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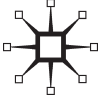
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Interlocking Histories and Legacies of Confinement

Reconsidering Confinement: Interlocking Locations and Logics of Incarceration

Chris Chapman, Allison C. Carey, and Liat Ben-Moshe

Through this collection, we hope to engage in and inspire dialogue across people interested in imprisonment, institutionalization, and other sites of incarceration and segregation. Disability is of course a central component to our discussion as we consider how these sites uniquely and collectively shape the experiences of disabled people and how disability as a concept undergirds the development and workings of incarcerative systems. Because the work in this book crosses fields, examines multiple sites of incarceration, and attends to the interlocking of oppression, this chapter is designed to provide a broad historical and theoretical overview in order to showcase the intersections across sites and forms of inequality.

Undifferentiated Confinement and Its Early Critique

In disability scholarship, the rise and fall of the medical institution dominates the historical and theoretical landscape. One thing so compelling about histories of the medical institution is imagining that life was possible before it, which wears away its normative self-evidence. Indeed, just as there was a time before the medical institution, before eighteenth-century Europe and North America, there was a time when imprisonment had never been used anywhere as a primary form of punishment. It had been a temporary measure used under specific circumstances—often when the duration served a specific end, such as awaiting trial or being released upon paying a debt (Carrigan 1994; Foucault 1995; Guest 1997; Rothman 1971). Incarceration was not thought to have any benefit to inmates whatsoever, except perhaps deterrence. It was not any more “rehabilitative” than torture, banishment, or paying a fine.

Following traditions from England and France, the confinement of disabled people emerged early in colonial North America. Although social norms placed primary responsibility for dependents upon family, communities also developed formal mechanisms of care and control to handle instances when families would not or could not fulfill their obligations and when social problems such as vagrancy and theft emerged (Katz 1996). Criminalization and class oppression were thus central to the earliest forms of confining disabled (and nondisabled) people. One of the earliest institutions was the almshouse or poorhouse, which housed poor,

disabled, widowed, orphaned, and sick people, in a relatively undifferentiated manner. In practice, early jails, poorhouses, and even “general hospitals,” confined the same undifferentiated populations together. The only common theme was poverty because nobody with other options chose to live in any of these spaces. Wealthy people who were sick would never stay in a hospital, which was understood as a place of contagion rather than cure (Foucault 1994a); wealthy people were also less likely than today to be incarcerated for crimes, given that those jailed were most often sentenced for outstanding debts (Carrigan 1994; Guest 1997); and families with money were unlikely to institutionalize disabled loved ones until doing so became socially sanctioned.

People of color were rarely held in the earliest incarcerative sites, but for different reasons. It was not that racialized people had additional options from which they freely chose alternatives to confinement; rather, the ruling classes had other options for the control and elimination of racialized people. At this time, unrestrained violence was normatively and unapologetically used against enslaved and colonized peoples. Yet, except for this one significant exception, the earliest confinements housed the various populations that are still overrepresented among those incarcerated and institutionalized today (Chapman this volume).

These earliest imprisonments were contradictory in their orientation toward “care” and punishment, as are their descendants today. Supporters of the almshouse claimed that a formal system of institutional care would provide the worthy poor (those perceived as unfit for paid employment such as people with intellectual disabilities and the aged) with superior care, while deterring the unworthy poor (those who “could” work) from needless dependence and idleness. These two goals proved inherently contradictory (Ferguson 1994; Guest 1997). According to Ferguson (1994), in order to deter the unworthy poor, conditions in almshouses had to be sufficiently inhumane and abusive to motivate anyone who could work to do so, making compassionate care of the worthy poor impossible. Thus, abusive custodialism emerged as the accepted means of “caring” for disabled people. Furthermore, new laws against vagrancy and begging criminalized poverty, which increased the vulnerability of disabled people to penal imprisonment (Scheerenberger 1983). Disabled people incarcerated for begging were therefore inseparably confined for being “criminals,” “paupers,” and “disabled.” The three stratifications came together in these new laws and earliest practices of segregating particular people away from “respectable society.”

While it is well documented that the poorhouse was a catchall for all deemed dependent, unproductive or dangerous, it seems to be less often noted that this was equally true of early county jails and hospitals. Foucault (1988, 38) writes that French practices of mass incarceration began in 1657 with the creation of the “general hospital” and the “great confinement of the poor.” Before long, one out of every hundred Parisians was incarcerated. Even after the differentiation of various confined groups had begun, due to efforts of reformers, the “treatment” of people in differentiated sites continued to be rationalized and practiced in ways understood as interrelated. This demands an interlocking analysis of them. For example, the National Conference on Charities and Corrections, founded in 1874 after confinement had become differentiated, was the leading authority on pauperism, insanity, delinquency, prisons, immigration, and feeble-mindedness, because they were seen as so closely related (Trent 1994). In many ways, the only thing connecting the diverse populations who were first clustered together in the almshouse is that they have consistently been clustered together ever since, as the responsibility of sites of confinement, professional intervention in the community, or both.

Differentiated Confinement, Resonant Rationalities

The reformed differentiation of sites of confinement led to increased internment of diverse populations. Importantly, though, rather than being an imposition from government or business interests, this increase in confinement at first came largely out of the vigorous advocacy of progressive reformers and the advent of “moral treatment.” In the eighteenth century, Pinel in France and Tuke in England described the then-normative approaches to psychiatric confinement as inhumane. They removed (some) patients’ restraints and attempted to treat them in asylums. American psychiatric hospitals were also founded by progressive religious reformers, such as Dorothea Dix. Like Pinel and Tuke, Dix sought to liberate the “mad” from the oppressive conditions of chains and squalor, and to provide them with therapies—while still confined (Braddock and Parish 2003). Around this same time, the first institutions for blind people and “deaf mutes” also emerged. In 1818, the New York Institution for Deaf and Dumb was established (the American Asylum at Hartford was already operative), and the Perkins School for the Blind was established in Massachusetts in 1832. Dix herself founded a school for the blind, suggesting again that these diverse endeavors were intimately related. They were all oriented by the concern that confinement be specialized. Undifferentiated confinement was now an injustice, but specialized confinement could educate or rehabilitate.

In the United States, penitentiaries were created through the efforts of progressive religious reformers who sought more humane and efficacious forms of punishment than corporal punishments (Foucault 1995). Auburn prison opened in 1817 in Auburn, NY, and Quakers founded the Eastern State Penitentiary in Philadelphia in 1829. This was considered part of progressive social reform, and was followed in other parts of the United States and Canada in subsequent decades (Carrigan 1994). Early penitentiaries were not only imagined as the lesser of two evils, but they were also an experimental ground for other socially progressive innovations in architecture, hygiene, education, and moral reform (Rothman 1971; 1995).

Various incarcerative and institutional solutions grew in popularity throughout the 1800s (Ferguson 1994; Rothman 1971). By the mid-nineteenth century, systems of “care” were transforming into the more expansive, specialized, medical systems that would dominate the early twentieth century. In terms of political rationality (Chapman this volume; Foucault 1994b, 324–325), it was only in the 1800s that confinement was first conceptualized as doing anything useful for those confined. This was partly a result of developments in technologies of discipline within spaces of confinement (Foucault 1995; 2008), but it also relates to a growing secularization in Christian Europe. This disrupted the belief that people’s lot in life was divinely predestined (Foucault 1994a). Now, for the first time in Christian Europe, it was believed that people could significantly alter the course of their lives. One could not only accrue wealth and status—as was evident in the new bourgeois class—but could also become educated, cultivated, sane, or “civilized” (Chapman this volume).

The idea of individual transformation intersected with the “treatment” of denigrated populations. Both the British New Poor Law and the Bill for the Total Abolition of Colonial Slavery (which abolished slavery in Canada and other British colonies) took effect in 1834, and both were premised on the idea that paupers and slaves could undergo tutelage to ready them for the responsibilities of “economic freedom” (O’Connell 2009). That paupers and Black people could ever handle such responsibilities was a new idea for ruling class Europeans. At this time, prisoners were

first subjected to strict routines as a means of developing self-discipline. Faucher's strict timetable for prisoners, which would not have made sense to anyone a few decades earlier, was published only four years after the British New Poor Law and the Total Abolition of Colonial Slavery (Foucault 1995, 6–7). In the year previous to this timetable, the construction of New York's Utica State Lunatic Asylum began in 1837, and by the 1850s there were 30 such institutions in the United States (Braddock and Parish 2003). The then Province of Canada built its first "Lunatic Asylum" in Toronto in 1850 (Voronka 2008), which was just four years after the Government had resolved "to fully commit itself to Indian residential schools" in 1846 (Fournier and Crey 1999, 53). And only two years later, in the United States, Hervey Backus Wilbur undertook the first instruction of an intellectually disabled pupil in 1848 (Rafter 1997, 17), after which he became Superintendent of the first American "Asylum for Idiots" in Albany, NY, in 1851. Although there were widely divergent effects on the groups incarcerated in these various settings, which all emerged within a 17-year time span, they loosely share a structure of political rationality: under the right conditions imposed from above, degenerate, disabled, criminalistic, or uncivilized peoples can be brought "up" to normative standards. Theoretically, any person was now capable of achieving normalcy. This may sound like a welcome development, but it offered a very narrow conception of normalcy, and everyone was now measured against it, which was never previously the case (L. Davis 1995). Anything outside this narrow conception still required elimination, but such elimination could now be achieved by transforming individuals. As US Indian Commissioner William Jones put it, the goal of Indian Residential Schools was to "exterminate the Indian but develop a man" (in Churchill 2004, 14).

Furthermore, such previously impossible "development"—whether of slaves, First Nations, paupers, criminals, or intellectually, physically or psychiatrically disabled people—aimed toward integration into society as menial laborers. Residential Schools, penitentiaries, and the various specialized schools and institutions for disabled people never oriented their efforts toward graduates who would be leaders or professionals. The secular dream that people are masters of their own destiny only extended so far, and it intersected with the capitalist requirement for cheap labor.

Capitalism and Its Interlockings with Disablement and Confinement

Transformations within disability incarceration were propelled by the spread of capitalism, the reliance on institutions to manage social problems, the medicalization of intellectual disability, and the rise of eugenics (Rothman 1971; Trent 1994). Capitalism slowly and fundamentally transformed social norms regarding care, disability, and dependence. Growing capitalist markets required a vast pool of mobile and free workers, and traditional systems of charity were increasingly understood to undermine work ethic and encourage dependence. Reformers advanced distinct agendas for the able-bodied and disabled poor. The able-bodied were to be inculcated with work ethic and "motivated" to work—either by the denial of assistance or the provision of assistance in conditions wretched enough to make paid labor seem attractive. Those incapable of working were provided with custodial care and institutional segregation, but in inhumane conditions that underscored the horror of dependency (Ferguson 1994; Foucault 1988; Scull 1977).

When considering these histories, it should be remembered that some of those who were now “incapable of working” had previously been gainfully employed within more flexible and heterogeneous economic spheres in which requisite tasks and wages were more immediately and intimately negotiated, such as those within families and small communities (Edwards 1997; Snyder and Mitchell 2006). Some of the “non-productive” within industrial capitalism were easily identified, but differentiation based on psychiatric and intellectual disability proved more challenging. Medical, psychological, and educational professionals took on the task of sorting productive from unproductive (or unworthy from worthy) and managing appropriate “treatment.” In reference to resultant practices of confinement, Foucault (1988) wrote: “Before having the medical meaning we give it, or that at least we like to suppose it has, confinement was required by something quite different from any concern with curing the sick. What made it necessary was an imperative of labor” (46). “Cure” was increasingly understood as “readiness for economic freedom,” but this goal was made ever more challenging by a progressively competitive industrial labor market demanding fast-paced and standardized work. As optimism about specialized schools faded, superintendents began to emphasize the cost-effectiveness of institutions for lifelong custodial care (Noll and Trent 2004; Trent 1994).

From 1820–1850 there was also an increase in public concerns about crime as a hazard. Rothman (1995) asserts that this preoccupation with delinquency most likely had more to do with a society in flux than with actual rising rates of crime.¹ Reformers looked to prisons and the medical institution as a remedy for the resultant chaos (Reilly 1991; Rothman 1971). Within the walls of the institution or penitentiary, experts could create an environment that exemplified the principles of a well-ordered society and thereby (it was believed) cure inmates of insanity, deficiency, and deviancy. This occurred alongside the creation of the closed institutional spaces of Indian Residential Schools, which were politically rationalized as a means of “saving” the children from the “death of their race” (as a result of the social chaos resulting from colonialism, but narrated as social Darwinism)—which was considered inevitable by most White people at the time (Kelm 2005; King 2003; Neu and Therrien 2003).

Confinement’s particularity was always contingent on interlocking power relations. The first institutions were marked by internal stratification, keeping the poor separate from privileged classes (Braddock and Parish 2003; Smith and Giggs 1988); while some wealthy families were able to pay for relatively comfortable institutional care for their loved ones, families with more moderate incomes had to accept institutional conditions which nobody would choose to inhabit. By 1860, 44 percent of the prisoners in New York State prisons were foreign-born, and these rates increased each decade thereafter (Rothman 1971). Aboriginal children in both Canada and the United States were often forcibly removed from their families by police and placed in Residential Schools, their parents occasionally imprisoned for resisting this (Churchill 2004, 17).

Medicalization, Eugenics, and the Return of Confinement as an End in Itself

Although early asylums were intended to provide temporary sanctuary and rehabilitation to those who were first time offenders, recently mad, temporarily

impoverished, newly orphaned, and so on (Rothman 1971), they began housing those with long-term psychiatric disabilities, people serving life sentences, and children becoming adults in poorhouses and orphanages. Prisons and penitentiaries also held more “hardened criminals” than anticipated, and those convicted served very long sentences. Instead of being a means to an end, incarceration in the mid-nineteenth century became an end in itself. Today this is normatively unremarkable, but it would have been a travesty for the reformers who pushed for the rehabilitative prison (Foucault 1995).

Custodialism served the interests of the new helping professions. Institutions centralized treatment, research, and funding, and thus played an important role in the advancement of professionals concerned with the feeble-minded (Rafter 1997). Medicine, social work, and other professions increasingly advocated eugenics, cementing a biological understanding of intellectual disability and the vital role of professional interventions (Carey 2003; Paul 1995). The rationality of eugenics was protecting society from social danger, and in many ways it was about criminalization, classism, sexism, racism, and homophobia as centrally as it was about disability (Rafter 1997; Trent 1994). Eugenicists conflated the “strength” of one’s intellect and morality, believing both were measurable through physiological, hereditary, and IQ testing.

Race, Gender, and Imprisonment in an Era of Slavery, Eugenics, and Emancipation

The history of eugenics, disability, and institutionalization cannot be radically separated from concurrent developments in the “scientific” study of race and sexuality. Discussing the second half of the nineteenth century, Somerville (2000) explores the relationship between physiological studies of African women and “female inverts” (lesbians), which took place concurrent to similar studies of paupers, convicted criminals, and diverse disabled people. These “concurrent” developments informed one another. For example, in 1866, Dr. Down isolated what came to be named Down Syndrome. However, drawing upon existing racist hierarchies, Down coined the term Mongolism. He wrote, “it is difficult to realize he is the child of Europeans, but so frequently are these characters presented, that there can be no doubt that these ethnic features are the result of degeneration” (cited in Clark and Marsh 2002, para. 12).

Eugenics was explicitly racist in its attempts to strengthen “population quality,” defined in reference to Anglo-Saxon characteristics and moral codes (Black 2003; Larson 1995; McLaren 1990; Noll 1995; Thobani 2007). Although popular rhetoric frequently portrayed the faces of “feeble-mindedness” and “insanity” as immigrants and women of color, institutionalization was initially reserved for Whites (Rafter 1988). Black people and immigrants were often denied any form of social assistance and left to fend for themselves (Carlton-LaNey 1999; Peebles-Wilkins and Francis 1990; Thobani 2007; Yee 1994), an exclusion that ironically protected them from the specific abuses of the disability system.

Snyder and Mitchell (2006, 88) note that it was not until the late 1940s that African Americans with disabilities were placed in medical institutions along with their White counterparts (see Erevelles this volume, for more on this). They also write that both English and German sources during the eugenics era portrayed the death of disabled people as beneficial to the nation, but Black people’s lives were

valued as exploitable labor. Folding disability back into the picture, they note that this “overlooks the mortality that always accompanies slave systems, particularly for human chattel who become disabled as a result of inhumane labor and living conditions or for those killed after being born with a disability on slave plantations” (122). Although people of color could be kept out of closed institutions through segregation, racially segregated spaces were never free from disability. The “inclusion” of African Americans in prisons only occurred following the abolition of the unapologetically violent practices of slavery (A. Davis 2003). Although, in practice, slavery continued in the convict leasing system, as a consequence of the thirteenth amendment’s allowance for convicted “criminals” enslavement (A. Davis 2000).

First Nations people were also normatively excluded from early penal and psychiatric incarceration. While sites of nearly exclusive White confinement based on disability were initially flourishing, both Canada and the United States attempted to incarcerate every single Aboriginal child in a residential/boarding school. These “schools” were incredibly violent, but were publicly rationalized through discourses of “pity” and “care”—rationales that in this respect had more in common with contemporaneous rationales of confining disabled people than Black people.

While Aboriginal and Black people were segregated from White settlers, Asians and other racialized groups were restricted from entering Canada and the United States (Thobani 2007). For those communities cautiously allowed to migrate (Jewish and Irish people, Eastern and Southern Europeans), immigration policy and institutionalization interlocked, rendering some confinements unnecessary; newcomers deemed degenerate were sent back to their home countries (Reaume this volume)².

Eugenics was also sharply gendered. Women could be institutionalized and sterilized for deviating from norms of sexuality and femininity (A. Davis 1983; Kline 2001; Rafter 1992; 1997). Imprisonment too was gendered. At the beginning of the nineteenth century, the majority of women convicted (of mostly petty crimes) endured, in some ways, worse conditions than men as prisoners, due to systematic abuse, exploitation, and a general lack of concern for them as a “constituency.” When prisons and jails were erected, they did not take women into account.

Mill’s (1869) *On the Subjection of Women* contrasts men’s “privilege” with women’s “disability.” In this line of thinking, men were best rehabilitated through harshness, women through sympathy. In practice, any such distinction was precarious, but it marks two ends of a continuum that has constrained practices of confinement ever since—from “harshness” to “sympathy.” Reform has consistently been constrained by these parameters, so that a given site of confinement might become more or less harsh but reform rarely transcended established practices of confinement.

Following emancipation, African American men and women were sent to prison for the most minor offenses of Jim Crow laws, and previously all-White prisons became filled with Black prisoners. After 1870, prison camps were established in the South, imprisoning emancipated slaves and exploiting their labor (Kurshan 1996). A two-tier system was created in which custodial and reformatory prisons were both established for women. The reformatories meant to rehabilitate female prisoners housed mostly White women, while custodial prisons were similar to men’s prisons and housed mostly racialized women. Southern prisons had the worst conditions, were unsanitary, and lacked medical care (Kurshan 1996). Racism and sexism interlocked in such a way that racialized female prisoners appear to

have been understood as “the kind of social threat” that—like male prisoners—required harshness rather than sympathy. Historical developments that are at once divergent, and inseparable, and intersecting, have worked together to create the diverse contemporary confinements that Foucault called “the carceral archipelago” (1995, 301). These developments established what Foucault called a “protective continuum,” ranging from the medical to the penal. “These are the two poles of a continuous network of institutions . . . This continuum with its therapeutic and judicial poles, this institutional mixture, is actually a response to danger” (2003, 34), rather than precisely to illness or crime. Differentiated institutions were created, to classify, to control and treat danger, and to safeguard the rest of the population from the dangerous individual—as McLaren (1990) demonstrates of eugenics in Western Canada, Thobani of both colonization and immigration in Canada (2007), and Angela Davis (2003) of anti-Black racism in the rise of the US prison.

Out of discourses of the dangerous individual and the need to defend society, from the nineteenth century on, the medical and judicial become increasingly intertwined, with doctors “laying claim to judicial power, and judges laying claim to medical power” (2003, 39). According to Foucault, this emerged through discourses of abnormality and normalization, which are related to medical notions of illness and legal notions of recidivism, but in ways that always spill into one another. Psychiatry, for example, was not initially established in France as a specialization in medicine, but as a branch of public hygiene—of social safety. By codifying madness as both illness and danger, psychiatry gained legitimacy. And legal psychiatry was established at the very time that psychiatry was legitimizing itself as a scientific medical sub-specialization (Foucault 2003).

Resistance, Reform, and Reiteration

“Between 1950 and 1970, state authorities built, refurbished, and added to more public facilities than in any other period of American history” (Trent 1994, 250). Between 1946 and 1967 the number of residents in institutions for people with intellectual disabilities rose from 116,828 to 193,188—an increase of nearly twice the increase of the general population. In the face of deteriorating institutional conditions, accusations of abuse and neglect, and the scientific discrediting of eugenics, the medical institution and related programs still offered “sociological advantages” (Ladd-Taylor 2004) that led to their widespread use (Trent 1993). Institutions provided places of research and domains of power for institutional superintendents, served as a means to control and segregate a range of individuals perceived as socially deviant, and offered a cost-effective method to deal with lifelong dependency.

As the use of institutions continued to grow into the mid-twentieth century, criticisms mounted regarding institutions and programs such as compulsory sterilization. These criticisms emerged alongside, and intersected with, the many other radical political movements of the 1960s: Disability Rights and Prisoners’ Rights movements gained new prominence; Indian Residential Schools began to give way to the “Sixties Scoop”; 32 different countries in Africa gained independence; and the Civil Rights and Black Power movements, American Indian Movement, Stonewall Riots, second wave feminism, and Vietnam War Protests raised many troubling social and political questions. Concurrent to these related developments, the dominance of the medical institutions began to decline for

people with intellectual disabilities in the early 1970s (Trent 1994). The critique of institutions stated that: disability was manufactured and perpetuated by the systems that identified and labeled people as disabled; this often led to negative rather than positive consequences and primarily existed to exert social control; this was intrinsic to institutions and could only be ameliorated by ending institutional care; and institutions violated peoples' human and constitutional rights to life, liberty, and the pursuit of happiness. Kanner (1942), Sarason (1958), Scheff (1966), and Szasz (1961) were among the first scholars to apply labeling theories to disability. In *The Myth of Mental Illness*, Szasz argued that mental illness was only a label used to repress socially unacceptable behaviors and that psychiatrists were sanctioned by the state to enforce "normality." If psychiatrists were the police force for normality, then medical institutions were analogous to a prison for society's unwanted, unacceptable, and socially deviant. Goffman's (1961) *Asylums* compared mental institutions, prisons, boot camps, and religious cults, arguing that they share the features of "total institutions."³ Human rights abuses were repeatedly documented in exposés (Blatt and Kaplan 1966; Deutsch 1948; Maisel 1946; Richardson 1946; Rivera 1972). World War II conscientious objectors who served in America's mental institutions led significant reform efforts, partly through such exposés (Taylor 2009). Nirje (1969) and Wolfensberger (1972) advocated that typical patterns of life, relationships, and roles be available to people with disabilities and that these qualities are essential to their development as people and citizens. But acclimatization to the local norms of an institution becomes a part of the problem for those incarcerated. Refuting that disabled people require protection from competition through segregation, Perske (1972) asserted that they deserve the "dignity of risk"; while Wald (1976) argued that disabled people have a right to privacy that is systematically violated in institutions and the broader service system. Parents and disabled people themselves organized to improve institutions and/or to replace institution-based services with community-based ones (Carey 2009, Carey and Gu this volume; Friedman and Beckwith this volume; Jones 2010). And Ferleger argued in the groundbreaking *Halderman v. Pennhurst* (1977) that institutionalization violated the constitutional right to liberty. A later case, *Olmstead v. L. C.* (1999) found that unnecessary institutionalization was legally discrimination under the Americans with Disabilities Act. Such activism cumulatively transformed a system that at one time was as normatively unproblematized as today's prison, group home, or nursing home.

Thanks to efforts of survivors of institutions and other activists, many intellectually and psychiatrically disabled people today live outside large-scale institutions (Friedman and Beckwith this volume), which is a great accomplishment. Unfortunately, institutionalization has not ended. In 2009, 33,732 American people were still housed in large state institutions housing 16 people or more, and most states continue to channel a significant proportion of long-term care funding into institutions (Braddock et al. 2011). As with the reform of women's imprisonment a century earlier, resistance to institutionalization was constrained by the long-standing "curative" versus "custodial" and "sympathy" versus "harshness" parameters. The earliest prison reformers of the 1700s advocated for gentler and rehabilitative forms of punishment, and this same sentiment has motivated reform toward gentler institutionalization rather than abolition (Carey and Gu this volume). Just as institutions survived early criticisms of eugenics, so too did they survive mid-twentieth century legal and philosophical challenges. Their survival is not due to their success

at providing treatment but is because they serve particular interests and rationalities, and because alternative models of service delivery are often blocked.

The large-scale institutionalization of disabled people, where it is rationalized as necessary specifically because of disability, has declined since the 1970s in the United States and Canada. And as institutions declined, community-based services emerged. But these have not offered the panacea that was desired. Like Ferguson noted regarding the similarities between the almshouse and the institution, so too are there similarities between community-based services and medical institutions. Community-based services are often run with a similar medical model and an asymmetry of power between staff and consumers (Drinkwater 2005; Rothman and Rothman 1984). They at times demand that people earn what should be basic rights to movement, privacy, and choice (Taylor 1988). They often create artificial homes and relationships without the true qualities (McKnight 1995).

Snyder and Mitchell (2006) suggest that current forms of surveillance, routine, and behavior modification in nursing homes, sheltered workshops, and so on, “remind us of a past that we had believed we had superseded and gesture toward a future we want to avoid” (135). They characterize these still existing institutions as continuities of a top-down model of power that is often assumed to have ended. Butler (2004) raises similar concerns discussing the indefinite detention of “terror suspects,” as does Asad (2003) of contemporary police torture behind closed doors. Top-down and heavy-handed power relations continue, in spite of reforms narrated as movement toward kinder persuasions in which people subjected to them are more democratically involved in their negotiation. The two structures of power (top-down sovereign power and persuasive disciplinary power) coexist in even the most specific contexts and interactions. Narratives comparing today’s programs favorably against “real institutionalization,” might actually prevent the recognition of ongoing institutionalization today (Ahmed 2006; Drinkwater 2005; Heron 2007). Perhaps this is not a “post-institutionalization” era at all, but is rather one of different now-normative institutionalization.

Following Stiker’s (2000) provocation that inclusion and exclusion are not mutually exclusive, community inclusion is continuous with longstanding practices and rationalizations of social control (Drinkwater 2005; Michalko 2002; Tremain 2005). People receive rights and inclusion only in exchange for conformity, normalization, self-support, silencing dissent, and erasing differences (Michalko 2002; Russell 1998; Snyder and Mitchell 2006; Stiker 2000; Titchkosky 2003). The tension between care and enforcing work in almshouses still informs disability policy, leading to “controlled integration” in which rights are offered or denied based on economic benefits to people without disabilities (Carey 2009). The “right” to be a part of the community is offered to those whose support is calculated as less costly, while institutionalization may be the only available option to those with more extensive care needs. The right to equal opportunity in the work place is provided for those considered viable workers, but income supports (which are always below the poverty line, following a similar logic of deterrence as early almshouses) are offered to others. “The disabled person is integrated only when disability is erased” (Stiker 2000, 152). And when such erasure is not achieved, integration is often not pursued at all.

The growth of the Prison-Industrial Complex, especially given its occurrence shortly following the massive closures of both medical institutions and Indian Residential Schools, further complicates the assumption that institutional forms of control are in any way behind us. The Prison-Industrial Complex could be

defined as a complex web interweaving private business and government interests in the growing industry of incarceration and prison development (A. Davis 2003; Sudbury 2004). The public rationale behind the Prison-Industrial Complex is the fight against crime, but those drawing on this conceptualization note the implicit goals as profit making and social control of mostly men of color (Christie 2000; Gilmore 2006; Goldberg and Evans 1997). According to Parenti, the criminal (in) justice system and the privatization of prisons “manage and contain the new surplus populations created by neo-liberal economic policies” and the global flow of capital (1999). Goldberg and Evans (1997) connect the US practice of acting as policeman of the world to the exportation of specific penal regimes in what Sudbury (2005) has called “global lockdown.” Canada’s Prime Minister, shortly after apologizing for Indian Residential Schools (Harper 2008) and then denying Canada’s history of colonialism (Canadian Business 2009), is now following the example of the United States in prison expansion (including building “Super Max” prisons). For the first time ever, in 2008, more than one in one hundred American adults was behind bars. In 2009, the adult incarcerated population in US prisons and jails was 2,284,900 (BJS 2010). The number of carceral edifices in the United States has also grown. From 2000 to 2005, the number of state and federal correctional facilities has increased by 9 percent, from 1,668 to 1,821 (BJS 2008). The United States incarcerates a greater share of its population, 737 per 100,000 residents, than any other country (Pew Center 2008). Race and disability play a significant role in incarceration rates. In 2006, Whites were imprisoned at a rate of 409 per 100,000 residents, Latinos at 1,038 per 100,000, and Blacks at 2,468 per 100,000. The number of prisoners with disabilities is not measured in the way that some races are, but in 2005 more than half of all prison and jail inmates were reported to have a mental health problem. Nearly a quarter of State prisoners and jail inmates with a mental health problem, compared to a fifth of those without, had served three or more prior incarcerations (Prison Policy Initiative 2008).

Framing imprisonment as the workings of the Prison-Industrial Complex aims to unhinge the normatively taken for granted one-to-one correspondence between crime and incarceration. As in other historical periods when incarceration rates have risen, the increase in the number of prisons and cells in recent decades is not correlated to any increase in crime. Prison abolitionists argue that it has rather been driven by capitalist greed and racist social control. The stated political rationalization behind imprisonment is the fight against crime, but the effects are profit making and the social control and removal of those same groups that were once enslaved, killed in colonial violence, or confined in poor houses and medical institutions. Furthermore, prisons are widely acknowledged to be unsuccessful in the deterrence or prevention of crime (A. Davis 2003; Goldberg and Evans 1997; Smith 2005), as was true even before they became the penalty for almost every crime (Foucault 1995).

Prison abolitionists suggest that the prison persists because it has become a core structure shaping social relations in our society—not just the relationships of those affected directly, but of everyone. Prison abolition is therefore not only about closing prisons, as that would not be enough. W. E. B. Du Bois, in *Black Reconstruction* (1956), discusses abolition as more than the negative process of tearing down. It is about creating social structures that assure equality. Du Bois insists that in order to truly abolish slavery, new democratic institutions are needed. Angela Davis (2003), following Du Bois, examines successful abolitions (of slavery, lynching, and Jim Crow segregation) and points to the gap between the change

“that we fight for” and the change “that we actually achieve” (A. Davis 2007). The closure of even the most terrible institution, in isolation, does very little to contribute to more far-reaching societal outcomes of a radical participatory democracy in which all people have the opportunity to shape society.

Toward a Working Definition of Institutionalization, in Its Variety and Its Rough Coherence

Taking into account the wide range of sites that have evolved from the earliest undifferentiated confinements, today we need to ask: What is an institution? What is institutionalization? What is its relationship with imprisonment and other forms of physical confinement? Among what he called total institutions, Goffman (1961) included sites that featured no locked doors or bars on the windows. And yet his work may not adequately address the diverse mish-mash of institutional sites in our communities today. Centering these sites’ relations to penal imprisonment, Foucault termed this mish-mash “the carceral archipelago” (1995). We are nuancing this slightly to call it an “institutional archipelago,” made up of diverse services and spaces that all trace back to undifferentiated confinement and its ongoing reform—in which penalty is no more or less central than medical care or the right to education. However diverse, these sites also share something in common. It is not stated purpose, and it is not degrees of freedom of movement. These would have one separating the penal from the medical from the educational, or separating closed sites from community services, none of which honor the shared genealogy of the institutional archipelago or the resonances still felt across its diverse sites today.

What makes something an institution? Disability rights coalition Self Advocates Becoming Empowered (SABE) defines an institution as “any place, facility, or program where people don’t have control over their lives” (2012). They thereby include many of today’s “community-based services” under the umbrella of institutions. This is an important starting point. Many services that have emerged “post-deinstitutionalization” should be understood as institutions.

A difficulty with SABE’s definition, however, is that there are countless noninstitutional contexts, such as many families, in which people have no control over their lives. Does the lack of control that many experience in families imply no distinction between a family and the broad range of sites and practices considered incarcerative and/or institutional in this volume? We do not think so. One difference may be that there is greater freedom on the part of those exercising authority in families, as compared to institutional sites in which even staff behavior is constrained by policies, norms, and surveillance. Staff members are not oppressed or affected the same way as those institutionalized; however, the institutionalization of staff/resident relations has a concrete effect on patients’ ability to resist and gain some self-control, as well as on staff’s agency to relate according to politics or values at odds with institutional norms and policies. Staff govern themselves in relation to many factors, but the added dimension of being disciplined as a “helping professional” or an employee of a particular institutional site also contributes to staff’s parameters of freedom in responding to inmate, patient, resident, or consumer resistance (Chapman 2010; 2012).

Practices of power and domination, and of resistance and negotiation, in these sites have something in common that they do not share with noninstitutional sites.

To further consider this, we draw on the conceptualizations of everyday negotiations of power, domination, and resistance that Foucault (1982; 2006) and Bhabha (1994) articulate. Power relations shape encounters, and yet Foucault and Bhabha suggest that such encounters are nevertheless always unique. Their uniqueness is due to resistance and contestation on the part of those subjected to power, as well as to the varied responses to such resistance from those exercising power. Bhabha's colonial encounters, then, are both predictable systemic domination and radically unique negotiation. To analyze this complexity, Bhabha attends to the complex and contingent factors at play in a given interaction between two people, or two communities, which determine the parameters of freedom to negotiate relationships. He conceptualizes these complex determinants as the "Third Space" or "the space between" two people or communities in any given encounter (1994, 53–56). This "space" exceeds what can be concretely known, but conceptualizing it as "there" allows for certain interrogations of power.

There are aspects of "the space between" unique and widely variant staff/resident relations and negotiations that are roughly shared across diverse sites of confinement. For example, that prison personnel, like inmates, are under surveillance and scrutiny and are disciplined to interact with inmates in certain ways (Foucault 1995) is one aspect of Bhabha's Third Space that is equally applicable to asylums, group homes, sheltered workshops, day programs, and many other diverse sites of institutionalization. Policies and procedures manuals delimiting appropriate standardized responses to patient/inmate/consumer behavior is another component of this "space between." The rhetoric that obedience, following routines, and even the immersion in the physical space of the site are somehow beneficial and transformative is another. And the moral exaltation/denigration in which staff are disproportionately responsible for positive outcomes, while inmates/consumers are disproportionately responsible for negative outcomes is yet another.

Family and caregivers abuse many disabled people in their homes and, although this is related to disablism and would resonate in that sense with much institutional violence, such abuse would not share other aspects of the "space between" staff and residents that appears to feature somewhat consistently in confinement and community service settings. This line that we're suggesting can be useful is only "strategic," in the sense of Spivak's "strategic essentialism" (1993)—let's feel free to draw this line when it helps our analysis and activism, and let's highlight its imperfections, arbitrariness, and problems when that's most pressing.

Interlocking Analysis and Particularity

To propose a more thoroughly interlocking history is to suggest that the similarities and the distinctions across sites are important to consider, in terms of rationality, practice, and the effects on people who are incarcerated in diverse sites of confinement. For example, at least on paper the penal system offers certain protections to the accused and the prisoner, such as due process during the trial and sentencing procedures, a sentence of a specified duration, and protection against cruel and unusual punishment, while medical institutions allow the compulsory admittance of patients against their will based only on a medical diagnosis, an indefinite time of commitment, and "treatments" that can be painful and harmful, such as extended isolation, physical restraints, and electric shock "therapy" (Conrad and Schneider 1992; Goffman 1961; Snyder and Mitchell 2006; Szasz 2009).

Broadening the historical and institutional lens also enables innovative readings of historical changes. We do not wish to diminish the gains of the closure of many institutions. This has taken place, however, at roughly the same time as an unprecedented rate of American prison expansion beginning in the 1980s—and we want to encourage disability and prison activists alike to attend more closely to what this means and what can be done about it.

Moreover, one cannot comprehensively analyze and resist the massive prison machine today without a disability critique. Prisoners are not randomly selected and do not equally represent all sectors of society. A disproportionate number of persons incarcerated in US prisons and jails are disabled, poor, and/or racialized. Poverty is known to cause a variety of disabilities and disabling conditions (Puar 2012), as does the prison environment, due to: hard labor in toxic conditions; closed wards with poor air quality; emotional, physical, and sexual violence; the circulation of drugs and needles; and lack of medical equipment and medication (Russell and Stewart 2001). In 2007, 19-year-old Ashley Smith died in an isolation cell in Kitchener, Ontario. After an initial sentence of one month in a youth detention facility for throwing crabapples at a letter carrier, she was transferred among 11 institutions in five different provinces over four years. This enabled her to be held in isolation for much longer than legally allowed because she was never isolated in one institution beyond what is legal. She died under guards' direct observation, as they waited for her to go unconscious before intervening, as per their directives. The "treatment" she had received included extensions of her sentence, isolation, emotional abuse, physical restraint, pepper spray, and a restraint apparatus called "the wrap" (Gartner 2010). Her death was not only a result of disablism, and it was not only about the injustice of prisons; these systemic injustices worked together in particular ways.

There is also need for more critical engagement with the pervasive narrative of "the failure of deinstitutionalization." The hegemonic story is that deinstitutionalization led to "dumping people in the streets" who were unable to live non-institutionalized and so they ended up in prisons or homeless. There are crucial aspects left out of this story. This pervasive narrative steers our attention away from neoliberal policies that led simultaneously to the growth of the prison system, the reduction in affordable housing, and the lack of financial support for disabled people to live viably in the community. These discussions about homelessness individualize and psychiatrize what is properly a political, ethical, and socioeconomic issue. This shifts responsibility away from the state and its policies onto the human service sector who are charged with ameliorating the problem with individualistic mental health interventions and haphazardly available free meals or sleeping bags.

Colonialism and Neocolonialism

Incarceration is now normative worldwide, due to ongoing colonialism and neocolonialism⁴. Neocolonialism is the imposition of European/White settler/Global North ways of doing things, responding to social issues, and imagining human relations onto (for the most part) people of color in the Global South. Many have pointed out that neocolonialism is being mobilized to address problems stemming from colonialism. Ahmed (2004) writes,

the West gives to others insofar as it is forgotten that the West has already taken in its very *capacity* to give in the first place...[P]ain and suffering,

which are in part effects of socio-economic relations of violence and poverty, are assumed to be alleviated by the very generosity that is enabled by such socio-economic relations. So the West takes, then gives, *and in the moment of giving repeats as well as conceals the taking* (22).

Julia Sudbury (2005) calls neocolonial impositions of imprisonment “global lockdown,” saying they address social problems related to increasing disparity between rich and poor. The IMF and World Bank finance (and at times mandate the creation of) large custodial institutions in the Global South, despite critiques of such practices in both the North and the South. IMF Structural Adjustment Programs and international “free” trade agreements also lead to increased poverty, disability, and incarceration in the Global South. These neocolonial impositions, in some cases, have a positive effect on measures such as gross domestic product, but this does not “trickle down” in the way that some claim (Chaudry 2011). The effect of these interventions seems rather to be that the wealthy get wealthier, while the poor become even worse off. The result, then, on a societal level, is an increase in what some have called “relative poverty,” which has been demonstrated to result in higher levels of the various social problems that prisons and other institutions are said to address (Wilkinson 2011).

This may appear to have little to do with disability and incarceration in North America, but this appearance is a result of the imaginary in which North America has no history of colonialism—as Canada’s Prime Minister recently boasted to the G20, much to the outrage of First Nations groups (Canadian Business 2009). But, it is only through processes of colonial imposition that the sites and practices of confinement that we explore in this book have come to this land. Voronka (2008) writes that the sequestering of First Nations people onto Reserves and the construction of asylums for the sequestering of people with psychiatric disabilities were both central to Canadian “nation building,” describing “sites of carceral containment as part of this colonizing project” (2008, 45). And contemporary First Nations’ critiques of everyday details of life and social structures in the United States and Canada note that North America has never moved into a period that is “post”-colonial (Smith 2005; Turner 2006).

Conclusion: The Institution Yet to Come, and the Institutionalized Yet to Come

Closure of large institutions has not led to freedom for all disabled people—nor has it resulted in the radical acceptance of the fact of difference among us. Institutional life, whether in a prison, hospital, mental institution, nursing home, group home, or segregated “school,” has been the reality, not the exception, for many disabled people, both throughout North American history since the poorhouse, and globally—again because of concrete impositions of colonialism and neocolonialism, here and the world over.

McRuer (2006) discusses what he calls “the disability yet to come,” describing both the fear that nondisabled people have of becoming disabled and the notion that if anyone lives long enough, they will eventually become disabled in some way. For example, in describing the interlocking forces in her childhood that worked against her resistance and confidence (sexism and ageism in her family; racism that her family lived with), bell hooks names the ever-present

threat of psychiatric incarceration if she does not follow the social mores of a Black girl.

Questioning authority, raising issues that were not deemed appropriate subjects... that was crazy talk, crazy speech, the kind that would lead you to end up in a mental institution. “Little girl,” I would be told, “if you don’t stop all this crazy talk and crazy acting you are going to end up right out there at Western State.”

[M]adness... was the punishment for too much talk if you were female... [T]his fear of madness haunted me... I was sure [it] was the destiny of daring women born to intense speech. (1989, 7)

The ghost of forced confinement haunts everyone, but does so much more materially and immediately for marginalized populations, especially poor, racialized, and disabled people.

Derrida writes (1994, xix),

no politics... seems possible and thinkable and *just* that does not recognize in its principal the respect for those others who are no longer or for those others who are not yet *there*, presently living, whether they are already dead or not yet born. No justice... seems possible or thinkable without the principle of some *responsibility*... before the ghosts of those who are not yet born or who are already dead.

How can there be accountability today to the childhood experience of bell hooks, a young Black girl threatened with institutionalization if she talked back to an adult? How can there be accountability to 19-year-old Ashley Smith, who died in her isolation cell in Kitchener just a few years ago? How can there be accountability to “Emily no. 049” who died in the Kuper Island Residential School and wasn’t grieved by the White adults running the school because she was Indigenous, deaf, and “quasi-dumb” (Fournier and Crey 1999, 60)? How can there be accountability to “X.X.” from Lennox Island whose toes had to be cut off due to severe frostbite in the Shubenacadie Indian Residential School, after having been exposed to severe cold as a punishment for running away (Chrisjohn and Young 2006, 54)? Or to the women forcibly sterilized or permanently incarcerated so that they wouldn’t give birth to another generation of “feeble-mindedness”? Or to emancipated slaves who found themselves working in similar conditions after being arrested for petty violations of Jim Crow laws? These are just some of the hauntings that need to inform politics, policies, activism, and scholarship today—real people who lived and died confined, or with the threat of confinement shaping the possibilities for their lives. And how can we live in a way that is also accountable, as Derrida says, to those “not yet born?” How can there be accountability to children who are born tomorrow or ten years from now—especially those who, because of disability, race, or class, are born disproportionately likely to live all or part of their lives in the terrible spaces of the carceral/institutional archipelago? This future “yet to come”—that of the Ashleys and the Emilys of tomorrow—is a looming presence that has to be lived with, that has to be contended with, today.

Notes

1. A similar phenomenon is at work today with widespread panic about mounting crime but no corresponding rise in crime rates (Gilmore 2006; Gottschalk 2006).
2. Patty Douglas (2011) documents how this in fact lives on in Canadian immigration policy and practice.
3. Chrisjohn and Young (2006) use Goffman's analysis and language in their discussion of Indian Residential Schools in Canada.
4. Aboriginal scholars tend to not place "neo" or "post" before "colonialism" in accounts of present-day North America and other White settler colonies. The argument is that colonization here has been continuous and that Canadian confederation and American independence brought about self-governance for settlers but not Aboriginal Nations. We therefore here distinguish "neocolonialism" in the Global South from ongoing colonialism in North America.

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