

UNCHAINING CIVIL RIGHTS THROUGH QUALITY HEALTH SERVICES & CARE

by **Tracie Gardner, Gabrielle de la Guéronnière,
Heather Howard, Roberta Meyers Douglas,
Victoria Palacio and Deborah Reid**

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**A CAMPAIGN OF THE
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INTRODUCTION

Legal Action Center & No Health = No Justice

For nearly 50 years, the [Legal Action Center](#) (LAC) has fought to dismantle systemic barriers that are rooted in racist and punitive policies and that perpetuate discrimination and disparities in health, justice, and access to life opportunities. Specifically, the historic and persistent racism entrenched in the health care and criminal legal systems, together make life difficult and disempowering - and too often deadly - for Black and brown people in the United States. A major driver of mass incarceration is the health care system's failure to appropriately address the health needs of Black, Indigenous, and People of Color (BIPOC) in the community; people with un- or inappropriately addressed mental health and substance use disorders are then driven into punitive, oppressive systems, such as the criminal legal and family regulation ("child welfare") systems. LAC has thus focused its fight against the discrimination faced by people with substance use disorders (SUD), mental health conditions, HIV or AIDS (health issues that, disproportionately for people of color, have been criminalized rather than treated), and arrest and conviction records.

Over the past two decades, the national movement to end the era of mass incarceration has been stymied by the disastrous outcomes of the era of deinstitutionalization, which systematically relinquished people with chronic addiction and mental health conditions to the criminal legal system without a commensurate investment in community-based care. In response, LAC launched its ["No Health = No Justice"](#) Campaign as a national call to end mass incarceration by addressing the persistent underlying inequities within the health care and criminal legal systems that have metastasized from the systemic racism embedded in and driving these systems.

Discriminatory laws and policies that lead to deficient health care access, high unemployment and under-employment, poor educational outcomes, and criminal legal responses hinder many in our nation from achieving success. These issues are intrinsically linked, and as a country, we need to first acknowledge that they are often caused by the racial and economic oppression enshrined in and perpetuated by historic and current policies and practices. Then we must take action to resolve them.

OUR VISION

Health & Justice For All

The No Health = No Justice Campaign is a natural outgrowth of the Legal Action Center's work to realize its vision of a United States where health care is provided to all, people are no longer criminalized for conditions related to their health, and racial inequities no longer exist in our health or legal systems. We believe this will only be achieved by ending punitive responses to substance use disorders and mental illnesses, eliminating practices that foster mass criminalization and incarceration and building community health care systems that fully and equitably respond to people's varied health needs.

Our objectives are to:

- **End policies that drive mass criminalization** and incarceration of Black, Indigenous, and People of Color as well as other marginalized groups.
- **Transform the health care system** to effectively promote the concept that mental illness and substance use disorders be addressed as chronic diseases that require evidence-based treatment as well as harm reduction practices that focus solely on an individual's health and well-being.
- **Effectively improve access to health care, including preventive care,** and ensure it is culturally and linguistically effective to eliminate racial disparities in mental health, substance use disorders, and physical health care.
- **Establish diversion to community-based treatment as the primary goal at all phases of the criminal legal system**—pre-arrest, pre-trial, pre-adjudication, and post-adjudication—with an emphasis on the earliest opportunities for diversion.
- **Reject the use of arrest and conviction records as a surrogate for race-based discrimination** and enhance civil rights protections to prevent discrimination in employment, housing, education, and other necessities of life against people with convictions.
- **Reshape the criminal legal system so that it is person-centered** and prioritizes rehabilitation, restoration, and recovery through an array of alternatives to arrest, prosecution, incarceration, and supervision.
- **Strengthen community reentry** for people leaving incarceration, so they have jobs that pay living wages with opportunities for growth, safe, secure, and affordable housing, sufficient health care coverage and services and can fully participate in society.

HISTORICAL BACKGROUND

Racism Embedded in Health Care Access & Delivery, Public Health Epidemics, & Disasters Impacting Health throughout US History

The existence of systemic racism in the United States' health care delivery system and underlying our health policies and responses to health-related crises is consistently revealed throughout the country's history. Whether intentional and overtly discriminatory, reflective of an indifference to racial discrimination, or stemming from actions or inactions that may not have appeared to be intentionally biased, one can refer to a multitude of laws, policies, and practices, all of which have caused (and continue to cause) disproportionate harm to members of Black, brown, and Indigenous communities.

When looking back at historic health care delivery scenarios involving people of color, rather than being offered clinically appropriate high quality health care services in their communities, the recipients of the so-called "health care" were regularly: (1) not informed of the actual services that they would receive (and thus could not consent to treatments); (2) provided with experimental and inhumane treatments (instead of the appropriate standard of care at the time); (3) provided with extremely limited or no health care services; and (4) warehoused against their will and forcibly given substandard treatments. Although the original Hippocratic Oath requires soon-to-be practicing physicians to vow to "first, do no harm" to their patients – the justification for this unjust treatment of or complete lack of treatment for communities of color is rooted in eugenics principles that view the lives of Black, brown, and Indigenous people as expendable, less than human, and worth less than white people. [See generally: ["Killing the Black Body: Race, Reproduction, and the Meaning of Liberty;"](#) and ["Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present."](#)]

History also reveals that in every public health or public safety crisis where war or disaster is literally or symbolically declared within the United States, Black families and communities suffer the most. From hurricanes, flooding, and droughts, to water and air contamination, viruses such as HIV and influenza, and addiction epidemics, Black Americans have either endured the most enforcement actions put in place to respond to these crises or struggled due to indifference or blatant neglect.

We witnessed the disregard for Black and brown life during the aftermath of natural disasters like Hurricane Katrina and Hurricane Maria in recent years, and we can see it in data that demonstrates the uneven response and disparate outcomes of health crises like anti-Black racism in response to smallpox, tuberculosis outbreaks in the early 20th century, the Spanish flu of 1918, the HIV epidemic, and most currently, the novel coronavirus, COVID-19. Moreover, the overt abuse and violence perpetrated against Black and Indigenous people since the founding of this country have calculably harmed generations of the progeny of Black and brown people. From the genocide of Native Americans to the atrocity of slavery, to the terror and lynching of Black Americans that began in the 1870s and arguably continues to this day with acts of state-sanctioned violence perpetrated by law enforcement, these horrific acts have longstanding and devastating impacts on the health of individuals, families, and whole communities over centuries.



WHERE WE ARE TODAY

COVID-19 as the Latest Example of a Crisis that was Already a Crisis in the Making

The COVID-19 pandemic, like the health crises before it, highlights all the ways in which our public health and safety systems are saturated with racism and continue to fail those who need them the most. It is not a coincidence that certain populations are disproportionately being infected and dying from the coronavirus, and if we do not make a concerted effort to effect real change, history will only continue to repeat itself and racial inequities will be further exacerbated by future national crises. Dr. Mary Bassett said it best in her seminal NEJM article, ["#BlackLivesMatter: A Challenge to the Medical and Public Health Communities,"](#) "If we fail to explicitly talk about racism in health, especially at this time of public dialogue about race relations in this country, we may unintentionally bolster the status quo and enable the perpetuation of health inequities."

Data regarding COVID-19 has revealed that Black people have died from the coronavirus at a [rate nearly two times higher](#) than their population share. CDC data reflects that COVID-19 hospitalization rates among Black and Latino people were about [2.8 times the rate](#) of white people. Another recent CDC report on the impact of COVID found that, from 2019 to 2020, Latino people experienced a three-year [drop in life expectancy](#) and Black Americans saw a decrease of 2.9 years. White people experienced a smaller decline of 1.2 years. Research indicates that when it comes to [health risk factors](#) people of color are more likely to die from COVID due to underlying health conditions, higher uninsured rates and being less likely to have a "usual source of care," which makes it harder for them to access COVID testing. As it pertains to [economic factors](#), people of color are more likely to work in the service industries that offer less financial stability during the pandemic, are more likely to have housing arrangements that make it difficult to social distance, and are less likely than their white counterparts to work at jobs that allow for telework, having a greater reliance on public transportation during this time. Consequently, people of color are more likely to be exposed to COVID.

People in congregate settings have also been disproportionately harmed by the virus due to an inability to appropriately social distance. And, due to systemic racism in the criminal legal system, people of color are over-represented in jails and prisons nationwide. Based on 2020 Census data, Black people make up [13%](#) of the U.S. population but comprise [40%](#) of the incarcerated population in this country. Racist policies have made Black people more likely to be incarcerated than any other group of people, and consequently they face an increased risk of contracting COVID in detention settings.

In jails and prisons, the challenges of a congregate setting are compounded by inhumane conditions including overcrowding, a lack of quality health care, including COVID testing, treatment, and vaccination, and poor availability of personal protective equipment and sanitizing products. COVID has hit incarcerated people particularly hard with **1 in every 5 individuals** incarcerated in state and federal prisons having contracted the virus. Although this represents an infection rate four times greater than the general public, it is likely that the rate of COVID infection and deaths in prisons and jails have been dramatically underestimated due to lack of testing and transparency by detention facilities.

Early in the pandemic, advocates were successful in securing greater use of compassionate release for older incarcerated individuals, those with underlying health conditions, and for people who were near their release date, which resulted in an **8%** reduction in the U.S. prison population. However, focus appears to be shifting from a public health approach back to one prioritizing incarceration. For example, although the Biden Administration recently released **guidance** and a funding opportunity aimed at mitigating the impact of COVID in prisons, jails, and juvenile facilities, the federal Bureau of Prisons considered requiring the 4,000 people who were released to home confinement due to the public health emergency to return to prison. Should these individuals be returned to prison, despite being close to the end of their sentences, having met criteria to qualify for early release, and having successfully reintegrated into their communities, it will be clear our political leaders place a greater value on punishment than promoting public health and successful reentry. Although efforts to expand compassionate release did lead to an 8% decrease in the US prison population, the decline will be temporary without structural changes to the front-end of the criminal legal system, including meaningful reforms to policing and sentencing.



A group of legislators, advocates, academics and public health officials gathered outside San Quentin State Prison in California to discuss a COVID-19 outbreak at the facility in July 2020.
Photo by Eric Risberg/Associated Press via [The Marshall Project](#)

**RACISM
IS A
PANDEMIC**



PHYSICAL HEALTH, RACISM & THE CRIMINAL LEGAL SYSTEM

There is a wealth of information and data that make clear the seriously sub-standard level of health care provided to incarcerated individuals, and the corresponding disproportionate rates of disease affecting this population compared to the general public. To understand how systemic racism further amplifies these truths for incarcerated individuals of color, not just in sheer numbers, but in qualitative measures, one should first look at the racial biases in physical health care outside of jails and prisons.

The racial biases that persist in health systems today are an extension of the time of during the enslavement of African bodies in the Americas included health treatment by the equivalent of what is known in more modern times as a veterinarian, or as part of animal husbandry was the norm, and being seen by a trained health professional was the rarity. Black bodies were property, commodities no different than cattle or horses. The health of a Black body was seen as solely monetary: a return on investment that demanded that slaves be "maintained."

Many of today's health providers have racial biases that have their foundation in this history, permeate policies and practices within the public health system, and informs the type of care they provide. These racist beliefs are not new, we have seen them throughout the history of medicine in this country. During the 1918 influenza epidemic in the United States, even though the death rate among African Americans was lower than that of whites, public health officials continued to assert racist theories about the biological inferiority of African Americans and considered them as a threat to the health of white people. At that time, Black Americans were treated in segregated and under-funded health facilities, yet Black physicians were called upon to help care for both Black and white Americans. Despite all this, following the epidemic, white public health and medical authorities still did not develop any significant initiatives to improve the health of Black people.

A [2016 University of Virginia study](#) revealed that half of white medical students and some white (non-medical) laypersons believed false statements about Black people's physiology (e.g., "Blacks' nerve endings are less sensitive than whites" and "Black people's blood coagulates more quickly than white people's blood"). These misconceptions only serve to hinder the accurate application of appropriate health services and policies, impede the ability of health providers to make sound and informed medical judgments, and proliferate racial disparities in pain assessment and treatment.

Moreover, supposedly standardized metrics for medical diagnostics for certain health conditions also contain racial biases that result in Black people obtaining inaccurate assessments of their own health statuses. For example, the medical community relies on scientific equations that use a certain algorithm to determine a patient's kidney function. This [algorithm](#) continues to be based on an assumption that Black people have higher waste factor levels than other individuals that determine their kidney function. Although recent health authorities and providers have challenged this assumption, the fact remains that Black communities disproportionately experience chronic kidney disease and failure, which also suggests that Black patients are not obtaining accurate kidney function assessments.

The lack of equitable health care access, delivery, and coverage, combined with racialized poverty, segregation, environmental degradation, and discrimination undoubtedly all harm Black Americans and drive poorer health outcomes, which, in carceral settings, are only exacerbated.



SUBSTANCE USE, RACISM & THE CRIMINAL LEGAL SYSTEM

The systems that have perpetuated inequity in health care delivery and health outcomes have also largely relegated mental health and substance use treatment to the criminal legal system, which has destabilized communities and further fueled mass incarceration. The so called “War on Drugs” has created a landscape in which behaviors and the health conditions that accompany them are criminalized. The legacy of slavery, racism, segregation, and the idea that the color of one’s skin makes them inferior or different from other human beings impacts every sector of the health system.

It is important to note that in the last 40 years, the confluence of the deinstitutionalization of people with mental illness, the attendant lack of investment in community mental health treatment and punitive drug laws and sentencing that incarcerated people with substance use disorder fueled the machinery of the US jail and prison system. The federal and state policies that link the “criminal” to “behavioral health” have resulted in very few accessible options for high quality substance use or mental health treatment, for Black and brown people. In many jurisdictions around the country, the likely source of health care at some point for Black men was in a detention setting and there is ample evidence that people returning to communities after incarceration have poorer health outcomes, including higher overdose death rates, - and are even more likely to end up in the criminal legal system due to these untreated health conditions. Studies show that Black and Latino people are **more likely** than white people to be imprisoned after drug arrests than to be diverted into community-based SUD treatment. Data also shows **65%** of the prison population has an active substance use disorder yet despite this high percentage rate, only **24%** reported illicit substance use after the time of release. However, post-release substance use is associated with expected risk factors such as untreated substance use disorders, male gender, parole status, time elapsed between release and the first medical encounter, and housing status.

The CDC estimates that there were **more than 90,000** overdose deaths in 2020, the highest annual number of overdose deaths on record* and the largest single-year percentage increase in the past 20 years. (*The most recent CDC data indicates there were **over 100,000** overdose deaths in the 12-month period ending in April 2021.) A disproportionate percentage of the people who died due to overdose were Black and brown people. In Philadelphia, for example, the City Department of Health found that, while overdose deaths in the city rose **11%** in the first three quarters of 2020, deaths among Black Philadelphians increased by 40.3 percent and deaths among Latino Philadelphians increased by 5.9 percent. Deaths among white residents decreased by 7.3 percent during the same time period. According to a recent JAMA study, overdose-related cardiac arrests increased **42.1%** across the United States in 2020, with the largest increases occurring among Black (50.3%) and Latino (49.7%) patients.

Racial biases can inform treatment approaches, further worsening disparate health outcomes for Black people. For example, despite the existence of extremely effective treatment medications for opioid use disorder, numerous studies have demonstrated that it is much more difficult for Black people to access the gold standard for opioid use disorder care. One study found that Black patients have **77%** lower odds of receiving a buprenorphine prescription during an office visit for opioid use disorder. **Studies** have also found that Black people seeking addiction treatment experienced significant delays of four to five years in entering treatment as compared to white people, leading to poorer health and treatment outcomes, including increased overdose rates. Black patients who do engage in treatment are also **less likely to be retained in treatment**.

Efforts to strengthen health equity have largely left people who need substance use disorder services and care out of the discussion. This must change so that Black, brown, Indigenous, and other people of color receive the SUD care and supports they need and to prevent their entry into systems that prioritize punishment and surveillance.

"While overdose death rates have increased in every major demographic group in recent years, no group has seen a bigger increase than Black men."

-Pew Research Center

WOMEN'S HEALTH AND SUBSTANCE USE DISORDERS

Much of the knowledge of modern gynecology is based on experiments on Black enslaved [women](#). The health of women of color, especially Black women in the United States has frequently been overlooked or only thought of when impacting the ability to work or give birth. Even today the ["Black Superwoman"](#) complex persists and its dangerous effects on Black women's mind, body and spirit have been ignored.

Historically, when Black and brown women have required substance use disorder services, they were often met with [punitive responses instead of treatment](#), particularly during the height of the nation's "War on Drugs" period of the 1980s and 1990s. This reaction set a dangerous precedent to subsequently respond harshly, and we see it today in the treatment of pregnant women of color who have substance use disorders. The District of Columbia and more than 20 states currently have [laws](#) that require health care providers to report SUD during pregnancy to the state's child protective agency or to law enforcement. While white women with substance use disorders have reported facing state prosecutions and interference by the family regulation ("child welfare") system while they were pregnant, Black newborns were [four times more likely](#) than white newborns to be reported to child protective services at delivery despite Black and white women having used alcohol/drugs at similar rates.

It is not surprising then that even when presented with today's standardized healthcare treatments or scientific and authorized clinical trials governed by informed consent requirements, Black people in particular continue to have a lingering distrust of health care systems and public health policies. [See generally: ["More than Tuskegee: Understanding Mistrust about Research Participation,"](#) and ["National Institutes of Health Advocates for Diversity In Research."](#)] For individuals living with SUD (particularly women), that mistrust is validated by current laws and policies that do not support SUD treatment, but instead authorize punishment by the criminal legal or family regulation system. Furthermore, a recent Massachusetts General Hospital [study](#) indicated that Black and brown women living with opioid use disorder continue to be disproportionately less likely to receive or to consistently use any medication to treat their opioid use disorder during pregnancy compared to white women. [See also: ["An Alternative To Foster Care For Babies Born To Opioid-Addicted Moms."](#)]

The American College of Obstetricians and Gynecology, however, recommends that its providers ["have an ethical responsibility"](#) to pregnant women living with SUD to work to eliminate punitive laws that impact this population, as well as to ensure they are not separated from their children based on their SUD status and that they receive SUD treatment. Hence, obstetricians providing care to pregnant women living with SUD may find themselves in conflict with satisfying their ethical obligations to provide quality care, or upholding state laws that apply punitive penalties to their patients.

BLACK HARM REDUCTION: BUILDING EQUITY & ENDING STRUCTURAL RACISM IN DRUG POLICY

Despite the increasingly popular calls for justice reform at all levels, few mainstream critiques make an explicit link between criminal legal systems, health inequities, and racial injustice. Criminal justice and health care reform movements, absent a critical lens toward social injustices, essentially address consequences and symptoms rather than root causes. America's current sympathy with and focus on white opioid users is evident in the nation's drug courts which often favor white over Black and brown defendants. While many advocates and policymakers shy away from overt discussions of race in favor of easier and, in the short-term perhaps more effective arguments, such approaches may risk building upon, rather than dismantling, the root causes of the problems. One innovative approach to tackling these root causes is an expansion of the concept of Harm Reduction into one that focuses on Black Harm Reduction.

Harm reduction in the United States was born out of a justified distrust of punitive systems and policies by people who use drugs, the lack of supportive services available to people who use drugs, and the epidemic of HIV and other blood borne infections that permeated American society. Harm reduction aims to humanize people who use drugs and reject deeply entrenched stigma against drug users. While harm reduction strategies have played a critical role of reducing new HIV infections among injection drug users, from the beginning roots in the AIDS epidemic in the 1980s to the current opioid overdose epidemic, the significant contributions and priorities of Black people have too often been whitewashed and disregarded. For example, a significant focus of the nation's current approaches to the overdose epidemic centers on the misuse of prescription drugs which was related to a small proportion of deaths and that disproportionately impacted whites. In reality, the overdose crisis has been largely driven by the proliferation of synthetic opiates including manufactured fentanyl which is hundreds of times more potent than heroin. While attention has been focused on opiate addiction among white people and the narrative of "accidental addiction" across the country, the rate of overdose deaths in Black communities grew at a faster pace than among white, even in places where Black people were a significant minority of the population.

Black and brown communities have been and continue to be devastated by heroin, synthetic opioids (e.g., fentanyl), and polysubstance use (a combination of opioids with other drugs such as benzodiazepines, methamphetamine, and especially cocaine) yet few, if any, strategies have been implemented to address the needs of Black and brown people. Black and brown communities are less likely to have access to buprenorphine as an option to address opioid use disorder especially since the medication tends to be available in less diverse areas. Moreover, Black and brown individuals living with substance use disorder may only have access to methadone instead of the three FDA-approved medications to treat opioid use disorder.

As a result, Black Harm Reduction efforts became a means to incorporate strategies to eliminate structural racism in health care systems that overlook or minimize the health needs of Black and brown people living with SUD. Accordingly, the Legal Action Center and additional members of the burgeoning [Black Harm Reduction Network](#) planned and executed an inaugural Black Harm Reduction Pre-Conference on October 17, 2018, in New Orleans, Louisiana. The primary focus of this convening was to place the opioid-related overdose epidemic within the larger context of drug policy and elucidate the role(s) that a Black Harm Reduction Network can potentially play in addressing racism in the nation's policy response.

This convening was a pre-conference to the 12th bi-annual, National Harm Reduction Conference hosted by the Harm Reduction Coalition. The Pre-Conference was a gathering of over one hundred self-identified Black individuals directly affected by the "War on Drugs," advocates, harm reduction practitioners, criminal justice and health experts, policy officials, and funders – all of whom have a personal stake in transforming drug policy and addressing the disproportionate harms that Black communities face from drug policy.

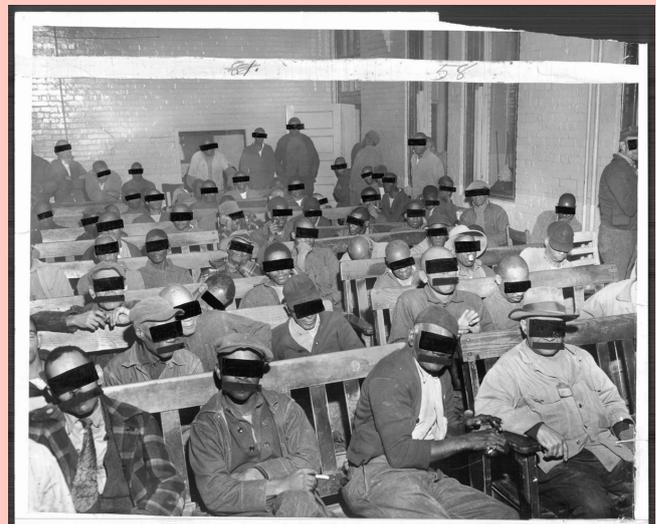
The over-arching goal of the Black Harm Reduction project has been two-fold. The first goal was, and still is, to establish a space in the harm reduction and drug policy reform movement where Black harm reductionists and other racial justice leaders can convene annually to center and discuss the needs of Black communities. The second broader goal was to promote a nationwide dialogue that centers racial equity with the harm reduction framework and elevates the needs, concerns, efforts, and accomplishments of Black people in the drug policy and harm reduction movement, as well as cuts across public health and social justice arenas. Black women and people in recovery have played vital roles in the planning and organizing the network.

The Network is being developed to bridge silos within drug policy, including building an explicit link between criminal legal systems, health inequities and racial injustice. This is especially critical considering the persistent racialized narrative of drug policy which implicitly, and explicitly, privilege white populations impacted by drug use and policy while vilifying and burdening Black people and whole communities. The Network, which is currently being incubated by the Legal Action Center, seeks to expand the concept of 'harm reduction' beyond mitigating the direct, immediate physical health threats of drug use -- to one that more broadly addresses the harms that society inflicts on Black and brown people impacted by drugs, (whether through policy, governmental or organizational practices, cultural attitudes, or interpersonal interactions).

MENTAL HEALTH, RACISM & THE CRIMINAL LEGAL SYSTEM

News accounts and current realities have shown that when Black people and other disenfranchised populations need mental health services, they instead usually receive particularly harsh treatment or none at all or are met with punitive and frequently deadly responses. [Data](#) shows that Black men exhibiting signs of mental illness or distress are at higher risk of police killing than white men. Take for instance, the tragic killings of [Daniel Prude](#), a 41 year-old man in Rochester, NY who in the midst of a mental health crisis was restrained and ultimately asphyxiated to death and [Walter Wallace, Jr.](#), a 27 year-old man in Philadelphia, PA who was met with lethal force and fatally shot 14 times by police even though his family had called for an ambulance and stated his bipolar diagnosis. These tragedies are all too common as "white men with mental illness are more likely to be given treatment, while Black men with similar behaviors are more likely to be [criminalized](#) for their actions" or even murdered.

The tragedy is not limited to police killings of Black people with mental illness, it also includes a deplorable history of inhumane "treatment" masquerading as an adequate health response. For example, in 1911, the [Crownsville State Hospital](#) (then known as the "Hospital for the Negro Insane") was established in Maryland as a response to the City of Baltimore's misguided efforts to help the "insane" and "unhygienic," as well as maintain Jim Crow segregation and eugenics principles. Both Black children and adults who were considered to be "unhealthy" were sent to Crownsville (their illnesses included genetic disorders, mental health issues, cerebral palsy, substance use disorders [e.g., alcohol], epilepsy, etc.). Along with Black people who had been convicted of serious crimes - Black people who resisted Jim Crow laws, advocated for equal rights for themselves, or merely existed were often charged with bogus crimes, diagnosed as mentally ill, and then sent to Crownsville. As was common in the United States during this time, Black and white people received different psychiatric diagnoses, which often portrayed whites in a more favorable light due to the perception of their superior intellect.



Photos showing Crownsville Hospital in the 1950s from the Baltimore Sun's "Darkroom"

Egregiously, patients at [Crownsville](#) were used to construct the facility, as well as maintain it by working in the laundry, making furniture and household items, tending to the crops, and other tasks. Moreover, Crownsville patients rarely received any appropriate treatment at the overcrowded and understaffed facility, and were instead forcibly administered anti-psychotic drugs and subjected to experiments such as lobotomies, injections of malaria and hepatitis, and pneumoencephalography (drilling holes in the skull and draining brain fluid). The justification for these horrific practices was that participation in these experiments was how patients could pay for their stay at Crownsville, since they were not going to be returned to their communities. The unclaimed bodies of those who died at Crownsville were either used for research and teaching purposes at area medical schools (with questionable, blank, or fabricated causes of death indicated on their autopsy reports and death certificates), or buried in unmarked graves on the grounds of Crownsville. [Note, in "[Race, Apology, and Public Memory at Maryland's Hospital for the 'Negro' Insane](#)," Zosha Stuckey explains: Blacks were viewed to be "more susceptible to mania than to depression or melancholia because whites supposedly had a higher developed intellect which made them more pensive and internally reflective; Black people were supposedly prone to outbursts, anger, and physical defiance, all embedded in an immoral lack of ability to care for the self." Also: In 1926, a Black man from New Jersey came to Maryland to marry a white woman in Elkton, Maryland, but the marriage license clerk refused to provide them with a license due to the difference in their races. When the man returned with a Black woman (by the same name as the white woman), he was charged with conspiracy and deemed to have a mental illness and sent to Crownsville. Similarly in 1932, a Black man who had been yelling in public in Baltimore was charged with disorderly conduct and committed to Crownsville. In addition, in 1961, civil rights activists were sent to Crownsville after engaging in civil disobedience. 'The Elkton Three' (Wallace Nelson, Juanita Nelson, and Rose Robinson) were arrested when trying to sit down and eat at Bar H Chuck House near Elkton, Maryland.]

In 1963, Crownsville was integrated, and its first Black superintendent was appointed the next year. During the mid-1960s, there were improvements in the treatment of people living with mental health issues, and the increased use of outpatient facilities also led to a [decline](#) of Crownsville's patient population. While Crownsville closed in 2004, and no such facilities currently exist, Crownsville's painful legacy of brutal treatment of Black individuals remains and has persisted in other iterations as we see daily Black Americans with mental illness mistreated, neglected, arrested, incarcerated and killed instead of treated, supported, and cared for.

POLICY RECOMMENDATIONS

How to Truly Move Forward & Make Lasting Change

It is crucial that all efforts to dismantle systemic racism within our health care system are coupled with reforms to our criminal legal system as the two intersect in a multitude of ways. We start by promoting a health-first rather than punitive approach to responding to all individuals in mental or physical distress. Furthermore, sustainable reform of unjust practices and policies cannot be achieved without the expansion and enhancement of quality community-based mental health and substance use disorder care and supports.

Below, we outline specific recommendations to reduce mass incarceration, increase restorative and rehabilitative efforts, improve access to care, eliminate disparities, and reduce the harms Black individuals and other marginalized groups disproportionately endure.

To Dismantle Policies that Drive Mass Criminalization and Incarceration of Black and Brown People and Other Marginalized Groups:

- Significantly reduce the number of people detained in local jails and detention facilities by:
 - Ending cash bail and other unfair and racially discriminatory policies and practices that cause over-incarceration of Black and brown and economically disadvantaged people.
 - Reducing the length of unnecessarily long minimum sentencing guidelines.
 - Expanding the use and availability of alternatives to arrest or incarceration for all but the most serious offenses.
 - Expanding the use of and eligibility for early release programs (including compassionate release).
- Provide health care as the primary resort wherever possible to the substantial percentage of people now being arrested who have SUD, mental health, and other illnesses by shifting resources and responsibility for first response from law enforcement to community-based equitable health interventions.
- Dramatically reduce the number of people who are on community supervision by reducing the amount of time they are supervised and prohibit incarceration based on technical violations of supervision conditions.

- Acknowledge the history of slavery and the racist unpinning of U.S. policing; and establish federal and state laws and policies governing police culture and practice including those focused on use of force, police accountability, racial profiling, militarization, data collection, and training.
- Reinvest and prioritize distribution of money saved from a reduced policing footprint to strengthen the community infrastructure of affordable, high quality health care, education, housing, and employment opportunities.
- Eliminate federal, state, and local barriers and strengthen access to housing, education, employment, public benefits, and voting for individuals with arrest and conviction records by:
 - Funding a dramatic expansion of the full continuum of housing models, including supportive housing, those that prioritize housing first, and recovery housing, to be flexible to accommodate people's specific needs.
 - Swiftly implementing the new law that restores Pell Grant eligibility to incarcerated people.
 - Instituting fair hiring policies.
 - Achieving clean slate initiatives that automate the clearing of records for as many people as possible.
 - Repealing the drug felony ban on SNAP and TANF benefits.
 - Eliminating disenfranchisement laws.

To Prioritize Person-Centered and Defined Rehabilitation, Restoration, and Recovery through Alternatives to Arrest, Prosecution, Incarceration, and Supervision:

- Bring to scale community initiatives that divert individuals away from the criminal legal system at every stage, incentivizing diversion as early as possible (pre-booking).
- Fund and bring to scale use of mobile crisis teams, led by, and staffed with teams of mental health and SUD experts including people with lived experience, to respond 24/7 to emergency calls related to people experiencing a health crisis.
- Make routine, through booking and other processes, screening for SUD, mental health conditions and health care needs, and ensure people throughout the criminal legal system receive clinically appropriate mental health and SUD services and medications by:
 - Requiring and funding education and training of key leadership and line staff throughout the criminal legal system on addiction, mental illness, and effective treatment and recovery services and medications.
 - Requiring law enforcement and corrections policies and practices reflect an understanding of the nature of the diseases of addiction and mental illness and evidence-based interventions.
 - Educating people in the criminal legal system about federal and state confidentiality laws that protect the privacy of their mental and SUD patient records to encourage adherence to treatment to achieve recovery; and train mental health and SUD providers about how to explain and apply these rights to and for their patients.

To Strengthen Continuity of Care for Individuals Leaving Incarceration or Moving within the Criminal Legal System:

- Promote continuous, uninterrupted Medicaid coverage and allow Medicaid to finance health care (including mental health and SUD community-based in-reach services/medication induction) prior to an individual's release, in their last 30 days of incarceration, as proposed in the federal Medicaid Reentry Act.
 - Require Medicaid eligibility screening and enrollment throughout the criminal legal system.
 - All states should develop systems to reactivate Medicaid 30 days before an eligible individual is released from prison
 - For eligible individuals who will be serving a term of less than one year, Medicaid coverage should be activated upon admission
 - Conduct thorough reentry planning and pre-release advocacy to assist people in applying for public benefits, housing, and other needed supports.

To Strengthen Availability, Coverage of, and Access to Mental Health and SUD Care:

- Build the infrastructure of community-based mental health and SUD care so that there is capacity in every locality (particularly under-resourced and low-income communities) to offer the full range of evidence-based culturally and linguistically responsive treatment services on demand, including crisis interventions, provision of medication, and recovery support services (including those provided by peers).
- Educate and train primary care providers about addressing the health needs and privacy rights of people with mental health and SUD histories using innovative care delivery models and funding incentives.
- Make permanent regulatory flexibilities extended to SUD and mental health care providers in response to the COVID pandemic such as telehealth.
- Ensure full coverage for SUD and mental health benefits in Medicaid, Medicare, and private insurance, in compliance with federal and state mental health and SUD parity laws and the Affordable Care Act and strengthen network adequacy and provider reimbursement rates to improve access to care in all communities.
- Significantly boost investment of federal and state discretionary funds to improve coverage and access to mental health and SUD care.
- Expand Medicaid eligibility in all states to reduce the number of uninsured people who need mental health and SUD care, prohibit policies aimed at restricting coverage (work requirements, drug testing, etc.), and utilize Medicaid waivers and initiatives to support innovation and improve the ability to seamlessly meet co-occurring physical, mental and SUD care needs.
- Ensure directly impacted people are meaningfully included and consulted as policies governing access to care are developed and implemented.
- Protect SUD patient confidentiality in the face of continued criminalization of the health condition of addiction and ensuing discrimination.

To Eliminate Racial Disparities in Mental Health, SUD, and Physical Health Care:

- Require health data collection, analysis, and reporting by race, ethnicity, sex, primary language, sexual orientation, gender identity, disability status, age, and socioeconomic status.
- Build and sustain a diverse, culturally competent workforce and ensure availability (including in under-resourced communities) of culturally and linguistically appropriate high-quality evidence-based SUD, mental health, and physical health care.
- Utilize financial and other incentives to encourage providers to successfully engage and retain in care Black, brown and other people of color and to improve patient outcomes.
- Protect and strengthen safety net programming and settings, including Medicaid, SNAP, TANF, SSI/DI, housing assistance, block grants, Title X Family Planning Clinics, and Federally Qualified Health Centers provided through HHS and other federal agencies.

To Reduce the Harms Associated with Drug Use:

- Expand the use of syringe exchange, including peer-delivered syringe services.
- Support, including through federal policy reform, and fund overdose prevention sites.
- Advocate for policies in health and human services that incentivize improving an individual's health and well-being regardless of whether they intend to stop all drug use.
- Prevent overdose deaths by expanding as broadly as possible the availability of Narcan throughout the community and link people to SUD care, including services utilizing addiction medications, and peer services, immediately following an overdose.
- Support harm reduction approaches to ensure that people using drugs and those with a history of drug use have a meaningful voice in designing the programs and policies intended to serve them and improve their health.
- Support and expand harm reduction programming and principles that encompass the intersectional experiences of Black people, particularly Black women, Black trans people, and Black people with disabilities

CONCLUSION

Racist and discriminatory policies and practices for far too long have been deeply rooted within the health care and criminal legal systems, which have starkly impacted Black and brown people. As if racial disparities did not already plague and have a dire effect on the health care and criminal legal systems, the COVID-19 pandemic has further amplified and brought these persistent racial disparities to the forefront. As such, now is a time of paramount importance to eradicate inequities within these systems not only to ensure equitable access and responses to mental health, SUD, and physical health care treatment, but also to ensure that individuals are no longer criminalized due to these health issues, nor denied quality health care within the legal system to become well. The Legal Action Center's No Health = No Justice campaign will continue working to foster fundamental changes in the health and legal systems by "Unchaining Civil Rights through Health Reform" and promoting policies to end systemic racism and advance civil rights.

