem. The reported prevalence of “mental health problems” of those imprisoned seems to also vary by race and gender. White inmates appear to have higher rates of reported “mental health problems” than African-Americans or Hispanics (Erickson & Erickson, 2008). However, African-Americans, especially men, seem to be labeled “seriously mentally ill” more often than their white counterparts[[1]](#footnote-1). It is also reported that, in general, women inmates had higher rates of “mental health problems” than men (Human Rights Watch, 2006).

Analyzing imprisonment from a disability studies lens also necessitates a closer look at the social and economic conditions of disablement and incarceration rather than looking at disability (psychiatric or otherwise) as a cause for criminal acts. Prisoners are not randomly selected and do not represent all strata of society. The majority of prisoners are poor, and are people of color. Poverty is known to cause a variety of impairments and disabling conditions. In addition, the prison environment itself is disabling- from hard labor in toxic conditions and materials; to closed wards with poor air quality; circulation of drugs and unsanitary needles; and lack of medical equipment and medication (Russell & Stewart, 2001). It is also crucial to take an expansive view of what constitutes as “disability” in such environments. For instance, the high prevalence of HIV/AIDS amongst prisoners and the various impairments that come with aging in a disabling environment such as a prison as a result of prolonged sentencing policies, should be of concern to Disability Studies scholars and those studying the effects of incarceration. Disability in this framework is not a natural biological entity, but related to economic and social conditions which lead to an increased chance of both disablement and imprisonment.

In addition, conditions of confinement may cause further mental deterioration in prisoners entering the system with diagnoses of “mental retardation” or intellectual disabilities. Most court cases show that the right to (re)habilitation is often not fulfilled in jails, prisons and institutions (Ben-Moshe 2011), and that this further distresses those incarcerated and worsens their mental and physical health overall. Those incarcerated (in institutions or prisons) with labels of intellectual and developmental disabilities may in fact lose crucial life skills that they had before they were imprisoned such as “the ability to communicate, perform daily self-care, remain physically safe, and to maintain even rudimentary emotional stability” (American Association of Mental Retardation et al. amicus brief in Goodman v. Georgia, 2005). Prisoners who are identified as mentally ill or exhibit “disruptive behaviors” are often sanctioned to “administrative segregation” in separate units, which are often isolation units. These segregated forms of incarceration, such as supermax or SHU (security housing units), are likely to cause or exacerbate mental and physical ill-health of those incarcerated, regardless of their mental state prior to incarceration.

In contrast to the constant expansion of prisons, deinstitutionalization and closure of large state institutions for people with labels of mental health and (what was then known as) “mental retardation” have been a major policy trend in most US states in the past few decades. Deinstitutionalization of people who were labeled as mentally ill began in 1950s onwards. The deinstitutionalization of people labeled as intellectually and developmentally disabled gained prominence in the 1970s, although this of course varied by state. The population of people with intellectual disabilities living in large public institutions (serving over 16 people) peaked at 194,650 in 1967. In 2009, the number had declined to 33,732 (Braddock et al., 2011). The shift from large facilities to community residential services can be viewed from the fact that in 1977, an estimated 83.7 percent of people with developmental disability labels who were receiving residential services lived in residences of 16 or more people. By 2009, an estimated 86.4 percent lived in community settings of 15 or fewer people, and 73.1 percent lived in residential settings with 6 or fewer people (Lakin et al., 2010). The trend in deinstitutionalization of people with intellectual disabilities resulted in closures of large state institutions across most of the US. By 2010, 11 states had closed all of their state-operated institutions for people with intellectual/ developmental disabilities (Braddock et al., 2011). In contrast, seven states had not closed any such public institutions (Lakin et al., 2010).

An accompanying shift occurred in the field of mental health with the establishment of community mental health centers in the 1960s and the closure of large state mental hospitals in most major cities. In 1955, the state mental health population was 559,000, nearly as large on a per capita basis as the prison population today. By 2000, it had fallen to below 100,000 (Gottschalk, 2010; Harcourt, 2011). In the public’s eye, the first half of the twentieth century is conceived as an era of relative stability in terms of incarceration, with a later explosion in the form of the growth of prisons and jails, a phenomenon which is referred to as “mass incarceration” (Gottschalk, 2010) or “hyper Incarceration” (Wacquant, 2010). However, as Harcourt (2006) suggests, if mental hospitalization and institutionalization were also covered in such analyses, the “rise in incarceration” would have reached its peak in 1955, when mental hospitals reached their highest capacity. Put differently, the incarceration rates in prisons and jails barely scrape the levels of incarceration during the early part of the twentieth century (controlling for population growth).

What needs to be empirically assessed, then, is not “the rise in incarceration” but the systemic and lingering effects of the continuity of confinement in modern times. What such arguments highlight is the need to reconceptualize institutionalization and imprisonment as not merely analogues but as in fact interconnected, in their logic, historical enactment and social effects. The theoretical and policy implications of such interconnectedness will also necessitate bringing in disability (psychiatric, developmental, physical etc.) as a focus in studies on incarceration, as well as working out questions of criminality and danger in studies of institutionalization and disablement.

**Connections between prison and institutions**

First, we need to examine some of the ways in which prisons and institutions for those with intellectual and psychiatric disabilities are connected and interrelated. As Goffman described in *Asylums* (1961), the incarcerated populations in institutions and prisons are subjected to stripping of their identities and to processes of dehumanization. Also, especially for people with intellectual and psychiatric disabilities, their citizenship and personhood is questioned. This can be done in the form of taking away or denying voting rights, performing medical experimentation and, for women, denying reproductive rights, including forced sterilization (Waldman and Levi, 2011).

On a theoretical level, the imperative to understand incarceration through both the prism of the prison but also that of the institution, as this paper suggests, is crucial to unveiling the underlying relations that legitimate confinement in a variety of settings. Such analysis also underscores the relation between penal and medical notions of danger, as they relate to both criminalization and medicalization. Historically, the connection between imprisonment and definitions of ‘abnormality’ seems to have arisen out of the modernity project, as a result of a new configuration of notions of danger. From the 19th century the webs of the medical and the judicial start to intertwine with the rise of a hybrid discourse, according to Foucault (2003). Its hybridity lies not just in the sense of amalgamation of several discourses (legal, medical) but also in the creation of a new power/knowledge structure in which “doctors laying claim to judicial power and judges laying claim to medical power” (Foucault, 2003, p. 39) lay down an intertwined system of surveillance, which includes psychiatric progress reports of the incarcerated, examination in court of the accused, and surveillance of ‘at risk’ groups. According to Foucault (2003), this medico-judicial discourse does not originate from medicine or law or in between, but from another external discourse- that of abnormality. The power of normalization is cloaked by medical notions of illness and legal notions of recidivism. The history of treatment and categorization of those labeled as feebleminded, and later “mentally retarded,” is also paved on cobblestones of notions of social danger, as prominent eugenicists tried to ‘scientifically’ establish that those whom they characterized as feebleminded had a tendency to commit violent crimes. In the late nineteenth century, as the eugenics movement gained momentum, it was declared that all feebleminded people were potential criminals (Rafter, 1997; Trent, 1995).

Another pervasive connection between institutionalization and imprisonment, both historically and at present, is offered through the framework of political economy. Many, including scholars and policy makers, believe that disabled people are a strain on the economy, especially under neoliberal ideology. But political economists of disability argue that disability supports a whole industry of professionals that keeps the economy afloat, such as service providers, case managers, medical professionals, health care specialists etc. (Charlton, 1998; Oliver, 1990). Elsewhere (Ben-Moshe, 2012) I suggest that the forces of incarceration of disabled people should be understood under the growth of both the prison industry and the institution-industrial-complex, in the form of a growing private industry of nursing homes, boarding homes, for-profit psychiatric hospitals and group homes. As an example, figures show that there is no correlation between the increase of the non-governmental institutional-industrial-complex and percentage of those “needing” these services. Between 1977 and 2009, the total number of residential settings in which people with developmental disability labels received residential services grew from 11,008 to an estimated 173,042 (a growth of 1,500 percent), while total service recipients increased from about 247,780 to an estimated 439,515 individuals (an increase of only 77.4 percent) (Lakin et. al., 2010).

In a similar vein, for those drawing on the conceptualization of the prison-industrial-complex, the increase in the number of prisons and cells is not seen as related to similar increases in crime, but as driven by capitalist and racist impetuses (Christie, 2000; Goldberg & Evans, 1997; Gilmore, 2006). According to Parenti (1999), the criminal (in)justice system generally and the privatization of prisons specifically exist to “manage and contain the new surplus populations created by neo-liberal economic policies,” and the global flow of capital. Under this new configuration, men of color in particular have turned into commodities in high demand for the growing prison industry. The prison comprises a solution to one of the deepest inherent contradictions of capitalism itself: how to maintain a proletariat class (in this case mostly poor people of color), while controlling them from rising up against their conditions of being. The prison solves this dilemma almost seamlessly. Some perceive the carceral system as a failing system, in that is actually creates criminality rather than reduces it. The prison thus becomes a hub and training school for criminal behavior (Morris, 1995). Foucault (1995) aids us in the realization that the prison has not failed, but indeed, has succeeded. Its success lies in the making of docile bodies and an underclass to imprison. This political economic analysis of imprisonment and institutionalization should therefore be of great interest to critical scholars and activists who are interested in understanding the phenomenon of “mass incarceration” from an intersectional lens.

**From analogies to intersections**

While such comparisons help crystallize the coalition building potential between those placed in institutions and in prisons, they also obscure the important ways in which one identity or form of oppression is used to discredit the other. In an essay in *Justice Matters*, Bird (2006) posits the important connections she finds between the two populations but cautions:

In 1995 I began sharing my story publicly of how being paralyzed in a drunk driving crash has changed my life. I’ll never forget the first time that someone said to me “…but you got a life sentence sitting in that wheelchair and all he got was a year in a restitution center!?” (Bird, 2006).

Such comparisons seem to create an equation of disability itself with punishment, which is not a new phenomenon. One of the earliest sources of stigmatization of disability can be found in religious or magical thinking that assumed that disability is a result of punishment from the gods or a result of witchcraft. In addition, if one listens to the narratives of disabled people who were segregated in institutions, another obvious connection emerges in which many describe their time there as a form of incarceration. Self advocates (activists with labels of intellectual and developmental disabilities) compare institutions to living in prisons, and characterize their existence their as incarceration or being jailed while committing no apparent crime (Hayden, 1997; Hayden, Lakin, & Taylor, 1995/6). Such statements, combined with McBride Johnson’s epigraph and Bird’s narrative above, help crystallize the vital connections between prisoners and people with disabilities, but may also pit one group against the other and ignore the both the differences and intersections between the two populations.

I argue that today one cannot analyze the forces of incarceration without having a disability lens. For instance, a disproportionate number of persons incarcerated in US prisons and jails are disabled. As suggested above, prisoners with disabilities are a population that is hard to count (and account for) but is definitely at the intersection of the disability and imprisonment juggernaut. There is much at stake in counting the percentage of disabled prisoners. In terms of policy and legislation, if one can prove sufficiently that there is a large percentage of prisoners with a specific disability, then it would require a specific solution such as requesting more hospital units to be built in specific prisons or prescribing more medications on a particular unit. For activists, using statistics that demonstrate the high prevalence of disabled prisoners could go in several directions. If one is an activist in NAMI (National Alliance of Mental Illness), for instance, then these statistics are used to show that deinstitutionalization failed and that prisons and jails had become a dumping ground for those labeled as mentally ill with the lack of other alternatives. Such campaigns, which have been ongoing since the early 1990s, call in essence for the (re)hospitalization of those with psychiatric diagnosis (see Torrey, 1996, for example). However, such critiques from activists and scholars about inappropriately placing disabled people in nursing homes (as some ADAPT activists protest) or prisons (as some NAMI activists protest) reproduce the sentiment that there are those who are somehow *appropriately* placed in nursing homes and prisons. In other words, it reinscribes the notion that there are those who really need to be segregated in carceral edifices, while those who are young and disabled do not.

However, others might use these statistics to showcase the cruelty of the criminal “justice” system and call for the just treatment of all those who are incarcerated. The downturn of such arguments, much like those in the calls to abolish the death penalty for those who are labeled as intellectually disabled, is that they can turn into arguments which reproduce ableist rhetoric and may seem to call for the release of some prisoners (i.e. those most disabled) but not others. A similar tactic is used by those who find the living conditions of disabled prisoners and those institutionalized so deplorable that they call for the creation of more hospital beds in prisons, the reform and overhaul of psychiatric hospitals and institutions for those labeled as intellectually disabled and the creation of more accessible prisons. Others call not for reforming these edifices, but for abolishing them altogether.

**Abolition as a form of resistance to incarceration**

In addition to the connections between the forces of incarceration and decarceration in prisons and institutions, I would like to end with an analysis of the connections between the movements that resist these forces. Instead of incarcerating people and segregating them, strands in movements such as anti-psychiatry, deinstitutionalization and prison abolition, propose radical new ways of treatment, care and governance that do not require the segregation of people from their peers. Deinstitutionalization could be characterized not only as a process or an exodus of oppressed people outside the walls of institutions and into community living, but as a radical anti-segregationist philosophy (Ben-Moshe, 2011). The resistance to institutionalization and psychiatric hospitals arose from a broader social critique of medicalization and medical authority (Conrad & Schneider, 1992; Zola, 1991) and a new understanding of human value, especially in regards to people with disabilities, as seen in the principles of normalization (Wolfensberger, 1972), the anti-psychiatry and ex-patients movement (Chamberlin, 1977; Szasz, 1961) and the People First movement (Williams & Shoultz, 1982). Although these ideological shifts did not solely bring about deinstitutionalization and the closure of psychiatric hospitals and large state institutions nationwide, I believe that any significant decrease in institutionalized populations would have been impossible without them.

There are many ways in which one can fight for social justice or social change. In the struggle to eliminate institutional settings for those labeled as developmentally or psychiatrically disabled, and replacing them with community living and community-based services, there were myriad possibilities through which the struggle could have taken place. But what is illuminating in these cases is that some took the view that the route for successful social change was to abolish these institutions and close them down, while others advocated for improving or reforming them. This tension between reform and abolition is a key characteristic of the prison abolitionist stance as well, and there is no agreement as to how to resolve it, as the movement is diverse and ranges from calls for focusing on the present circumstances of prisoners and advocating for gradual release; to those who contend that any type of reform would lead to the growth of the prison-industrial-complex and should be avoided by activists. Some (such as Knopp et al., 1976) suggest conceptualizing the long term goal of prison abolition as a chain for shorter campaigns around specific issues- like jail diversion, restitution programs, or the move of those released to community placements. Such strategic use of abolition and reform can also be applied to the context of abolishing psychiatric confinement and forced medical treatments, as suggested by anti-psychiatry activist Bonnie Burstow. In her keynote speech in the 2009 PsychOut conference, Burstow suggests that the short term goals of anti-psychiatry activists, such as reform efforts, should be kept as concrete and direct partial abolitions (or reforms) on the road to long term change of abolishing psychiatry.

This contention between abolition and reform is not only a scholarly debate but one with pragmatic implications. For instance, Angela Y. Davis (2003), as a practicing abolitionist, suggests to question what kinds of reforms are sought and whether they will strengthen the system in the long run. For instance, fighting for health care for prisoners is something activists should support, as integral to abolitionist and decarcerating strategies. However, some health care initiatives are opposed by abolitionists, such as attempts to open prison hospitals or clinical wards in existing prisons, as these would only expand the scope of incarceration in the long haul. Many prison abolition and anti-psychiatry activists are insistent that the trend to develop mental health services within the prison only serves to criminalize those with psychiatric and cognitive disabilities further, as quality health services of this nature are sparse outside the walls of the prison, while funds go to operate them within an already oppressive system.

I suggest that abolition can become a useful strategy for resistance to all forms of incarceration, as it does not acknowledge the structure as it is but envisions and creates a new worldview in which oppressive structures do not exist. It thus goes beyond protesting the current circumstances, to creating new conditions of possibility by collectively contesting the status quo. Thomas Mathiesen conceptualizes abolition as an alternative in the making: “The alternative lies in the ‘unfinished’, in the sketch, in what is not yet fully existing” (Mathiesen, 1974, p. 1). According to Mathiesen, abolition takes place when one breaks with the established order and simultaneously breaks new ground. Abolition is triggered by making people aware of the necessary dilemma they are faced with- continuing with the existing order with some changes (i.e. reform) or transitioning to something unknown. The question becomes not "what is the best alternative" in its final formulation, but how this new order shall begin from the old.

The most powerful relevance of the prison abolitionist and anti-institutional stance is to analyze imprisonment and institutional segregation as a core structure that shapes social relations in society, not just for those affected directly but for everyone. It is not merely about closure of prisons or institutions, but it is a revolutionary framework, which transforms the way we analyze and understand forces that shape our histories and everyday lives: notions like “crime” or “innocence” (what gets to be defined as crime, and who gets to be defined as criminal); “disability” (as an identity not just a medical diagnosis) and rehabilitation (a benign process or a force of assimilation and normalization); ideas of punishment (justice vs. revenge or retribution); notions of community (as in “living in the community” or “community re-entry”); or “institution” (who defines what gets to be called an institution); notions of freedom and equality (can we feel free and safe without locking others away?) and on the other hand concepts of danger and protection (who do we protect by segregating people behind bars in psychiatric hospitals and prisons? Is it for “their own good?”).

As Angela Y. Davis (2003) suggests, there is no one single alternative to imprisonment, but a vision of a more just society- revamping of the education system, comprehensive health care for all, demilitarization, and a justice system based on reparation and reconciliation. One of the main problems with prisons and institutions is that they become a catch all for “problematic populations” that are deemed socially undesirable or dangerous. The alternative to incarceration therefore cannot be a catch all solution, but an individual one, in relation to the harm done and the community in which one is involved. Prison abolition and deinstitutionalization, therefore, is not about helping prisoners, people with disabilities, or disabled prisoners, but is about societal change that will improve the lives of all, inside and outside prisons and institutions.

According to liberal discourses that call for social change, change entails incorporating excluded groups into current structures- such as education systems, the government, corporations and politics. But these frameworks only change the hierarchy of the structures in which marginalized populations are placed, and not the structures themselves. Under a more abolitionary mindset it is clear that forms of oppression are not always characterized by exclusion, but by pervasive inclusion that sometimes does more damage. The goal of a non-carceral society is not to replace one form of control, such as a hospital, institution and prison, with another, such as psychopharmaceuticals, nursing homes and group homes in the community. The aspiration is to fundamentally change the way we react to each other, the way we respond to difference or harm, the way normalcy is defined and the ways resources are distributed and accessed. It is no wonder then that the abolitionary approach to institutionalization and imprisonment, as an epistemic change that breaks down the segregationist model altogether, did not occur overall, even when closures of hospitals and institutions did. Or at least have not occurred yet…

**Conclusion**

This article suggests the pressing need to expand notions of what comes to be classified as “incarceration,” as including institutionalization in a wide variety of enclosed settings, including prisons, jails, detention centers, institutions for the intellectually disabled, and psychiatric hospitals. Such formulations conceptualize incarceration as a continuum and a multi-faceted phenomenon, not one that occurs in one locale or in one historical period, in contrast to current interpretations of “the rise in incarceration” or the success (or failure) of deinstitutionalization. Closure of large institutions has not led to freedom for disabled people, nor has it resulted in the radical acceptance of the fact of difference amongst us, but it is an important strategy in the struggle against incarceration. My main argument in this chapter is that the (his)story of disability is the (his)story of incarceration and there is a need to connect them in terms of their history, as medico-judicial hybrids; their present, in the disproportionate number of disabled prisoners and those still institutionalized; and the future, in terms of movements that seek to abolish the segregationist model that underpins systems of incarceration. It is only through such coalitions that we can truly analyze, and perhaps circumvent, “the institution yet to come.”

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1. Jonathan Metzl's (2010) *The Protest Psychosis: How schizophrenia became a black disease* (Beacon Press) provides a possible explanation of this phenomenon [↑](#footnote-ref-1)