VOLUME 24

COLUMBIA SOCIAL WORK REVIEW

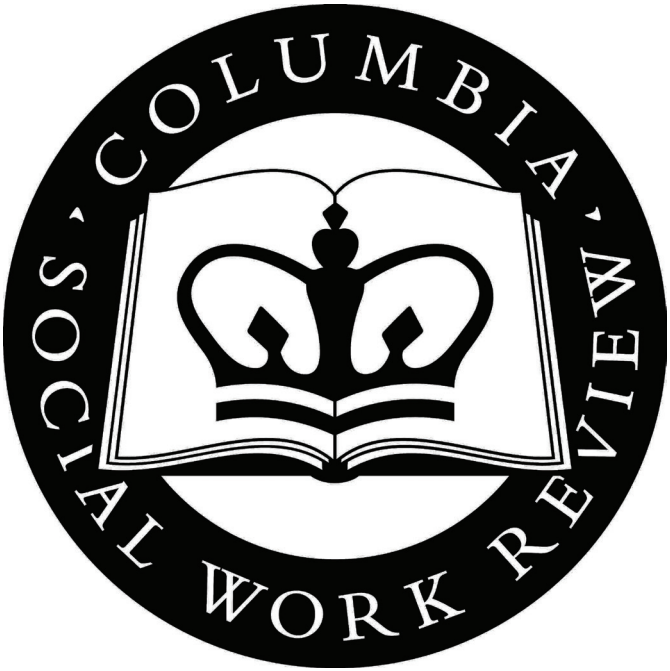
SPRING 2026

COLUMBIA
SOCIAL WORK REVIEW

Columbia School of Social Work
1255 Amsterdam Avenue | New York, NY 10027
Volume XXIV ©2026
https://journals.library.columbia.edu/index.php/cswr/

COLUMBIA SOCIAL WORK REVIEW

The mission of the *Columbia Social Work Review* is to provide a forum for the exchange of innovative ideas that integrate social work practice, education, research, and theory from the perspective of social work students. Founded by students at Columbia University School of Social Work in 2003 as the Columbia University Journal of Student Social Work, this academic journal provides an opportunity for students and scholars in the field of social work to share their unique experiences and perspectives with fellow students, faculty, and the larger social work community.



SPRING 2026

EDITORIAL BOARD 2025-2026

ACKNOWLEDGEMENTS

The *Columbia Social Work Review* & *Amsterdam* are collaborative endeavors that publish social work centric scholarship for the Columbia School of Social Work community and beyond.

We are deeply grateful to everyone who made this year's articles and posts possible.

To our authors, thank you for submitting your meaningful and provocative ideas and scholarship to our journal and blog! We value your trust in our publications and we're honored to amplify your voices and contributions to social work practice and scholarship, as well as your calls for furthering social justice in our communities and world.

To our editorial staff, thank you for bringing your enthusiasm, skills, and support to our authors and our organization! We appreciate your dedication to advancing social work scholarship and practice, and the opportunity to learn, grow, and work together this year. We hope you see how your contributions matter and continue to pursue editorial opportunities in the future.

To our faculty advisor, Susan Witte, we are eternally grateful for your energy, dedication, and indispensable support of the Review and Amsterdam! All the ways you advocate on behalf of students, scholarship, and social justice make the Review and Amsterdam possible. Thank you from the bottom of our hearts for all that you do!

To our Advisory Board, thank you for your commitment to consulting on the Review's and Amsterdam's initiatives and

for the ways that you reinforce our endeavors. We value your relationships, contributions, and time. Special mention to: Adam Pellegrini and Kae Bara Kratcha for their invaluable custom workshops for our editors, Esther Jackson and our Columbia Libraries Publishing partners for their support in navigating the online university publication process, and to Ana Angeles and Allison Aguilar for their support with all things student organization and finance-related.

To our copy editor Julie Hersh, and our layout and design editor Savannah Brogan, thank you so much for your patience, commitment, and expertise! We deeply value your precision, skill, and all the ways you support our publications.

To our publisher Thomas Group Printing, thank you Glen and team so much for helping us navigate the waters of print publishing and making our physical edition shine on the shelf.

We also thank Danielle Lennon for her contributions to the strategic direction of the Review and Amsterdam in the summer and early fall of 2025.

Please enjoy this year's Review and thank you for supporting our authors and work!

TABLE OF CONTENTS

REFLECTIONS FROM THE EDITORS-IN-CHIEF: EMILY CARCHIA, EZZIE PEREZ, & SARAH THOMAN

2025-2026 has been a watershed year for Columbia University and the School of Social Work, echoing ongoing and significant social, political, and economic changes nationally and globally.

Here at the *Columbia Social Work Review*, we remain committed to amplifying the vital and timely voices of students and alums on a range of social work and social justice issues. As such, a significant restructuring of the Review's Editorial Board and Advisory Board this year helped align our mission and goals, while fostering organizational longevity.

Our combined, collaborative Editor-in-Chief team across the Review and Amsterdam decenters colonialism, hierarchy, and builds community. It also elevates The Amsterdam, our blog featuring contemporary, short-form, and creative think pieces, and enables more authors to engage with our audiences in important and meaningful ways, particularly at a time when knowledge, access, and connection continue to be curtailed. In addition, we also instituted content specific leadership roles among our Editorial Board and furthered relationships across Review and Amsterdam staff promoting development opportunities and unity. Furthermore, refreshing our Advisory Board this year, poises the Review and Amsterdam to further the School of Social Work's mission and vision, and to make decisions in concert with important campus partners to ensure that both publications enrich discourse and practice for years to come.

This year's Review represents a range of content within the social work zeitgeist. Authors take us across the globe with a critical look towards the intergenerational toll of bonded labor practices in India, and call for change within mental health policy and practices in New York's involuntary psychiatric

admissions, as well as in how we diagnose and support the mental health and developmental needs of African American boys and youth. We also learn of needed reform related to the care and (mis)treatment of pregnant, incarcerated women in the U.S. Each of these pieces asks us to face uncomfortable, necessary truths and harness the hope, skills, stamina, and advocacy within our social work toolkit to further essential inquiries and steps towards justice.

This year, we aimed to build bridges and encourage growth and change within the Review and Amsterdam. We wanted to offer both a platform and a sandbox - a place where important conversations are raised, while also leaving room for creativity, learning, and connection.

It's been our honor and privilege to steward the Review and Amsterdam into a new era of scholarship and advocacy. The power of the pen (or computer keystroke!) has never been more needed or timely. In addition, the Review and Amsterdam would not be possible without the time and dedication of its authors and editors and we continuously thank those who have helped us along the way including our faculty advisor Dr. Witte, our Advisory Board, and campus partners.

We hope whatever influence we may have had on the *Columbia Social Work Review* and *Amsterdam* will inspire more creativity, collaboration, and interdisciplinary work for a continued holistic and community driven approach to social work and social justice for all.

In community and gratitude,

EMILY CARCHIA
EDITOR-IN-CHIEF, *2025-2026*
COLUMBIA SOCIAL WORK REVIEW

EZZIE PEREZ
EDITOR-IN-CHIEF, *2025-2026*
COLUMBIA SOCIAL WORK REVIEW

SARAH THOMAN
EDITOR-IN-CHIEF, *2025-2026*
COLUMBIA SOCIAL WORK REVIEW

THE PLIGHT OF BONDED LABORERS IN INDIA: EXPERIENCING EXPLOITATION AND BONDAGE IN THE BRICK-KILN INDUSTRY

NEHA MALLICK

NEHA MALLICK

BIO

Neha Mallick is a PhD student in the Social Policy and Policy Analysis concentration at the Columbia School of Social Work. Her research focuses on migration, bureaucracy, and social policy in India. Building on her experience in policy practice, her collaboration with policymakers, and her direct work with communities, she examines how caste, informality, and uneven implementation together shape marginalized workers' access to rights and protections.

INSPIRATION

This paper was inspired by my longstanding interest in labor exploitation, migration, and the limits of policy implementation in India. In particular, bonded labor in brick kilns is especially urgent because it reveals how deeply caste and poverty remain tied to contemporary forms of unfreedom. This connection led me to write about the issue, as it challenges the comforting idea that exploitation survives only where laws are absent. Here, the law exists, but enforcement, rehabilitation, and accountability remain deeply uneven. That contradiction stayed with me throughout the writing process and further motivated my research. I was also driven by the need to make this issue more visible, both within India and internationally, as bonded labor in brick kilns often remains hidden behind the language of informality and development. Ultimately, my hope is that readers come away understanding that this is not an isolated labor problem, but a structural and moral failure that demands stronger enforcement, survivor-centered rehabilitation, and sustained public attention.

ABSTRACT

Atrocities in the form of forced labor, forced servile marriage, debt bondage, and human trafficking, known as modern-day slavery, continue to be used to exploit the most vulnerable. Despite efforts to curb these atrocities, their continued presence reflects deeply entrenched social and economic inequalities. Unfortunately, in India, like in many other South Asian countries, these atrocities are rooted in caste hierarchies, colonial policies, and feudal land ownership practices that continue to shape contemporary realities. Around the 1970s, India made efforts to mitigate such incidents by enacting the Bonded Labour System (Abolition) Act, 1976, and designed targeted policies such as the central sector scheme for rehabilitation. At the same time, civil society organizations emerged as the fourth pillar, increasing the system's accountability. In this essay, we delve deeper into understanding why one of the most exploitative forms of modern slavery, bonded labor, persists in India and how policies have failed to combat such atrocities.

Keywords: bonded labor, modern slavery, India, caste hierarchy, Bonded Labour System (Abolition) Act 1976, human trafficking, social inequality, rehabilitation policies, civil society

THE PLIGHT OF BONDED LABORERS IN INDIA: EXPERIENCING EXPLOITATION AND BONDAGE IN THE BRICK-KILN INDUSTRY

Despite India's status as the world's largest democracy and its remarkable economic growth and modernization, the country continues to grapple with deep-seated atrocities. This includes bonded labor, a legacy drawn from India's colonial and feudal past that has trapped millions of disadvantaged

individuals in a cycle of exploitation. Reports indicate that South Asia, particularly Afghanistan, Pakistan, India, and Nepal, accounts for about 89% of the world's bonded labor, with 15% estimated to be in brick kilns (Kara, 2009). The 2023 Global Slavery Index Report states that approximately 11 million people in India are subjected to bonded labor, entangled in debt bondage across generations (Walk Free, 2023). This is the consequence of a practice rooted in the caste system and exacerbated by feudal agrarian relations and colonialism (Srivastava, 2005). Despite the enactment of the Bonded Labour System (Abolition) Act (BLSA) of 1976, these issues have persisted within the current social structure, worsened by economic inequalities.

The Indian brick-kiln industry, the second-largest brick producer globally, starkly illustrates this exploitation. Laborers, primarily men, women, and children from Scheduled Castes (SCs, or Dalits)[1] and Scheduled Tribes (STs, or Adivasis),[2] who are usually landless, impoverished, and lacking agency to change their circumstances, are trapped in this cycle (Srivastava, 2005). This reflects not just an economic problem but also a social system characterized by caste-based stratification.

The formation of BLSA in 1976 and the central sector scheme for the rehabilitation of bonded laborers, alongside

1 The Constitution of India recognizes certain castes, races, and tribal groups as Scheduled Castes and Scheduled Tribes under Articles 341 and 342. Scheduled Castes are those castes/communities that suffered from the age-old practice of untouchability. They are subjected to geographical isolation and need special consideration for safeguarding their interests.

2 Scheduled Tribes are people belonging to tribes. They often live in forests, although there are some nomadic tribes as well. As these people are usually not a part of any organized religion, they are commonly considered outcastes. Socially they have their own traditions, dressing styles, and food habits, and a distinguished culture.

other welfare schemes (wage employment, food security, social security, urban poverty alleviation), were designed to address both the demand and supply-side challenges of the bonded labor system. However, progress was limited to the exit-only level, focusing on identifying, releasing, and rehabilitating laborers, while the structural levels of bondage persisted without much change. Civil society and voluntary organizations worked in tandem to identify and mitigate the incidence by ensuring greater accountability among government stakeholders, contractors, and brick-kiln owners. However, this remains a complex, multidimensional challenge.

Delving deeper, this paper examines the complex interplay of caste dynamics, economic inequalities, weak law enforcement, and poor policy implementation that perpetuates this exploitative system in the brick-kiln industry in India. By exploring the historical roots of this issue alongside current realities, this paper will shed light on why bonded labor in brick kilns persists even today in the world's largest democracy.

HISTORICAL IMPACT AND FACTORS SHAPING THE CURRENT STATE

India's caste system, a social stratification system that is hereditary by nature, positions an individual's social status based on birth and family background rather than personal merit. This system has long supported most forms of slavery. The *Manu Smriti*,[3] written between 200 B.C.E. and 200 C.E., established rigid social hierarchies based on the varna system, which enforced stratification and inequality. Rooted in this stratification, the caste-based system flourished during

3 Traditionally the most authoritative of the books of the Hindu code (Dharma-shastra) in India. It is attributed to the legendary first man and lawgiver, Manu. The received text dates from circa 100 C.E.

medieval India and persisted under British colonial India.

THE COLONIAL PERIOD

Britain led global abolitionist efforts in the 18th and 19th centuries, abolishing chattel slavery in the British Empire through the Slave Trade Abolition Act of 1807 and the Slavery Abolition Act of 1833. But at the same time, the British Raj's economic and legal policies significantly expanded slavery in India. This expansion took various forms, including caste-based debt bondage, laborers' movements to fuel the growth of the textile and agricultural sectors, and exploitative land revenue policies. Bonded labor in particular thrived under contracts and credit advances (Kara, 2012).

Repeated famines in the early 1700s had forced thousands of landless people into extreme poverty and vulnerability. This situation worsened with the introduction of the Zamindari system by the British through the Bengal Permanent Settlement Regulation (1793) and the Madras Permanent Settlement Regulation (1802), which turned millions of peasants into tenants-at-will, exposing them to severe exploitation by feudal landlords (Mishra, 2011). This system persisted for over 150 years, created, supported, and enforced by the colonial rulers. The inevitable consequences of this system included rack renting, absentee landlordism, poverty, indebtedness, and bondage. Over time, the system of bonded labor pushed itself into the twenty-first century, where these workers, beyond income loss, carried generational trauma and faced continuous social exclusion. These factors culminated in centuries of exploitation of an entire subclass of disenfranchised, low-caste, and utterly deprived workers (Kara, 2012).

The atrocities prevailed even after India freed itself from British rule in 1947. Aggravated by caste-based discrimination,

bonded labor persisted. Acknowledging the presence of this atrocity, policymakers enshrined fundamental rights[4] in Article 23 of the Constitution of India, which aimed to abolish forced labor. Simultaneously, India ratified the International Labour Organization's Forced Labor Convention on November 30, 1954. While these legislative and policy efforts were made with good intentions, their implementation failed to tackle the issue comprehensively, allowing the problem to persist in a new shape. This was evident in the increasing number of bonded labor cases. Many state governments enacted legislation to curb these cases, which eventually led to the first national legislation to mitigate bonded labor.

PASSAGE AND IMPLEMENTATION OF THE BLSA

The BLSA, passed in 1976, was a pivotal legislative step toward ending bonded labor. The BLSA was drafted during India's Emergency period (1975–1977),[5] when then Prime Minister Indira Gandhi prioritized its abolition (Mishra, 2011). Following a Labor Ministry conference on July 19, 1975, and subsequent drafting of an ordinance, the law was enacted in 1976. The BLSA aimed to abolish bonded labor, free those trapped in the system, and prevent its recurrence. The legislation was a beacon of hope, signaling the government's commitment to ending this exploitative practice.

4 The Indian Constitution offers all citizens, individually and collectively, some basic freedoms—equality, dignity, and liberty. These are guaranteed in the Constitution in the form of six broad categories of fundamental rights, which are justifiable. Part III, Articles 12 to 35 of the Constitution deal with fundamental rights.

5 Between June 25, 1975, and March 21, 1977, India was placed under a state of emergency under Article 352 of the Constitution. It was declared on a backdrop of mounting political unrest and judicial developments that shook the legitimacy of the ruling leadership. Constitutional safeguards were systematically suspended.

While the legislation was drafted at the national level, its success could only be ensured through complete accountability at the local level. Under section 13 of the BLSA, vigilance committees were to be constituted at the subdivisional and district levels[6] under the chairmanship of the district magistrate (DM)[7] and subdivisional magistrate (SDM). Each committee aimed to identify the incidence of bonded labor systems in that region, rescue bonded workers and issue release certificates, provide economic and social rehabilitation to freed workers, and coordinate with rural banks and cooperative societies to augment rehabilitation efforts.

Despite the optimism surrounding the BLSA, its implementation faced significant challenges, particularly in identifying and rehabilitating bonded laborers. Official mechanisms for identifying bonded laborers proved ineffective, and efforts to rehabilitate freed laborers failed to comprehensively address their needs (Samonova, 2019). Further, several state governments refused to acknowledge the presence of bonded labor in their regions and thus never formed vigilance committees. This limited the act's ability to achieve its intended outcomes and showed gaps in enforcement and support structures. Further, it highlighted the government's apathy toward those affected by the bonded labor system, particularly where the most marginalized suffered—thus maintaining the status quo.

Following the enactment of this legislation, in May 1978 a centrally sponsored scheme was introduced that provided $48 to rehabilitate each bonded worker. The scheme was

6 A district is a territorial division for administrative, judicial, electoral, and other purposes, equivalent to a county in the United States.

7 A district magistrate is an Indian Administrative Service officer who is the seniormost executive magistrate and chief in charge of general administration of a district in India.

expected to be implemented through land-based, non-land-based, and art, craft, or skills–based programs. The rehabilitation process was supposed to be consistent with the fundamental principles of social justice, which served as the basis for rehabilitating the freed laborers.

PUBLIC INTEREST LITIGATION AND JUDICIAL ACTIVISM

While the legislation and policies were implemented, structural gaps within them led voluntary organizations and civil societies to use the judiciary to hold the union and state governments accountable. This resulted in some landmark judgments.

From 1976, with the formulation of BLSA, to 2000, the apex court of India, the Supreme Court, delivered 23 judgments on various aspects of the law relating to forced and bonded labor. Among them, two seminal cases of 1982 and 1983 laid the grounds for addressing the law's critical implementation challenges.

- **1982: People's Union for Democratic Rights v. Union of India and Others.** The so-called Asiad Construction Worker case established three crucial legal principles in the fight against bonded labor.
    - First, it underscored the role of public-interest litigation in enforcing the fundamental rights of India's poorest citizens.
    - Second, it affirmed that bonded labor constitutes forced labor as defined by Article 23 of the Constitution of India.
    - Third, it stated that any worker paid below the government-stipulated minimum wage should be considered a forced laborer.

- **1983: Bandhua Mukti Morcha (Bonded Labor Liberation Front) v. Union of India and Others** (Giordano, 1986). This landmark case focused on the issue of bonded labor and the implementation of the BLSA, while examining the state's role in identifying, releasing, and rehabilitating bonded laborers to ensure the protection of their fundamental rights. The guidelines from this case set basic principles that the Supreme Court emphasized should be considered while formulating any rehabilitative program for released bonded laborers. The case reinforced three key points:
    - The state must identify, release, and rehabilitate bonded laborers, upholding their fundamental rights under Articles 21 and 23.
    - Failure to implement the act would violate the fundamental rights of bonded laborers and direct the state to take immediate action.
    - The state must acknowledge the importance of judicial activism in safeguarding the rights of marginalized and vulnerable populations. The state must submit periodic reports on the measures taken to enforce the BLSA.

While this shows the recurring efforts to mitigate exploitation, there are a myriad of reasons for the ongoing failure to implement the BLSA. Forces impacting the Indian government's inability to eliminate bonded labor include corruption; an apathetic bureaucracy that poorly understands and implements the law; the district magistrate and vigilance committees' inability to identify, free, and rehabilitate bonded laborers; and insufficient prosecution of the crime. These structural gaps are further aggravated because powerful brick-kiln owners maintain high control over local policies and law enforcement. This has created challenges for government

officials seeking to intervene against labor exploitation in brick kilns (Kara, 2012). Unfortunately, these gaps and the policies meant to address them are interwoven and mutually reinforcing, so any piecemeal solution, such as more rescues or more committees on paper, will not dismantle the system. As a result, the cycle of bonded labor exploitation persists.

PREVALENCE OF BONDED LABOR IN INDIA'S BRICK-KILN INDUSTRY

With an annual production of 233 billion bricks, India ranks second globally in brick production, behind China. The unorganized brick-kiln industry operates nationwide, predominantly in rural areas, employing 10 to 23 million migrant workers (Zaffar, 2024). This industry is pillared on a caste-based hierarchical division of labor framed under the guise of "skill-based labor." Work responsibilities in this industry are primarily predetermined by caste. Brick molders (pathera), responsible for tasks such as digging and molding clay, typically belong to the lowest castes, constituting Dalits and Adivasis, with no opportunity for upward mobility. Brick molding accounts for approximately 70% of total labor in brick kilns, and studies show that 90% of patheras belong to SC or ST communities. Other roles in the industry, such as loaders (kumar/bharaiwala), stackers (beldar), arrangers, and firemen (jalaiwala), are often assigned to individuals from marginally higher castes (Anti-Slavery International & Volunteers for Social Justice, 2017).

Rapid urbanization and construction have intensified labor demand in the brick-kiln industry. In India, the construction industry is regarded as one of the most important sectors of the economy, as it provides about 35 million jobs and adds almost 9% to the country's gross domestic product (GDP) (Jha & Kumar, 2025). The demand for infrastructure and

services will continue to grow, as India's towns and cities are projected to swell by an additional 404 million people by 2050 (Garcia, 2023). For the construction industry to remain sustainable, brick production will also need to increase.

ECONOMIC EXPLOITATION BY KILN OWNERS

To maximize profit within this industry, brick-kiln owners often resort to exploitative practices that reinforce existing caste dynamics. Jamadars (subcontractors/middlemen), often from the same villages as the workers, exploit individuals with limited livelihood options. These middlemen recruit laborers of marginalized castes from rural areas by offering enticing packages, including monetary advances, transportation, and assurances of wages, food, and shelter. However, due to widespread illiteracy among these workers, agreements are usually verbal or signed with a thumbprint, making them legally ambiguous. These contracts bind not only the male workers but also their families, creating a system of generational bondage.

Wages are often withheld for entire seasons and loans are provided at the start of work periods so that workers are immediately in debt. This system of advances, which ultimately perpetuates debt, is beneficial to brick-kiln owners because it ensnares a captive labor force throughout the brick-making season. This further keeps wages heavily depressed and helps kiln owners avoid wage competition, thereby boosting their profits and competitiveness (Kara 2012). During the brick-making season, which lasts from October to May, after the monsoon (which is from June to September), workers often receive no payment until the season ends. This delay forces workers to seek additional advances to meet subsistence needs, perpetuating their indebtedness.

Furthermore, women and children actively participate in the labor process, yet their contributions are frequently unpaid and unacknowledged, exacerbating the systemic exploitation within the industry (Anti-Slavery International & Volunteers for Social Justice, 2017).

GOVERNMENTAL REHABILITATION ATTEMPTS

Given the persistent nature of this exploitation, the government has repeatedly announced initiatives to curb it across various settings. In July 2016, the Union Government of India announced a 15-year plan to achieve "total abolition of bonded labor" by 2030, aiming to identify, release, and rehabilitate 18.4 million bonded laborers. Recent government data show that between 1978 and January 2023, 315,302 people were freed from bonded labor, of whom 94% were successfully rehabilitated (Standing Committee on Labour, Textiles and Skill Development, 2022). However, the latest Parliamentary Standing Committee report, 2025, states that since 1978, 297,038 bonded laborers have been rescued—highlighting inconsistencies in the government's data reporting (Standing Committee on Labour, Textiles and Skill Development, 2025).

A possible reason for this inconsistency, as unofficially reported by an official from the labor ministry, is the difference in the use of the terms "rescued" and "rehabilitated." While rescue refers to the release of bonded laborers, rehabilitation implies providing post-rescue support. Given that the rehabilitation scheme is demand-driven rather than based on fixed targets, rehabilitation often proceeds more slowly, which helps explain why the number of people rescued differs from the number rehabilitated (Paliath, 2025). At its current rate, India will miss its objective of identifying, releasing, and rehabilitating 98% of bonded laborers.

In addition to technical flaws in the policy design, the continued poor implementation of the policy to curb bonded labor has been a key reason that the Indian government has consistently lagged in eliminating bonded labor. Similarly, the Central Sector Scheme for Rehabilitation of Bonded Laborers of 2016 has encountered significant challenges stemming from design flaws. One major issue is that the payment of full cash assistance to bonded laborers is conditionally linked to the conviction of offenders. This requirement has severely limited the expansion of allocations within the scheme, as convictions are rare. This problematic design creates a substantial obstacle to rehabilitation (Socio-Economic and Educational Development Society [SEEDS], 2009). To address this issue, many have proposed that cash assistance be provided to bonded laborers immediately upon issuance of the subdivisional magistrate's release certificate, without waiting for offenders to be convicted. The release certificate should be considered adequate proof of bondage (Khan, 2018).

Furthermore, this 2016 scheme did not increase funding for crucial components such as awareness programs and evaluation studies. This lack of financial support also extends to other critical areas (Khan, 2018). For instance, vigilance committees, which are vital to addressing bonded labor issues, often cannot function due to constraints such as insufficient funding, limited training and capacity-building opportunities, and inadequate infrastructure. These systemic shortcomings have a cascading effect on the identification, release, and rehabilitation of bonded laborers. The current approach fails to provide timely, effective support to those who need it most, underscoring the urgent need for comprehensive reforms to the scheme's design and implementation.

The present state of bonded workers is precarious. The state-crafted frameworks are nearly impossible to implement efficiently, making it difficult for workers to access relief and funds. This situation is further worsened by the need for workers to make multiple court visits and endure threats from employers. If they do escape bonded labor, the alternative livelihood opportunities are limited.

Bonded labor in the brick-kiln industry demands urgent attention due to its widespread prevalence and profound socioeconomic implications. Despite being prohibited under international law and national legislation, bonded labor remains highly prevalent, particularly in these kilns.

WIDER ECONOMIC IMPLICATIONS OF BONDED LABOR

The brick-kiln industry's reliance on bonded labor stems from the arduous nature of brick-making, its low wages, and its colonial lineage. Workers, often entire families, are trapped in a cycle of debt bondage, forced to work long hours under hazardous conditions to repay loans taken from their employers. This system of advances effectively binds laborers to their workplace, making it extremely difficult for them to leave or seek alternate employment. The average workweek exceeds 70 hours. Laborers perform repetitive tasks in harsh environmental conditions, which exposes them to health risks and physical strain (Anti-Slavery International & Volunteers for Social Justice, 2017). Furthermore, when the debtor dies, their debt is transferred to their next of kin, such as their children or spouse. This intergenerational transfer of debts is common among brick kilns across India (Mitra & Valette, 2017).

The impact of bonded labor extends beyond the individual worker, affecting entire families and communities. Children are particularly vulnerable, often forced to work alongside

their parents to help repay family debts. A health study on child labor estimated that brick kilns employ about 1.7 million children in India (International Labour Organization [ILO], 2014). This practice not only violates children's rights but also perpetuates intergenerational cycles of poverty by denying children access to education and opportunities to develop their skills. The lack of education and transferable skills further entrenches these families in the brick-kiln industry, making it nearly impossible to break free from the cycle of bondage.

The economic implications of bonded labor in brick kilns are significant. Workers often earn less than the extreme poverty threshold of $2.19 per day, with wages frequently falling below the legal minimum wage (Anti-Slavery International & Volunteers for Social Justice, 2017). As noted earlier, the payment system in brick kilns is designed to keep workers in perpetual debt. This system not only violates labor laws but also contributes to income inequality and economic marginalization of vulnerable populations. This situation persists due to brick-kiln owners' resistance to any meaningful government intervention in the brickmaking system, as this sector contributes the highest net profit per laborer among forms of bonded labor in South Asia (Kara, 2012).

Addressing incidents of bonded labor in brick kilns is crucial not only from a human rights perspective but also for sustained economic development. The endemic nature of this practice in certain regions undermines efforts to reduce poverty, improve education, and promote social mobility. Furthermore, the ongoing exploitation of workers in this industry perpetuates social inequalities, particularly along caste and gender lines, as evidenced by the disproportionate representation of marginalized groups in bonded labor situations.

On paper, policies and laws are necessary, as they delegitimize bonded labor, focus on mitigating debt, and create a pathway for release and rehabilitation. But they are not sufficient to dismantle the system. The government views these schemes as demand-driven and implements them primarily through a victim-centered framework. This approach does not adequately challenge the structural conditions that perpetuate bonded labor, especially when both employers and the industry benefit economically from its continuation.

This represents the demand side of this system and dismantling it would require credible enforcement against brick-kiln owners and contractors, which the BLSA aims to do to some extent but not sufficiently. On the supply side, to systematically uplift bonded laborers, structural protections are necessary to prevent households from needing coercive credit and from returning to bondage. As bondage is closely tied to the current social structure, eliminating the cycle will take a long time.

THE ROLE OF SOCIAL WORK IN RESPONDING TO BONDED LABOR

While the legislative, executive, and judicial branches form the foundation of governance, civil society organizations and voluntary organizations serve as a crucial fourth pillar that holds these institutions accountable and complements government efforts to support citizens. Although formal social work existed in limited form in rural India before independence, it was only after independence that efforts to address caste-based discrimination became more visible and organized. Social reformers advocated for the rights of marginalized communities and laid the groundwork for future social work interventions (Mishra, 2011).

The passage of the BLSA in 1976 and the establishment of the rehabilitation scheme in 1978 empowered voluntary organizations to intensify their efforts across two interconnected levels: At the macro level, they employed institutional and legal channels to strengthen enforcement, which included advocating for the formation of and participation in vigilance committees, documenting implementation gaps, and filing public-interest litigation. At the meso/micro level, they prioritized direct intervention, which included rescuing bonded laborers, mobilizing these bonded laborers, and providing them with legal aid. These efforts were instrumental in mitigating atrocities and establishing obstacles to their recurrence.

Bandhua Mukti Morcha (Bonded Labor Liberation Front), founded in 1981, became one of the most prominent voluntary organizations in the fight against bonded labor in stone quarries, brick kilns, and the agricultural sector, including through its landmark litigation in the mid-1980s. The group prioritized two objectives: one, to eradicate bonded labor, with greater emphasis on children; and two, to ensure that rescued laborers receive the full rehabilitation packages provided by law. Similarly, Shramjeevi Sangathan, founded in 1982, concentrated on rescuing bonded laborers from sugarcane farms and providing post-rescue support.

In the 1990s and 2000s, there was increased focus on rehabilitation programs for freed laborers. For example, Vimukti Trust (established in 1996) worked extensively in the southern state of Karnataka through a rights-based approach that combined macro-level advocacy and enforcement with meso- and micro-level organizing, mobilizing bonded laborers and landless agricultural workers, and increasing workers' legal awareness of their rights (Mishra, 2011). The trust's presence in Karnataka reduced the incidence of bonded

labor. Furthermore, the trust promoted effective leadership among ex–bonded laborers and agricultural workers. Through this reformed leadership, they addressed oppressive practices and mobilized Dalit (SC) youth from rural areas to become activists in the fight against the bonded labor system. Additionally, Kailash Satyarthi's Bachpan Bachao Andolan (Association for Voluntary Action) played a significant role in rescuing children from bonded labor.

Through collective action and coalition building, meso-level mobilization helped expand macro-level pressure. The creation of the National Campaign Committee for the Eradication of Bonded Labor (NCCEBL) in 2014 was one such effort, involving activists, human rights organizations, trade union leaders, students, and several voluntary organizations. NCCEBL focused on identifying, releasing, and rehabilitating bonded laborers. Around the same time, a transnational advocacy group, Union Solidarity International, in collaboration with the human rights and legal organizations Prayas, ActionAid, War on Want, and Thompsons Solicitors, launched the "Blood Bricks" campaign to fight bonded labor in the Indian brick-kiln industry. This movement resulted in wage increases through unionization by brick-kiln workers, resolution of wage disputes, and a greater awareness of legal rights (Wainwright, 2014).

CONCLUSION

The prevalence of bonded labor in India's brick-kiln industry reflects a complex interplay of historical, social, and economic factors that maintains this cycle of exploitation. Despite legislative efforts and judicial interventions, the deeply entrenched caste-based discrimination, widespread poverty, and weak enforcement of labor laws have allowed this exploitative system to endure. The challenges faced

by brick-kiln workers, predominantly from Dalit and Adivasi communities, are multifaceted and require a comprehensive approach to address effectively.

A comprehensive strategy to address bonded labor should include stricter enforcement of existing laws—for example, establishing fast-track courts that would solely handle cases related to bonded labor and child labor. Since local district magistrates would oversee this, independent observers could help ensure neutral support and limit the effect of any magistrate bias. On the supply side, implementing comprehensive rehabilitation programs and alternative livelihoods for affected communities—such as expanding microcredit, forming self-help groups for women, and enrolling rescued children in school—can support reintegration. Providing initial financial support for their education and dedicated counseling can further help women and children reintegrate into the community.

Additionally, to effectively combat bonded labor, it is crucial to strengthen the role of civil society organizations and foster greater collaboration among government agencies, voluntary organizations, and international bodies. Moreover, addressing the fundamental issues of poverty and social inequality is vital to breaking the cycle of debt bondage and achieving lasting change. We can only fulfill the constitutional promise of dignity and equality for all citizens—including those trapped in brick kilns—through coordinated efforts that tackle systemic issues. This includes dismantling systems such as those perpetuated by brick-kiln owners, in which profit-making trumps human rights and acts as a major barrier to progress.

REFERENCES

Anti-Slavery International & Volunteers for Social Justice. (2017). *Slavery in India's brick kilns and the payment system.* Anti-Slavery International. https://www.antislavery.org/wp-content/uploads/2017/09/Slavery-In-Indias-Brick-Kilns-The-Payment-System.pdf

Garcia, K. (2023, February 10). *Understanding India's urban future.* Penn Today. https://penntoday.upenn.edu/news/understanding-indias-urban-future

Giordano, C. S. (1986). Bandhua Mukti Morcha v. Union of India. *NYLS Journal of International and Comparative Law*, *7*, Article 5. https://digitalcommons.nyls.edu/journal_of_international_and_comparative_law/vol7/iss2/5

International Labour Organization. (2014). *A health approach to child labour—A synthesis report of four country studies from the brick industry.* https://www.ilo.org/publications/health-approach-child-labour-synthesis-report-four-country-studies-brick

Jha, A. K., & Kumar, V. (2025). *Path of construction industry in economic development of India* (Working Paper No. 297). Institute for Studies in Industrial Development.

Kara, S. (2009). *Sex trafficking: Inside the business of modern slavery.* Columbia University Press. https://www.jstor.org/stable/10.7312/kara13960

Kara, S. (2012). *Bonded labor: Tackling the system of slavery in South Asia.* Columbia University Press. https://www.jstor.org/stable/10.7312/kara15848

Khan, J. A. (2018). *Research study on assessing budgetary priorities for the rehabilitation of bonded labour.* Centre for Budget and Governance Accountability.

Mishra, L. (2011). *Human bondage: Tracing its roots in India.* SAGE Publication India. https://sk.sagepub.com/book/mono/human-bondage/toc

Mitra, D., & Valette, D. (2017). *Environment, human labour and animal welfare: Unveiling the full picture of South Asia's brick kiln industry and building the blocks for change.* International Labour Organization, the Brooke Hospital for Animals, and the Donkey Sanctuary.

Paliath, S. (2025, June 6). *India's fight against bonded labour: A tale of delayed rehabilitation.* IndiaSpend. https://www.indiaspend.com/governance/indias-fight-against-bonded-labour-a-tale-of-delayed-rehabilitation-956126

Samonova, E. (2019). *Modern slavery and bonded labour in South Asia.* Routledge.

Socio-Economic and Educational Development Society. (2009). *A report on Bonded Labour Rehabilitation Scheme under Centrally Sponsored Bonded Labour System (Abolition) Act, 1976 in the state of Madhya Pradesh, Orissa, Rajasthan, Tamil Nadu and Uttar Pradesh.*

Srivastava, R. S. (2005). *Bonded labour in India: Its incidence and pattern.* International Labour Organization, Special Action Programme to Combat Forced Labour. https://www.ilo.org/publications/bonded-labour-india-its-incidence-and-pattern

Standing Committee on Labour, Textiles and Skill Development. (December 2022). *Fortieth Report of the Standing Committee on Labour, Textiles, and Skill Development (2022–23) (Seventeenth Lok Sabha), Ministry of Skill Development and Entrepreneurship.* Lok Sabha Secretariat. https://eparlib.sansad.in/bitstream/123456789/1464519/1/17_Labour_Textiles_and_Skill_Development_40.pdf

Standing Committee on Labour, Textiles and Skill Development. (March 2025). *Fourth Report of the Standing Committee on Labour, Textiles and Skill Development (2024–25) (Eighteenth Lok Sabha) on Demands for Grants (2025–26) of the Ministry of Labour and Employment.* Lok Sabha Secretariat. https://eparlib.sansad.in/handle/123456789/2989674?view_type=browse

Wainwright, O. (2014, January 8). Blood bricks: How India's urban boom is built on slave labour. *The Guardian.* https://www.theguardian.com/artanddesign/architecture-design-blog/2014/jan/08/blood-bricks-india-urbanisation-human-rights-slave-labour

Walk Free. (2023). *The global slavery index 2023.* Minderoo Foundation. https://walkfree.org/global-slavery-index/

Zaffar, H. (2024, July). *Indian kiln workers are trapped in cycles of debt and illness.* FairPlanet. https://www.fairplanet.org/editors-pick/indian-kiln-workers-are-trapped-in-cycles-of-debt-and-illness/

POLICY ANALYSIS OF INVOLUNTARY PSYCHIATRIC HOSPITAL ADMISSION IN NEW YORK

STEPHANIE CHENG

STEPHANIE CHENG

BIO

Stephanie Cheng is an alumna of the Columbia School of Social Work, with experience in both an inpatient psychiatric unit and a mobile crisis team. She has a keen interest in research and practices that advance mental health systems and promote trauma-informed, person-centered care.

INSPIRATION

I was inspired to write this piece after my experience in the inpatient psychiatric unit, where I interacted with patients and gained insight into their experiences in the hospital. Involuntary hospitalization presents a complex ethical dilemma, and for this vulnerable population, questions remain as to whether current policies are sufficient to protect their safety and dignity. In this paper, I aim to explore these challenges and the evolution in policies and practices related to involuntary hospitalization. I also aim to highlight the importance of fostering sustainable recovery in the community and minimizing reliance on institutionalized care.

ABSTRACT

Involuntary hospitalization is used when an individual with serious mental illness is at imminent risk of harming themselves or others. Homelessness and racial disparities in mental health care can contribute to higher risks of involuntary hospitalization. Since 2023, former New York City Mayor Eric Adams proposed the Supportive Interventions Act, which would lower the criteria for transporting to hospitals and involuntarily admitting those who are unable to maintain their basic needs, even with no recent act of harm to self or others. The proposal sparked debate: Some groups believe that involuntary admission is necessary to preserve safety, while others believe it can cause more harm by infringing on the individual's well-being, autonomy, and dignity. Accordingly, recommendations follow for alternative proposals to provide sustainable care to individuals with serious mental illness. Social workers should advocate for the expansion of community-based programs, provide compassionate and holistic care, and advocate for more research and policy changes to examine biases in mental health care and advance legal rights for people with severe mental health challenges.

Keywords: involuntary hospitalization, mental health, serious mental illness

POLICY ANALYSIS OF INVOLUNTARY PSYCHIATRIC HOSPITAL ADMISSION IN NEW YORK

In 2021–2022, an estimated 3.2 million adults in New York state were living with mental illness, while 783,000 adults had serious mental conditions (DiNapoli, 2024). Serious mental illness, such as schizophrenia, bipolar disorder, and recurrent major depression, causes significant and long-term

psychosocial impairments (Maura & Weisman de Mamani, 2017). Social determinants of health, including discrimination, racism, and poor living conditions, can also contribute to poor mental health (Mayor's Office of Community Mental Health, n.d.). People with serious mental health challenges, especially those who are racially marginalized and homeless, are vulnerable to civil commitment to involuntary inpatient hospitalization. While involuntary inpatient civil commitment policies aim to preserve the safety of the individual and the public, these policies can also result in unintended harmful consequences (McCall, 2023).

HISTORICAL CONTEXT

Before the 1970s, all psychiatric hospital admissions were involuntary, as people who were mentally ill were presumed to be incapable of making decisions and had little autonomy to decide their treatment and commitment process (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

The first hospitals in the United States that acknowledged the need to address mental health began operating in the 1700s and early 1800s. However, by the mid-1800s, the number of mental hospitals was so small that it was common to put mentally ill people into almshouses, where they were "tossed together" with people who were physically disabled, had alcohol use disorder, were developmentally disabled, or were elderly (SAMHSA, 2019). Dorothea Dix was one of the reformers in the mid-1800s who addressed the poor living conditions at almshouses and advocated for residential care facilities for people with mental illness, leading to the expansion of state-run asylums across the United States at that time. The admission criteria were simply that the patient

would benefit from treatment due to mental illness. Admission was often proposed by family members, and physicians would certify an indefinite stay in the institution (SAMHSA, 2019).

By the 1960s, the deinstitutionalization movement had shifted focus from long-term stays at state facilities to short-term stays or community-based care (Edwards & Morris, 2024). In 1963, the Community Mental Health Act was enacted to allocate federal funding to community-based mental health programs and to prohibit payment for institutional care (Saunders & Rudowitz, 2025). In 1964, through the federal Ervin Act, the required criteria for admission were narrowed to "dangerousness." Congress also recognized a preference for less restrictive treatment, as the Ervin Act expanded options for alternative, less restrictive treatment outside hospitals (SAMHSA, 2019). In 1975, the U.S. Supreme Court ruled that a state could not confine a person solely on the basis that they had a mental illness and that to be involuntarily committed, an individual must present a danger to the public or self (McCall, 2023).

MENTAL HYGIENE LAW

According to the 2014 U.S. federal data on psychiatric inpatient admissions, 46% were voluntary admissions, 34% were involuntary and nonforensic admissions (the person was civilly committed), and 19% were involuntary and forensic admissions (the person was ordered by a criminal court to be evaluated and treated; Lutterman et al., 2017). From 2011 to 2018, among 25 states with publicly available data, the all-age emergency involuntary detention rate in hospitals per 100,000 people ranged from 29 in Connecticut to 966 in Florida (Lee & Cohen, 2020).

The New York State Office of Mental Health (NYSOMH) Mental Hygiene Law Article 9, Hospitalization of Persons With

a Mental Illness, outlines definitions, criteria, and processes for such hospitalizations (New York State Senate, 2021a). Within Article 9, Section 9.13 explains that voluntary admission means that the patient requests evaluation and admission to the hospital, and that the patient must notify the hospital in writing prior to leaving (New York State Senate, 2014b). Section 9.27, Involuntary admission on medical certification, is used in psychiatric hospital settings, accompanied by an application for admission by a family member or relative, officer, director of community services or facilities, director of a hospital, or qualified psychiatrist (New York State Senate, 2025). Two medical doctors of a hospital must certify that the person requires involuntary admission because they have a mental health concern that poses a "substantial" risk of harm to themselves or others, that the treatment is essential to their welfare, and that their judgment is too impaired for them to seek care and treatment on their own (Sullivan & Smith, 2022).

Section 9.39 explains the guidelines for emergency admission at a hospital for people who need immediate observation and care. If the patient is discharged before they are admitted to an inpatient psychiatric center, appropriate referrals and discharge care should be provided (New York State Senate, 2014a). The patient can be held up to 15 days under emergency admission; after that, they must be discharged if they no longer have a likelihood of risk of harm (New York State Senate, 2014a). If the patient continues to show high risks of harm to self or others and needs to stay at the hospital for more than 15 days, the patient has to be converted to either voluntary legal status if they agree to remain in the hospital for treatment, or involuntary legal status through 2PC if they do not agree to remain in the hospital (New York State Senate, 2024).

Sections 9.41 and 9.58 state that a mobile crisis team member, peace officer, or police officer may direct or initiate a mentally ill person's removal and transportation to a facility for a psychiatric evaluation (New York State Senate, 2021b, 2024). NYSOMH outlines legal rights for patients staying at an OMH state psychiatric facility, including the right to privacy, the right to refuse treatment, and the right to be legally represented (NYSOMH, 2022).

PSYCHOSOCIAL FACTORS THAT CONTRIBUTE TO INVOLUNTARY HOSPITALIZATION

HOMELESSNESS

The relationship between homelessness and serious mental illness is complex and bidirectional. Predisposed factors for homelessness can include psychiatric issues, poverty, and substance use disorders, while some suggest that homelessness is a vulnerability that may lead to mental illness (Castellow et al., 2015).

The social disadvantages that unhoused individuals face make mental health access difficult. Unhoused individuals face day-to-day challenges to meet basic needs, such as access to food, water, and shelter, which take priority over psychiatric needs until a crisis occurs (Balasuriya et al., 2020). Unhoused individuals may have difficulty accessing transportation to attend regular mental health visits or to pick up medication (Balasuriya et al., 2020). Additionally, they may not attend treatment consistently due to past negative experiences with mental health care, and their mental health condition itself may decrease their motivation to seek care (Balasuriya et al., 2020).

Studies demonstrate that people with untreated severe mental illness have higher mortality rates due to increased risks of

suicide and exposure to violence (Balasuriya et al., 2020; Jain et al., 2022). Experiences of trauma, substance use, and unstable social environments associated with being homeless can heighten the risk of harm. Being unhoused for longer is associated with more difficulty sustaining mental health recovery to maintain optimal functioning, and psychiatric problems and substance use issues can persist even after the person becomes stably housed (Balasuriya et al., 2020; Castellow et al., 2015). These psychosocial vulnerabilities place unhoused individuals at higher risk for involuntary hospital admission and readmissions (Banerjee et al., 2023; Jain et al., 2022).

RACIAL DISPARITIES

People of color are more likely to be involuntarily admitted to inpatient psychiatric settings than white patients. This may be explained in part by the overdiagnosis of psychotic disorders in people of color and lack of access to culturally sensitive mental health care (Shea et al., 2022). A study found that among a sample of people admitted to a hospital's psychiatry unit, a higher percentage of people of color (41% to 58%) had been diagnosed with psychotic disorders compared to white patients (25%). Black Americans are diagnosed with schizophrenia three to four times more than white Americans, while Latinx Americans are three times more likely than white Americans to be diagnosed with schizophrenia (Schwartz & Blankenship, 2014). Misdiagnosis can occur due to clinician bias, stereotyping, lack of attention to cultural contexts that shape behaviors, and interpretation of culturally normative behaviors as psychopathology, leading to ineffective pharmaceutical interventions and inequities in mental health treatment (Maura & Weisman de Mamani, 2017; Schwartz & Blankenship, 2014; Shim, 2021).

Additionally, people of color have less access to healthcare, lower quality of care, less trust in mental health professionals, and heightened social stigma for seeking mental health care (Maura & Weisman de Mamani, 2017). In medical settings, people of color are more likely to use psychiatric emergency services than community mental health services and are more likely to be hospitalized when seeking care (Maura & Weisman de Mamani, 2017). In 2018, data from the Substance Abuse and Mental Health Services Administration showed that 69% of Black adults and 67% of Latinx adults did not receive treatment for mental health issues (Shim, 2021). For those with serious mental illness, 42% of Black adults and 44% of Latinx adults did not receive treatment (Shim, 2021).

One study followed individuals with serious mental illness one year after discharge from a psychiatric hospital. Black patients had less improvement in psychotic symptoms, a lower likelihood of returning to work, and less improvement in functioning compared to white patients, even after controlling for socioeconomic status, gender, and diagnosis (Maura & Weisman de Mamani, 2017). These social factors lead to psychiatric vulnerabilities and increase the risk of involuntary hospitalization.

NEW PROPOSALS ON INVOLUNTARY HOSPITALIZATION

Unhoused individuals in New York City have increased vulnerability to serious mental illness, which has become a public health concern. In 2022, about 3,400 people in New York City lived in the streets and subway systems, and one-third of them had serious mental health issues (Newman & Fitzsimmons, 2022).

In 2024, former New York City Mayor Eric Adams focused efforts on people experiencing homelessness and having severe mental health issues. He cited a 2022 NYSOMH

memorandum, clarifying that people who are unable to "meet basic living needs, even when there is no recent dangerous act" could legally be involuntarily admitted. He claimed that removing these vulnerable individuals would provide them with an opportunity for assessment and treatment, and would enhance public safety (Sullivan & Smith, 2022, p. 1). The former mayor advocated to expand police officers' authority to remove and involuntarily commit people who cannot care for their basic needs to prevent future harm to themselves or others (Lewis, 2024; Newman & Fitzsimmons, 2022; Rajamani, 2023). The former mayor cited an incident in 2023 in which a homeless man with schizophrenia, Jordan Neely, was murdered by a former Marine (Rajamani, 2023). Neely was said to have cycled in and out of hospitals and jails before he was murdered. The former mayor also cited an incident in 2024 in which Ramon Rivera, a homeless man who had several interactions with the justice system, went on a stabbing spree that resulted in three deaths (Lewis, 2024).

The former mayor proposed the Supportive Interventions Act to codify and clarify involuntary commitment guidelines in the law, address gaps in the current Mental Hygiene Law, and make it legal for people who are unable to meet their basic needs to be transported and admitted to a hospital (Blau, 2024; Kerman et al., 2023; Lewis, 2024; Newman & Fitzsimmons, 2022; Rajamani, 2023). Following the former mayor's proposal, New York State Governor Kathy Hochul announced a $1 billion plan to expand mental health services by adding 850 psychiatric beds to public and private hospitals to reach pre-COVID numbers in an effort to enable a higher level of care for those affected by homelessness and severe mental health issues (Blau, 2024; DiNapoli, 2024).

In July 2025, President Donald Trump signed Executive Order 14321, aiming to broaden the use of involuntary

civil commitment for unhoused adults with serious mental illness by putting individuals into long-term institutions and assisted outpatient treatment programs to preserve public safety (Exec. Order No. 14321, 2025). Trump highlighted the increasing number of people living on the streets, saying the majority are affected by mental health conditions and substance use issues. He described this as a threat to order and as promoting violence. Trump also announced plans for the National Guard to clear homeless encampments in the capital to relocate unhoused individuals and use involuntary commitment to move individuals to institutions (Saunders & Rudowitz, 2025).

FINANCIAL EXPENDITURES ON INVOLUNTARY HOSPITALIZATION

Involuntary psychiatric stays in the U.S. can cost an average of just over $7,000 for 6.4 days (Morris & Kleinman, 2020). Among the 2 million inpatient hospitalizations in 2016, public programs like Medicaid and Medicare covered 60% of the stays; private insurance covered 27%; and 10% were either self-paid or free of charge (Morris & Kleinman, 2020). New York City reported that from January to October of 2024, an average of 126 people per week were involuntarily taken to the hospital, with Medicaid as the primary insurance provider (DiNapoli, 2024; Lewis, 2024). Billing for involuntary psychiatric admission requires close attention because while patients are evaluated and detained against their will, the incurred cost may be passed to them. This further infringes on their rights by forcing them to assume financial responsibility (Morris & Kleinman, 2020).

There are questions about which party should bear the cost of involuntary admission. Some argue that the patient should bear the financial cost for receiving treatment and

benefits; others argue that the public should contribute to the cost, as involuntary psychiatric admission is part of the legal framework enforced by the government, and the public benefits from the policies. Any decision to admit a patient involuntarily needs to be made carefully due to the financial burden it imposes on the patient or the public.

It is also important for hospitals' finances and billing to be scrutinized to preserve patients' best interests. This is especially true because patients with mental health issues are vulnerable to financial exploitation (Morris & Kleinman, 2020). Involuntary hospitalization requires additional financial oversight, as the patient is billed for care that they did not agree to; they are thus vulnerable to surprise medical bills, or unexpected out-of-pocket costs for hospital care (Morris & Kleinman, 2020). One organization that financially exploited patients was Acacia Healthcare, which made a profit by holding patients involuntarily without medical necessity while maximizing payout from their insurance (Lindner, 2024).

THE BENEFITS OF INVOLUNTARY HOSPITALIZATION

Involuntary hospitalization is a necessary last resort for individuals at imminent risk of harm to themselves or others, to preserve safety and prevent further decompensation (Danzer & Wilkus-Stone, 2015). Hospital units provide a structured and social support system where patients can be stabilized by receiving supervision, appropriate medication, and intensive therapy (Danzer & Wilkus-Stone, 2015; Wilkes, 2019). Even if the patient may not have insight into their mental health condition and refused help when they were first admitted, they may shift their initial negative attitude about "confinement" to accepting their illness and focusing on recovery (Danzer & Wilkus-Stone, 2015). Involuntary hospitalization may especially lead to positive outcomes for

patients in an active psychotic or manic episode who refused medication in the community because their psychiatric symptoms inhibited their ability to make informed decisions (Danzer & Wilkus-Stone, 2015).

THE CHALLENGES AND HARM OF INVOLUNTARY HOSPITALIZATION

Despite the potential benefits of involuntary hospitalization, the goal of reducing the risk of harm is not always met. Initial coercion by law enforcement and healthcare providers may lead to disengagement, poor clinical rapport, and lower chances of recovery, resulting in future dissatisfaction with care (Corderoy et al., 2025; Danzer & Wilkus-Stone, 2015). Perceived coercion, such as seclusion, restraint, and lack of decision-making power, could increase patients' suicide attempts on the unit and heighten their post-discharge suicide risk (Corderoy et al., 2025; Gerlach, 2024).

Hospitals often implement safety measures that restrict patients' freedom, such as locked doors, 15-minute security checks, limitations on visits, and limited access to personal belongings (Edwards & Morris, 2024; Gerlach, 2024). In one study, patients noted that during their stay, they were treated as objects and disrespected by staff. Patients also reported a lack of communication regarding their hospitalization, treatment plan, side effects of medications, and legal rights (Shields & Davis, 2024). Patients can experience a loss of autonomy, self-esteem, and self-control, and diminished hope for recovery (Danzer & Wilkus-Stone, 2015). Adverse events such as self-harm, violence, and breach of confidentiality can happen in inpatient care, even though the goal of hospitalization is to preserve patients' safety (Edwards & Morris, 2024).

Additionally, patient outcomes are affected by incomplete discharge planning. Patients may have difficulties accessing outpatient treatment or lack social support in treatment after discharge, resulting in repeated hospitalizations (Gerlach, 2024). Some patients are discharged from the hospital before they are stable, and some do not have adequate aftercare programs when discharged, which can lead to poor outcomes in the community (Newman & Fitzsimmons, 2022). A tragic incident occurred in 2022 in which a woman, Michelle Go, was killed when Simon Martin, a man who had schizophrenia and was unhoused, pushed her onto the subway tracks (Newman et al., 2022). He had been hospitalized multiple times, and there were indications that he had been discharged before he was fully stabilized (Newman et al., 2022). The incident serves as an example that simply forcing people into the hospital without addressing aftercare means they could be unsafe in the long run.

The determination of involuntary hospitalization is nuanced. Psychiatrists have different training on how to assess immediate danger, which means they may make varied judgments on whether to hospitalize a patient (Richmond, 2025). Some patients fall into a gray area because clinicians may have different interpretations of "imminent harm," which determines whether the patient would be admitted as an inpatient (Richmond, 2025). For patients who were admitted as inpatients but were considered to be in a gray area, involuntary hospitalization did not lower the risk of danger but actually doubled their risk of violent crime charges or dying by suicide in the next months (Richmond, 2025).

One study showed that one in five patients involuntarily admitted died within five years (Richmond, 2025). Involuntarily admitted patients are also no more likely to attend outpatient mental health care than those who were evaluated and not

held (Richmond, 2025). Patients can be trapped in a revolving door, where they are frequently readmitted with no effective long-term treatment (Alliance for Rights and Recovery, 2025). Defaulting to involuntary hospitalization is ineffective and unsustainable. Instead, it can worsen long-term outcomes, increase trauma, reinforce stigma, and increase expenditure (Alliance for Rights and Recovery, 2025; Eastgate, 2025).

PUBLIC OPINION ON THE POLICY

The public has mixed attitudes toward involuntary inpatient commitment and the former mayor's push to reform the Mental Hygiene Law. Advocates for involuntary hospitalization agree that some people living with serious mental illness may not be aware that they need treatment due to their illness, and many end up in the streets or in prison (Gerlach, 2024). For example, a person in active psychosis who is experiencing a disoriented reality may decline treatment due to their mental state. Some clinicians question whether not treating people who do not consent would truly advance civil liberties, considering that not treating them could risk further harm to them (Gerlach, 2024). In *Psychiatric Times*, Daniel Morehead argued that the public has an inaccurate image of involuntary admission and framed psychiatrists as the representatives of social control (Morehead, 2023). Morehead stated that involuntary treatment is common across medical care and is essential to preserving the life and well-being of individuals, where the individual still preserves the right to accept or reject treatment within the facility (Morehead, 2023).

Sullivan et al. (2024) suggested that involuntary hospitalization is a necessary option even when the act can infringe on a patient's autonomy. The authors drew a comparison to epilepsy, noting that medical providers do not withhold antiepileptic medication for a person in active

seizure just because they cannot provide consent. They suggested that people with serious mental illness should similarly be provided with care even when unable to consent (Sullivan et al., 2024). As psychiatrists working in inpatient units, they observed patients who were involuntarily admitted showing improvement in functioning: Patients with catatonia began to walk and talk, or patients were relieved of auditory hallucination after treatment on the unit (Sullivan et al., 2024). Sullivan et al. also suggested that involuntary hospitalization and commitment are necessary tools to provide lifesaving care in a situation where withholding treatment would endanger individuals.

Advocates against the expansion of involuntary hospitalization are concerned about the unclear guidance on removal and transport to the hospital (Newman & Fitzsimmons, 2022). Some members of public defender organizations, including the Legal Aid Society, stated that the former mayor's announcement leaves too much uncertainty about implementation and intentions (Newman & Fitzsimmons, 2022). The chief executive of the New York Association of Psychiatric Rehabilitation Services, Harvey Rosenthal, believes that the former mayor's proposal would traumatize individuals by forcing them into an overburdened and failed system (Newman & Fitzsimmons, 2022).

Representatives of the New York Civil Liberties Union (NYCLU) believe that expanding involuntary hospitalization violates the individual's civil rights, worsens the stigma around people who are unhoused with a mental illness, and may lead to abuses of power (Gerlach, 2024; Lewis, 2024). They believe that increasing involuntary commitment does not address the chronic issues of homelessness and lack of access to mental health care (Rajamani, 2023). They also believe that people on the streets have more medical needs

than psychiatric needs and that the administration should focus on funding supportive housing, mobile treatment teams, and street psychiatry (Lewis, 2024). Psychiatrists advocating for reform in inpatient psychiatric settings added that hospitals can resemble the carceral system, as racially marginalized people are more likely to be subjected to coerced healthcare systems such as involuntary psychiatric admission and restraints (Edwards & Morris, 2024).

RECOMMENDATIONS

Expanding involuntary hospitalization is not sufficient to support long-term treatment for people with severe mental health issues. This paper advocates for alternative proposals, including allocating funding for Assertive Community Treatment programs, strengthening cultural competency in mental health care, providing complete discharge planning and continuity of care, and improving the quality of care at inpatient psychiatric hospitals.

ALLOCATE FUNDING FOR ASSERTIVE COMMUNITY TREATMENT PROGRAMS

Evidence-based community mental health treatments are more cost-effective and can reduce acute care and hospital stays (Saunders & Rudowitz, 2025). Assertive Community Treatment (ACT) is an accessible form of treatment that can effectively address psychosocial complexities and improve social determinants of health (Balasuriya et al., 2020). ACT involves mobile, evidence-based, intensive, multidisciplinary teams that deliver 24/7 care for people with serious mental illness at risk of psychiatric crisis and hospitalization (Duch et al., 2025). ACT services include psychiatric evaluation, medication management, therapy, supported employment, supported housing, case management, and peer support (Duch et al., 2025).

Though ACT is considered an alternative to decrease inpatient care costs, the cost can still be substantial due to its intensive nature, costing an average of $21,481 per person per year, which can limit the extent of its usage (Duch et al., 2025). But these costs will be offset and will decrease in the long term, as inpatient admissions and criminal justice system–related expenses will decrease and use of regular outpatient care will increase (Duch et al., 2025). Value-based payment based on provider performance has been shown to decrease expenditures for ACT and shift high-cost inpatient expenditures to community-based care (Duch et al., 2025).

STRENGTHEN CULTURAL COMPETENCY IN MENTAL HEALTH CARE

Increased diversity and collaborative care can foster trust in mental health services for people of color with severe mental illness (Maura & Weisman de Mamani, 2017). Integrating cultural perspectives and increasing patients' involvement in treatment decisions can improve treatment engagement. This can include asking patients about their preferences on treatment and providing options (Maura & Weisman de Mamani, 2017). Cultural competency training can strengthen communication with patients and avoid stigmatizing them (McGregor et al., 2019).

Care providers need to maintain cultural humility through ongoing self-reflection and adaptation, and reflect on their own biases and cultural identities, which can affect how they interact with patients (Delfish & Chadha, 2025). Providers can limit implicit bias by attending workshops or seminars to broaden their knowledge about cultural diversity in mental health care (Delfish & Chadha, 2025). Mental health providers need to recognize the intersection of race, gender, and socioeconomic status, and how identities can shape a person's mental health experience (Delfish & Chadha, 2025).

In response, the provider should tailor treatment based on the individual's culture and perspective (Delfish & Chadha, 2025). Mental health providers are also encouraged to challenge existing discriminatory practices and advocate for policy reform (Delfish & Chadha, 2025).

PROVIDE COMPLETE DISCHARGE PLANNING AND ENSURE CONTINUITY OF CARE

Prior to discharge, the patient should be assessed for previous and future barriers to maintaining treatment in the community. Inpatient clinicians need to ensure that patients maintain continuity of care by linking them to appropriate community mental health care. This linkage is essential because individuals who do not attend an aftercare appointment are associated with increased risk of relapse, homelessness, suicide, and criminal justice involvement (Smith et al., 2019). Communication between inpatient hospital staff and outpatient mental health providers should be the standard practice to maintain continuity of care (Smith et al., 2019). Inpatient staff can provide details on the patient's treatment plan and the circumstances around the inpatient admission to better inform outpatient treatment (Smith et al., 2019). Among patients who were not engaged in outpatient mental health services prior to inpatient admission, those who have an outpatient appointment scheduled prior to discharge are three times more likely to attend a follow-up psychiatric visit within seven days (Smith et al., 2022).

Additionally, broadening the use of Critical Time Intervention (CTI) can support patients' transition out of inpatient care. CTI is a time-limited case management model for individuals who require support in "critical time" transitions (NYSOMH, n.d.). CTI teams help individuals transition from an inpatient hospital to their community and to long-term providers (NYSOMH,

n.d.). Prior to discharge, the CTI team meets the individual at the inpatient psychiatric unit to build rapport with them (NYSOMH, n.d.). After discharge, the CTI team conducts visits to support the connection between the individual and the long-term community provider (NYSOMH, n.d.). CTI teams continue to monitor the individual's support networks before they fully transition out of care (NYSOMH, n.d.).

IMPROVE QUALITY OF CARE AT INPATIENT PSYCHIATRIC HOSPITALS

It is important to improve the overall quality of care in inpatient hospital settings. For inpatient admission to achieve the goal of reducing harm, hospital staff need to be transparent about patients' rights and use trauma-informed and person-centered care. The hospital should be a healing setting where the patient can use the time and space to focus on their mental health.

Instead of using a "zero-risk" approach, hospitals can consider using a new safety paradigm to promote safety and equity in inpatient care (Slemon & Dhari, 2024). Mental health professionals should decrease the power imbalance between staff and patient, decrease the use of chemical and physical restraints, and promote a collaborative approach (Slemon & Dhari, 2024). The design of inpatient units should foster autonomy and promote safety and social interactions (Bodryzlova et al., 2024). Colorful spaces and home-like design can reduce stress and stigma (Bodryzlova et al., 2024; Slemon & Dhari, 2024). Inpatient mental health staff can incorporate individual or group outdoor activities to promote social interactions (Bodryzlova et al., 2024; Slemon & Dhari, 2024).

CONCLUSION

It is complex to achieve long-term safety for people with severe mental health issues. While people at imminent risk can benefit from involuntary hospitalization as a necessary last resort, the criteria for admission need to be closely examined. Simply moving unhoused people who have mental health issues to an inpatient hospital involuntarily is not an effective solution to address the root cause and will result in readmissions and add financial burden to the public.

Social workers should advocate to expand community-based programs to prevent individuals from getting to the point of hospitalization and institutionalization. Social workers in practice should work alongside other mental health professionals to provide compassionate and holistic care, whether in the setting of community programs or at inpatient institutions. More qualitative research is needed on patients' perspective of their experiences in involuntary admission and hospital stays. Social workers must be aware of structural discrimination in mental health care and advocate for more research and policy changes to examine biases in mental health care and to advance legal rights for people with severe mental health challenges. Policies and practices involving involuntary hospitalization must be continuously reviewed and revised.

REFERENCES

Alliance for Rights and Recovery. (2025, August 1). *Involuntary commitment is not a solution to homelessness—It's a step backward!* https://rightsandrecovery.org/e-news-bulletins/2025/08/01/involuntary-commitment-is-not-a-solution-to-homelessness-its-a-step-backward/

Balasuriya, L., Buelt, E., & Tsai, J. (2020). The never-ending loop: Homelessness, psychiatric disorder, and mortality. *Psychiatry Times*, *37*(5). https://www.psychiatrictimes.com/view/never-ending-loop-homelessness-psychiatric-disorder-and-mortality

Banerjee, S., Yassin, M., Dyer, W., Thomas, T., Rodriguez, L., & Schmittdiel, J. (2023). Hospital readmissions among patients experiencing homelessness: An electronic health record data study. *The Permanente Journal*, *28*(1), 55–61. https://doi.org/10.7812/TPP/23.075

Blau, R. (2024, January 9). *Many psych hospital beds are back in action a year after Hochul vow.* The City. http://www.thecity.nyc/2024/01/09/psychiatric-hospital-beds-hochul-office-mental-health/

Bodryzlova, Y., Lemieux, A. J., Dufour, M., Côté, A., Lalancette, S., & Crocker, A. G. (2024). Hospital design for inpatient psychiatry: A realistic umbrella review. *Journal of Psychiatric Research*, *178*, 94–106. https://doi.org/10.1016/j.jpsychires.2024.07.045

Castellow, J., Kloos, B., & Townley, G. (2015). Previous homelessness as a risk factor for recovery from serious mental illnesses. *Community Mental Health Journal*, *51*(6), 674–684. https://doi.org/10.1007/s10597-014-9805-9

Corderoy, A., Kisely, S., Zirnsak, T., & Ryan, C. J. (2025). The benefits and harms of inpatient involuntary psychiatric treatment: A scoping review. *Psychiatry, Psychology and Law, 32(5)*, 734–781. https://doi.org/10.1080/13218719.2024.2346734

Danzer, G., & Wilkus-Stone, A. (2015). The give and take of freedom: The role of involuntary hospitalization and treatment in recovery from mental illness. *Bulletin of the Menninger Clinic*, *79*(3), 255–280. https://doi.org/10.1521/bumc.2015.79.3.255

Delfish, M., & Chadha, P. (2025). From competence to humility: Advancing culturally responsive mental health care. *Psychiatric News*, *60*(1). https://doi.org/10.1176/appi.pn.2025.01.1.39

DiNapoli, T. (2024, March). *Mental health: Inpatient service capacity.* New York State Comptroller. https://www.osc.ny.gov/files/reports/pdf/mental-health-inpatient-service-capacity.pdf

Duch, D. A., Herschell, A. D., Ferrone, C. T., Maqsood, J., Fertall, L. A., & Hutchison, S. L. (2025). Effectiveness of value-based payment and Assertive Community Treatment to reduce psychiatric hospitalizations. *The Journal of Behavioral Health Services & Research*. https://doi.org/10.1007/s11414-025-09982-y

Eastgate, J. (2025, August 1). *Involuntary psychiatric commitment of the homeless: A dangerous, costly failure.* Citizens Commission on Human Rights International. https://www.cchrint.org/2025/08/01/involuntary-psychiatric-commitment-homeless-dangerous-costly-failure/

Edwards, M. L., & Morris, N. P. (2024). How inpatient psychiatric units can be both safe and therapeutic. *AMA Journal of Ethics*, *26*(3), 248–256. https://doi.org/10.1001/amajethics.2024.248

Exec. Order No. 14321, 90 F.R. 143, 35817 (July 24, 2025). https://www.govinfo.gov/content/pkg/FR-2025-07-29/pdf/2025-14391.pdf

Gerlach, J. (2024, April 2). What we don't talk about with involuntary hospitalization. *Beyond Mental Health* (blog). Psychology Today. https://www.psychologytoday.com/us/blog/beyond-mental-health/202404/what-we-dont-talk-about-with-involuntary-hospitalization

Jain, S., Mansuri, Z., Trivedi, C., Shah, K., Adnan, M., & Manikkara, G. (2022). Psychiatric disorders in hospitalized homeless individuals: A nationwide study. *The Primary Care Companion for CNS Disorders*, *24*(6), 21m03209. https://doi.org/10.4088/PCC.21m03209

Kerman, N., Kidd, S. A., & Stergiopoulos, V. (2023). Involuntary hospitalization and coercive treatment of people with mental illness experiencing homelessness—Going backward with foreseeable harms. *JAMA Psychiatry*, *80*(6), 531–532. https://doi.org/10.1001/jamapsychiatry.2023.0537

Lee, G., & Cohen, D. (2020). Incidences of involuntary psychiatric detentions in 25 U.S. states. *Psychiatric Services*, *72*(1), 61–68. https://doi.org/10.1176/appi.ps.201900477

Lewis, C. (2024, November 25). *Adams renews bid for easier involuntary commitments after Manhattan stabbing deaths*. Gothamist. https://gothamist.com/news/adams-renews-bid-for-easier-involuntary-commitments-after-manhattan-stabbing-deaths

Lindner, E. (2024, September 9). Exposing a hospital chain's disturbing practices. *New York Times.* https://www.nytimes.com/2024/09/09/insider/acadia-healthcare.html

Lutterman, T., Shaw, R., Fisher, W., & Manderscheid, R. (2017). *Trend in psychiatric inpatient capacity, United States and each State, 1970 to 2014.* National Association of State Mental Health Program Directors. https://nri-inc.org/media/1319/tac-paper-10-psychiatric-inpatient-capacity-final-09-05-2017.pdf

Maura, J., & Weisman de Mamani, A. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. *Journal of Clinical Psychology in Medical Settings*, *24*(3), 187–210. https://doi.org/10.1007/s10880-017-9510-2

Mayor's Office of Community Mental Health. (n.d.). *Mental Health Data Dashboard*. Retrieved November 10, 2024, from https://mentalhealth.cityofnewyork.us/dashboard/

McCall, M. (2023, June 25). *Involuntary commitment: Patient and public rights.* FindLaw. https://www.findlaw.com/healthcare/patient-rights/involuntary-commitment-patient-and-public-rights.html

McGregor, B., Belton, A., Henry, T. L., Wrenn, G., & Holden, K. B. (2019). Improving behavioral health equity through cultural competence training of health care providers. *Ethnicity & Disease*, *29*(Suppl. 2), 359–364. https://doi.org/10.18865/ed.29.S2.359

Morehead, D. (2023, May 9). What the public does not know about involuntary hospitalization. *Psychiatric Times 40(5)*. https://www.psychiatrictimes.com/view/what-the-public-does-not-know-about-involuntary-hospitalization

Morris, N. P., & Kleinman, R. A. (2020). Involuntary commitments: Billing patients for forced psychiatric care. *American Journal of Psychiatry, 177*(12), 1115–1116. https://doi.org/10.1176/appi.ajp.2020.20030319

New York State Office of Mental Health. (n.d.). Critical Time Intervention. Retrieved March 23, 2026, from https://omh.ny.gov/omhweb/adults/cti.html

New York State Office of Mental Health. (2022). *Rights of inpatients in New York State Office of Mental Health psychiatric centers.* https://omh.ny.gov/omhweb/patientrights/inrtsweb.pdf

New York State Senate. (2014a, September 22). *Section 9.39 Emergency admissions for immediate observation, care, and treatment.* https://www.nysenate.gov/legislation/laws/MHY/9.39

New York State Senate. (2014b, September 22). *Section 9.13 Voluntary admissions*. https://www.nysenate.gov/legislation/laws/MHY/9.13

New York State Senate. (2021a, August 6). *Article 9 Hospitalization of persons with a mental illness.* https://www.nysenate.gov/legislation/laws/MHY/TBA9

New York State Senate. (2021b, October 8). *Section 9.58 Transport for evaluation; powers of approved mobile crisis outreach teams.* https://www.nysenate.gov/legislation/laws/MHY/9.58

New York State Senate. (2024, May 3). *Section 9.41 Emergency assessment for immediate observation, care, and treatment; powers of certain peace officers and police officers.* https://www.nysenate.gov/legislation/laws/MHY/9.41

New York State Senate. (2025, August 8). *Section 9.27 Involuntary admission on medical certification.* https://www.nysenate.gov/legislation/laws/MHY/9.27

Newman, A., & Fitzsimmons, E. G. (2022, November 29). New York City to involuntarily remove mentally ill people from streets. *New York Times.* https://www.nytimes.com/2022/11/29/nyregion/nyc-mentally-ill-involuntary-custody.html

Newman, A., Schweber, N., & Marcius, C. R. (2022, February 5). Decades adrift in a broken system, then charged in a death on the tracks. *New York Times.* https://www.nytimes.com/2022/02/05/nyregion/martial-simon-michelle-go.html

Rajamani, M. (2023, May 10). *Adams calls Neely's death a "tragedy," pushes mental health plan.* Spectrum News. https://ny1.com/nyc/all-boroughs/news/2023/05/10/eric-adams-jordan-neely-mental-health-plan

Richmond, L. (2025). A new look at involuntary hospitalization. *Psychiatric News*, *60*(10). https://doi.org/10.1176/appi.pn.2025.10.10.6

Saunders, H., & Rudowitz, R. (2025, August 15). *A look at the new executive order and the intersection of homelessness and mental illness.* KFF. https://www.kff.org/mental-health/a-look-at-the-new-executive-order-and-the-intersection-of-homelessness-and-mental-illness/

Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World Journal of Psychiatry*, *4*(4), 133–140. https://doi.org/10.5498/wjp.v4.i4.133

Shea, T., Dotson, S., Tyree, G., Ogbu-Nwobodo, L., Beck, S., & Shtasel, D. (2022). Racial and ethnic inequities in inpatient psychiatric civil commitment. *Psychiatric Services*, *73*(12). https://doi.org/10.1176/appi.ps.202100342

Shields, M. C., & Davis, K. A. (2024). Inpatient psychiatric care in the United States: Former patients' perspectives on opportunities for quality improvement. *Journal of Patient Experience*, *11*. https://doi.org/10.1177/23743735241257810

Shim, R. (2021). Dismantling structural racism in psychiatry: A path to mental health equity. *American Journal of Psychiatry, 178(7)*. https://doi.org/10.1176/appi.ajp.2021.21060558

Slemon, A., & Dhari, S. (2024). Envisioning a safety paradigm in inpatient mental health settings: Moving beyond zero-risk approaches. *SSM–Mental Health, 5*, 100315. https://doi.org/10.1016/j.ssmmh.2024.100315

Smith, T. E., Haselden, M., Corbeil, T., Tang, F., Radigan, M., Essock, S. M., Wall, M. M., Dixon, L. B., Wang, R., Frimpong, E., Lamberti, S., Schneider, M., & Olfson, M. (2019). Continuity of care and discharge planning for hospital psychiatric admissions. *Psychiatric Services, 71(1)*, 75–78. https://doi.org/10.1176/appi.ps.201900233

Smith, T. E., Haselden, M., Corbeil, T., Wall, M. M., Tang, F., Essock, S. M., Frimpong, E., Goldman, M. L., Mascayano, F., Radigan, M., Schneider, M., Wang, R., Rodgers, I., Dixon, L. B., & Olfson, M. (2022). The effectiveness of discharge planning for psychiatric inpatients with varying levels of pre-admission engagement in care. *Psychiatric Services*, *73*(2), 149–157. https://doi.org/10.1176/appi.ps.202000863

Substance Abuse and Mental Health Services Administration. (2019). *Civil commitment and the mental health care continuum: Historical trends and principles for law and practice*. https://www.samhsa.gov/resource/ebp/civil-commitment-mental-health-care-continuum-historical-trends-principles-law

Sullivan, A. M. T., & Smith, T. (2022, February 18). *Interpretative guidance for the involuntary and custodial transportation of individuals for emergency assessments and for emergency and involuntary inpatient psychiatric admissions*. New York State Office of Mental Health. https://omh.ny.gov/omhweb/guidance/interpretative-guidance-involuntary-emergency-admissions.pdf

Sullivan, M., Scherban, B., & Bera, S. (2024). Involuntary commitment: A humanitarian treatment. *Psychiatric Services*, *75*(12). https://doi.org/10.1176/appi.ps.20240145

Wilkes, T. (2019). The circumstances behind involuntary hospitalization: A personal ethics narrative. *Voices in Bioethics, 5*. https://doi.org/10.7916/vib.v5i.5922

MISDIAGNOSED AND OVERMEDICATED: HOW U.S. SCHOOLS PATHOLOGIZE BLACK BOYS WITHOUT PROVIDING COMPREHENSIVE MENTAL HEALTH CARE

KENNI RUDD

ABSTRACT

Attention-deficit/hyperactivity disorder (ADHD) and conduct-related disorders, including oppositional defiant disorder (ODD) and conduct disorder (CD), are commonly used to classify children's behavior in school settings. When applied appropriately, these diagnoses can support academic and social functioning. However, national disparities in behavioral referral and classification raise concerns about how diagnostic pathways operate for Black boys. This paper examines patterns of ADHD and conduct-related diagnoses among Black boys ages 6 to 14, focusing on how similar behaviors are interpreted and classified differently across racial groups. It argues that Black boys are disproportionately labeled as disruptive or defiant and are more likely to be diagnosed with conduct-related disorders rather than ADHD, even when presenting comparable symptoms as their white peers, reflecting patterns of racialized misclassification. This increases their use of psychiatric medication, while they are less likely to receive counseling, trauma-informed care, or comprehensive mental health support. Drawing on research on adultification bias and structural racism, this paper demonstrates how disparities in diagnosis and treatment are shaped by institutional processes, including referral systems, behavioral documentation, and resource inequities in under resourced schools. It further examines how surveillance practices and diagnostic decision-making influence long-term developmental outcomes. This analysis calls for structural reform grounded in trauma-informed screening, culturally responsive assessment, strengthened Multi-Tiered Systems of Support (MTSS), and social work–informed practice to promote more equitable school-based mental health evaluation.

Keywords: ADHD, adultification bias, Black boys, conduct-related disorders, diagnostic misclassification, disruptive, impulse control and conduct disorders, Multi-Tiered Systems of Support, racial disparities, school social work, structural racism, trauma-informed care

MISDIAGNOSED AND OVERMEDICATED: HOW U.S. SCHOOLS PATHOLOGIZE BLACK BOYS WITHOUT PROVIDING COMPREHENSIVE MENTAL HEALTH CARE

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental disorder characterized by persistent patterns of inattention and/or hyperactivity-impulsivity that interfere with functioning, as outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). Symptoms may include difficulty sustaining attention, excessive movement, and impulsive decision-making, and must be present across multiple settings. Oppositional defiant disorder (ODD) is defined by a pattern of angry or irritable mood, argumentative or defiant behavior, and vindictiveness toward authority figures lasting at least six months. Conduct disorder (CD), a more severe behavioral disorder, involves a persistent pattern of behavior that violates the rights of others or major societal norms, including aggression, destruction of property, deceitfulness, or serious rule violations. These disorders are commonly used in clinical and school-based settings to assess and classify children's behavioral concerns.

ADHD is one of the most commonly diagnosed neurodevelopmental disorders among children in the United States, with prevalence estimates ranging from approximately 9% to 11% (Danielson et al., 2018). In school settings, behavioral concerns are typically identified through teacher observations, which often serve as the primary entry point into referral, evaluation, and diagnostic processes. In most

districts, educators initiate the majority of ADHD evaluations through classroom-based concern documentation and behavioral rating scales (Morgan et al., 2013). Educators, school counselors, and psychologists play a central role in determining whether a child is referred for further assessment, shaping early pathways into mental health and special education systems.

Research demonstrates that Black boys are more likely to be perceived as disruptive, aggressive, or intentionally defiant compared to their white peers, even when exhibiting similar behaviors. Skiba and colleagues (2014) analyzed national school discipline data and found that African American students were more likely to receive office referrals and suspensions than white students, even for similar behavioral patterns. This suggests that disciplinary decisions are influenced not only by student behavior but also by how that behavior is interpreted. Okonofua and Eberhardt (2015) found that teachers were more likely to interpret identical behaviors as more severe and indicative of future misbehavior when attributed to Black students. These perceptions increase the likelihood that Black boys will be referred for behavioral evaluation or subjected to exclusionary discipline practices, such as suspension, removal from the classroom, or placement in alternative settings. These practices limit their access to supportive interventions and increase the likelihood that their behaviors are pathologized rather than contextualized.

Beyond disparities in discipline and referral processes, research has also identified racial differences in diagnostic outcomes. Black boys are more likely to be diagnosed with disruptive behavior disorders, such as ODD and CD, and less likely to receive ADHD diagnoses, even when presenting similar behavioral symptoms. Stevens and colleagues (2005)

identified disparities in diagnostic classification, with African American youth more frequently labeled with conduct-related disorders rather than attention-based or internalizing conditions. These patterns suggest that differences in diagnosis may reflect interpretations and categorizations of behavior, rather than actual differences in behavior.

MISDIAGNOSIS VS. OVERDIAGNOSIS AND NATIONAL PATTERNS OF ADHD AMONG BLACK BOYS

OVERDIAGNOSIS VS. MISCLASSIFICATION

Although often used interchangeably, the terms "overdiagnosis" and "misclassification" refer to distinct processes. Overdiagnosis refers to the identification of a condition that would not have caused significant impairment or symptoms if left untreated, often resulting from broadened diagnostic criteria or increased screening sensitivity (Moynihan et al., 2012; Welch et al., 2011). This process may lead to the labeling of individuals whose symptoms do not meet the threshold for clinical necessity, increasing the likelihood of unnecessary intervention. In contrast, misclassification refers to the incorrect assignment of a diagnosis due to errors in interpretation, assessment, or bias, resulting in an individual being placed into an inappropriate diagnostic category (American Psychiatric Association [APA], 2013).

Misdiagnosis occurs when a child's behavioral presentation is inaccurately categorized, often resulting in alternative labels such as ODD or CD. For example, in school settings, behaviors commonly associated with ADHD, such as difficulty sustaining attention, impulsiveness, or restlessness, may be interpreted as intentional defiance or aggression rather than symptoms of a neurodevelopmental disorder. These labels are often

interpreted as reflecting intentional misconduct rather than developmental or regulatory challenges, which can shape how educators respond to and support students. Diagnoses of CD and ODD are associated with more severe disciplinary consequences than diagnoses of ADHD, including higher rates of suspension, expulsion, and placement in alternative or restrictive educational settings (Fairchild et al., 2019). In contrast, ADHD is more often addressed through academic accommodation, behavioral supports, or individualized education plans (IEPs).

RACIAL DISPARITIES IN DIAGNOSTIC CLASSIFICATION

A substantial body of research documents racial disparities in how childhood mental health conditions are diagnosed and classified within school and clinical settings. Black children are more often diagnosed with behavior disorders within the DSM-5 category of disruptive, impulse-control, and conduct disorders such as ODD and CD, which emphasize patterns of defiance, rule-breaking, and aggression, often interpreted as willful or intentional within school-based contexts (Stevens et al., 2005). Stevens and colleagues (2005) found that African American boys were more likely to be classified with conduct-related disorders compared to attention-based diagnoses.

Morgan and colleagues (2013) found that even when controlling for similar behavioral presentations, African American children were approximately 69% less likely than white children to be diagnosed with ADHD and more likely to be identified with disruptive behavior disorders. This suggests that identical behaviors may be categorized differently depending on how they are perceived and documented within the educational and clinical systems. Distinguishing between overdiagnosis and racialized misclassification is essential for understanding whether disparities reflect inflated rates of

diagnosis overall or systematic differences in how diagnoses are applied across populations.

ADULTIFICATION BIAS AND STRUCTURAL RACISM IN SCHOOLS

DEFINING ADULTIFICATION BIAS

Adultification bias refers to the perception that Black children, particularly Black boys, are older, less innocent, and more responsible for their actions than white peers of the same age (Goff et al., 2014). This bias leads adults to interpret typical childhood behaviors as intentional misconduct rather than developmentally appropriate actions. This can lead to distorted perceptions that influence disciplinary responses and classroom expectations. Research demonstrates that Black boys are perceived as less innocent than their white peers as early as age 10, with participants overestimating their age by an average of 4.5 years (Goff et al., 2014). These distorted perceptions shape how behavior is interpreted before any formal diagnostic or intervention process begins.

DISCIPLINARY SYSTEMS AND RACIAL DISPARITIES

These biased interpretations are embedded within school disciplinary systems that rely heavily on punitive responses such as suspensions, expulsions, and behavioral referrals, with Black boys representing a disproportionate share of these disciplinary actions. National data indicate that Black students are suspended at nearly three times the rate of white students (Office for Civil Rights, 2014). In some districts, Black boys account for over 30 to 40% of suspensions despite representing a significantly smaller proportion of the student population. This disparity reflects not only differences in disciplinary outcomes but also differences in how behavior is perceived and categorized.

Within these systems, behavior is documented through mechanisms such as incident reports, office referrals, and behavioral write-ups. These records are not neutral; they are shaped by adult interpretation, which can see minor behaviors as patterns of "aggression" or "noncompliance." This suggests that early interpretations of behavior can shape long-term disciplinary trajectories. Over time, this documentation contributes to cumulative disciplinary action and increases the likelihood of exclusionary practices, reinforcing the school-to-prison pipeline for marginalized youth.

INTERPRETIVE PROCESSES AND STRUCTURAL BIAS

Several stages within the school-based behavioral and disciplinary process rely on subjective interpretation. These include teacher observations, behavioral documentation, incident reporting, and disciplinary decision-making. Because these stages lack fully standardized criteria and depend heavily on adult perception, they are particularly vulnerable to implicit bias.

Experimental research demonstrates that teachers are more likely to label Black students as "troublemakers" and anticipate future misbehavior after a single infraction compared to white students (Okonofua & Eberhardt, 2015). Similarly, research shows that Black students are more likely to receive harsher punishments for comparable behaviors, even when controlling for severity of behavior (Skiba et al., 2011).

Behaviors such as hyperactivity or emotional reactivity may be interpreted as intentional misconduct rather than potential indicators of developmental or mental health needs. This contributes to patterns in which Black boys are disproportionately funneled into punitive disciplinary

pathways rather than supportive interventions. Rather than reflecting true differences in behavior, these outcomes highlight how systems of interpretation, documentation, and discipline collectively shape how children, particularly Black boys, are understood and treated within educational environments.

TEACHER REFERRAL PRACTICES AND RACIALIZED PERCEPTION

DEFINING DISRUPTIVE BEHAVIOR IN A CLASSROOM CONTEXT

Disruptive behavior in classroom settings is not defined solely by objective criteria but is shaped by classroom norms, teacher expectations, and institutional standards of compliance. Behaviors such as talking out of turn, difficulty remaining seated, impulsiveness, or failure to follow directions may be interpreted differently depending on context. In early educational settings, many of these behaviors fall within the range of typical neurodevelopmental variability, particularly among children ages 6 to 14, when executive-function skills are still developing.

However, national data indicate that Black students are disproportionately disciplined for subjective behavioral categories or offenses such as “defiance,” “disrespect,” and “disruption,” rather than objective infractions, whereas white students are more often disciplined for observable and clearly defined infractions (Skiba et al., 2011). These subjective categories lack clear operational definitions and allow greater room for interpretation, increasing the likelihood that interpretation, not behavior alone, drives disciplinary response and increasing the influence of bias in disciplinary decision-making. Implicit bias research demonstrates that

when repeated minor behavioral incidents are interpreted through racialized perception, the incidents are seen as more serious when coming from Black children (Okonofua & Eberhardt, 2015). Behaviors such as talking out of turn, failing to follow directions, or displaying restlessness may be interpreted as patterns of defiance for Black students, while similar behaviors in white students are more likely to be viewed as situational or developmentally typical.

These differences influence classroom responses, including increased surveillance, stricter disciplinary actions, and quicker escalation to referral, contributing to cumulative behavioral documentation that disproportionately positions Black students for formal evaluation. This distinction is critical, as behaviors associated with ADHD, including inattention, impulsiveness, and difficulty with task persistence, may overlap with behaviors labeled as disruptive in classroom environments.

STRUCTURAL CONTEXT AND RACIALIZED REFERRAL PATTERNS

Referral processes do not occur in isolation but are embedded within broader structural and institutional contexts. Several stages of the referral process, including behavioral observation, incident documentation, and referral decision-making, are inherently interpretive and influenced by subjective judgment. These processes are further shaped by classroom management demands, school disciplinary policies, and institutional expectations regarding behavioral compliance.

Teacher perception and referral practices play a central role in shaping how student behavior is interpreted before formal evaluation begins. Structural constraints within school-based

evaluation systems further contribute to misclassification: School psychologists and evaluators often manage high caseloads, limiting time available for comprehensive environmental assessment (National Association of School Psychologists [NASP], 2020). As a result, assessments may rely more heavily on teacher-reported behavior and less on contextual factors such as trauma exposure, family dynamics, and cultural context. In combination with inconsistent implementation of intervention frameworks such as MTSS, these conditions create a diagnostic environment in which behaviors are more likely to be pathologized than contextualized.

In school settings, teachers often serve as the first point of identification for behavioral concerns, and their observations, referral narratives, and rating scales frequently become the foundation for later assessment and classification. Because ADHD-related behaviors such as distractibility, impulsivity, and difficulty following directions can overlap with behaviors interpreted as defiance or noncompliance, early distinctions are often shaped by subjective interpretation rather than clinical certainty. Referral can be a pathway to needed support; however, when referrals are made before classroom-based interventions are meaningfully attempted, or when behavior is framed primarily through willfulness rather than context, students may be positioned within diagnostic systems through a deficit-oriented lens. In under-resourced settings, where comprehensive neuropsychological evaluation may be less accessible and school-based documentation carries greater weight, these early interpretations can have disproportionate influence on diagnostic trajectories.

The racial climate and teacher–student relational trust also shape behavioral interpretation and academic engagement (Huguley et al., 2019). Lower levels of relational trust and

school belonging are associated with decreased engagement and increased likelihood of disengagement-related behaviors. In this context, behaviors such as withdrawal or noncompliance may reflect unmet relational or environmental needs rather than individual deficits. These factors should be considered prior to referral, as interventions that strengthen relationships and classroom belonging may reduce unnecessary referrals and improve outcomes.

TRAUMA, THE DIFFERENTIATION BETWEEN HYPERVIGILANCE AND HYPERACTIVITY, AND CULTURAL MISINTERPRETATION

Trauma-related hypervigilance refers to a persistent state of heightened alertness in response to real or perceived threat, often developed through repeated exposure to stress or adversity. This may include increased scanning of the environment, difficulty concentrating, rapid emotional reactivity, and sensitivity to perceived danger or correction. Black boys must often navigate racialized school climates characterized by disproportionate discipline, increased behavioral surveillance, lowered academic expectations, and experiences of bias or differential treatment. Additional sources of chronic stress may include exposure to community violence, over-policing, school-based disciplinary disparities, and racial discrimination within educational settings.

National Center for Education Statistics (2022a, 2022b) data indicate that approximately 79% of public school teachers identify as white, while Black students represent approximately 15% of the public school population. Research suggests that this demographic incongruence can influence expectations, disciplinary responses, and interpretations of classroom behavior (Gershenson et al., 2016). This disparity reflects a structural mismatch between racial composition

of the teaching workforce and the student population, increasing the likelihood of cross-racial interpretations of behavior, which has been linked to disparities in expectations, disciplinary responses, and referral decisions. Black students are less likely to be identified for gifted programs and more likely to receive disciplinary referrals, even when exhibiting similar behaviors as white students.

Both ADHD and trauma-related hypervigilance can present with difficulty sustaining attention, impulsive responses, and increased motor activity. However, ADHD symptoms are typically persistent across settings, whereas trauma-related behaviors are often context-dependent and may intensify in environments perceived as unsafe. When this distinction is not recognized, trauma-related responses may be misinterpreted as oppositional or defiant behavior, increasing the likelihood of classification under conduct-related disorders such as ODD or CD.

Many educators receive limited preparation in differentiating trauma-related hypervigilance from neurodevelopmental hyperactivity or in assessing how environmental stressors influence classroom behavior (Milner, 2012). In the absence of structured pre-referral intervention protocols such as Multi-Tiered Systems of Support (MTSS), teacher-generated observations and documentation may disproportionately shape early referral and evaluation processes before targeted supports are consistently implemented. When teachers do not systematically assess contextual factors, they may misinterpret behaviors rooted in adaptive vigilance as evidence of impulsivity or defiance rather than stress responses (Carter, 2007; Overstreet & Chafouleas, 2016).

Cultural differences in communication and expression may further contribute to misinterpretation. Expressive

communication patterns, assertiveness, and call-and-response interactions common in many Black cultural contexts may be misread as disruptive in classrooms structured around dominant behavioral norms (Emdin, 2016). These misinterpretations can shape referral processes, classroom discipline, and teacher expectations, often resulting in increased correction, social labeling, or exclusion.

MEDICATION AS A DEFAULT INTERVENTION

In under-resourced school districts, pharmacological intervention may be a more accessible behavioral management tool than longitudinal treatments. Although stimulant medications are well established as evidence-based treatments for ADHD when diagnostic criteria are appropriately met (APA, 2022; MTA Cooperative Group, 1999), national data indicate that African American children are less likely to be diagnosed with ADHD and, as a result, are less likely to receive stimulant medications, despite exhibiting similar behavioral symptoms (Danielson et al., 2018; Morgan et al., 2013). However, when behavioral concerns escalate or are classified under conduct-related frameworks, intervention pathways may rely more heavily on medication in the absence of comprehensive mental health support.

Access to psychotherapy and school-based mental health professionals is uneven across districts, particularly in schools serving predominantly low-income and marginalized populations (Thomas & Holzer, 2006). In these contexts, medication may be viewed as the most efficient mechanism for stabilizing classroom behavior because it requires fewer resources than implementing ongoing behavioral interventions or coordinating sustained support. But while medication may be perceived as more efficient within school

systems, the ongoing financial burden—including prescription costs, required follow-up care, and inconsistent insurance coverage—may limit access and continuity of treatment for many families.

There are no FDA-approved medications specifically for treating ODD or CD; however, medications such as atypical antipsychotics, including risperidone and aripiprazole, may be prescribed to address severe irritability or aggression. In contrast, stimulant medications commonly used for ADHD, such as methylphenidate (e.g., Ritalin, Concerta) and amphetamine-based medications (e.g., Adderall, Vyvanse), are evidence-based treatments when diagnostic criteria are appropriately met. This distinction highlights the importance of accurate diagnosis in guiding appropriate pharmacological intervention.

When trauma exposure, cultural expression, environmental instability, and academic challenges are not fully explored during assessment, pharmacological treatment risks targeting surface-level symptoms rather than underlying causes. This concern is compounded by systemic constraints, including limited access to school-based mental health services, high student-to-provider ratios, and pressure on teachers to manage classroom behavior efficiently, which may position medication as a first-line response. These disparities are further intensified for Black children, who are less likely to receive consistent follow-up care and more likely to experience fragmented treatment pathways. In the absence of coordinated care, psychotherapy, or family- or school-based supports, medication may be used in isolation, limiting opportunities to assess effectiveness, monitor adherence, and develop a comprehensive understanding of the child's behavioral and emotional needs (Stevens et al., 2005).

SPECIAL EDUCATION LABELING, SURVEILLANCE, AND DEVELOPMENTAL IMPLICATIONS

LABELING AND SPECIAL EDUCATION DECISIONS

Behavioral documentation within school systems accumulates through disciplinary records (e.g., office discipline referrals, suspension reports), teacher-generated documentation (e.g., behavior logs, incident reports, and communication with administrators or parents), and formal evaluation materials (e.g., psychological assessments, IEP eligibility reports, and functional behavioral assessments conducted under the Individuals with Disabilities Education Act [IDEA]).

African American boys are disproportionately represented in behavioral disability categories, including emotional disturbance and conduct-related classifications (U.S. Department of Education, 2020). Because special education eligibility determinations rely on patterns of documented behavior, early disparities in discipline can influence later special education placement decisions. This means referral patterns are part of a cumulative record that shapes institutional perception.

The IEP is a legally mandated document under IDEA that outlines a student's eligibility for special education services, learning needs, and required support. Eligibility is determined by a multidisciplinary team based on evaluation data and documented patterns of academic and behavioral functioning. Teacher reports, disciplinary records, and observational summaries become embedded in documentation that follows students across grade levels.

The distinction between ADHD and conduct-related diagnoses carries practical consequences within special education classification systems. Under IDEA, ADHD is

commonly classified under “other health impairment,” while conduct-related diagnoses such as ODD or CD are more often associated with the “emotional disturbance” category. These classifications influence the types of services students receive. Other health impairments are associated with academic accommodations and executive functioning supports, while emotional disturbance is more often linked to behavior-focused interventions, increased monitoring, or more restrictive placements.

Documentation may be framed as supportive, but it also produces written evidence of behavioral concerns that shapes how students’ behavior is interpreted in future evaluations. The accumulation of behavioral records can influence eligibility discussions for special education classification, particularly when evaluators rely on documented history rather than comprehensive contextual assessment. Repeated documentation of behaviors such as noncompliance, aggression, or disruption may support eligibility under categories like emotional disturbance and lead to behavior-focused interventions, increased monitoring, or placement in more restrictive settings, rather than academic accommodations or executive functioning supports.

Labeling theory suggests that once students are categorized, these labels influence how their future behavior is interpreted and responded to, reinforcing deficit-based narratives (Fergus, 2016). Students identified with behavioral disabilities are more likely to experience increased monitoring, exclusionary discipline, and placement in more restrictive educational settings (Skiba et al., 2011; U.S. Department of Education, 2020). Conduct-related labeling has also been linked to increased rates of suspension and expulsion, school disengagement, and higher likelihood of contact with school-based policing and juvenile justice systems, reflecting

pathways that connect school discipline to broader carceral involvement (Skiba et al., 2014).

SURVEILLANCE AND DEVELOPMENTAL IMPLICATIONS

While special education services can provide essential support, disproportionate placement raises concerns about how labeling interacts with surveillance practices. Once categorized, students may experience increased monitoring, altered academic expectations, and more restrictive environments (Sullivan & Bal, 2013), including reduced access to rigorous coursework and increased behavioral compliance demands.

These shifts occur during critical developmental stages when identity formation, peer relationships, and academic self-concept are evolving (Huguley et al., 2019). Persistent framing of a student's behavior as oppositional or disruptive may contribute to the student's internalized stigma, decreased academic engagement, and increased risk of exclusionary discipline (Okonofua & Eberhardt, 2015; Skiba et al., 2014).

LONG-TERM CONSEQUENCES

The cumulative effects of misdiagnosis, overmedication, and disproportionate disciplinary practices may extend beyond the elementary and middle school years. Research linking exclusionary discipline and behavioral labeling to academic disengagement indicates that students who experience early disciplinary removal are more likely to demonstrate lower academic achievement, decreased school attendance, reduced participation in extracurricular activities, and increased likelihood of repeated disciplinary actions over time (Annamma et al., 2019). When Black boys are repeatedly categorized through conduct-oriented frameworks rather

than neurodevelopmental or trauma-informed lenses, they may encounter reduced access to advanced coursework, diminished teacher expectations, and heightened disciplinary scrutiny. This may occur through gatekeeping practices such as teacher recommendations for advanced classes, where students with documented behavioral concerns are less likely to be nominated or encouraged to enroll, as well as limited opportunities for enrichment or flexible academic support (Gershenson et al., 2016; Okonofua & Eberhardt, 2015).

Long-term implications also extend to mental health engagement. If early interventions are experienced primarily as behavioral control rather than supportive care, trust in educational and healthcare systems may erode. The framing of behavior as willful misconduct rather than contextualized dysregulation may influence self-perception and help-seeking patterns across adolescence, contributing to increased internalized stigma, reduced trust in educators and mental health providers, and lowered likelihood of seeking support for emotional or behavioral concerns. Some studies also link these patterns to higher risk of disengagement and substance use among marginalized youth (Carter, 2007; Okonofua & Eberhardt, 2015).

Addressing disparities in ADHD and conduct-related diagnosis among Black boys ages 6 to 14 is therefore not solely a matter of immediate classroom management; it represents an investment in long-term educational equity and psychological well-being.

POLICY FAILURES AND REFORMING DIAGNOSTIC PRACTICE

Although IDEA mandates equitable evaluation and placement procedures, racial disparities in diagnosis and special

education classification persist. Enforcement mechanisms are often weak, as patterns of misdiagnosis among Black boys ages 6 to 14 remain obscured. Addressing disparities in ADHD and conduct-related diagnoses requires reform that extends beyond individual bias to institutional safeguards. School-based social workers can lead culturally responsive practices (National Association of Social Workers [NASW], 2021); however, reform must move beyond aspirational commitments toward standardized, enforceable protocols that reduce subjectivity.

One critical reform involves embedding structured, trauma-informed differential screening prior to formal behavioral classification. Incorporating trauma-informed tools (Trauma and Justice Strategic Initiative, 2014) and requiring cross-setting symptom consistency can improve diagnostic accuracy and align evaluation practices with DSM-5-TR criteria for ADHD diagnosis (APA, 2022), while evaluating conduct-related labels helps distinguish persistent behavioral patterns from context-driven responses. The Trauma and Justice Strategic Initiative (2014) emphasizes that trauma-informed systems must recognize how environmental stressors including discrimination, housing instability, and community violence shape behavioral presentation. Incorporating validated trauma-screening tools during the pre-evaluation phase would help differentiate hypervigilance from hyperactivity and reduce premature conduct-related labeling. Requiring documentation of environmental context, cross-setting symptom consistency, and prior intervention attempts would strengthen diagnostic precision.

Strengthening the fidelity of MTSS represents another critical intervention point. MTSS frameworks are designed to provide graduated behavioral and academic support prior to referral for special education evaluation (Sugai & Horner, 2002), yet

implementation varies across districts, particularly in under-resourced schools. Policy reform should require documented evidence that Tier 1 and Tier 2 interventions were implemented with fidelity before children are classified under emotional disturbance or conduct-related categories. School social workers can coordinate Tier 2 interventions, monitor progress, and ensure that referral reflects demonstrated need rather than classroom frustration.

Positive Behavioral Interventions and Supports (PBIS) models may also be strengthened through culturally responsive adaptation. While PBIS emphasizes proactive reinforcement and behavioral skill-building (Bradshaw et al., 2010), its implementation must explicitly address implicit bias and adultification to prevent differential interpretation of similar behaviors across racial groups. This can be supported through structured training modules that include implicit bias assessment, case-based analysis, and ongoing coaching to help educators differentiate between culturally normative behaviors and behavioral concerns.

Transparency and accountability mechanisms are equally essential. Schools should collect and report referral rates, diagnostic classifications, medication patterns, and disciplinary outcomes disaggregated by race and gender to identify disproportionality trends and evaluate reform efforts, while maintaining compliance with the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). Both the NASW (2021) and NASP (2020) emphasize culturally responsive and anti-oppressive practice as ethical obligations, and embedding these standards within district-level accountability systems would shift reform from individual discretion to institutional responsibility.

Importantly, reform does not require rejecting ADHD diagnosis when clinically warranted. Rather, it requires ensuring that diagnostic decisions for Black boys are grounded in contextual assessment, equitable access to intervention, and structured safeguards against misclassification. Strengthening referral protocols, trauma screening, tiered intervention fidelity, and data oversight can reduce disparities while preserving appropriate treatment access. Transforming school-based mental health systems in this way prioritizes developmental support over behavioral containment and aligns policy with principles of clinical precision and educational equity.

CONCLUSION

Disparities in ADHD and conduct-related diagnoses among Black boys ages 6 to 14 cannot be fully explained by differences in behavioral prevalence. While ADHD is a well-established neurodevelopmental disorder requiring appropriate intervention when criteria are met (APA, 2022), Black boys may not simply be over-identified with ADHD. The distinction between overdiagnosis and misdiagnosis is therefore critical. The pathways leading to diagnosis for Black boys are shaped by adultification bias, racialized teacher referral practices, trauma misinterpretation, and institutional policy pressures, so that they are often differentially classified into conduct-related categories such as ODD or CD when their behaviors are interpreted through racialized disciplinary lenses.

These disparities are the product not of isolated decision-making but of cumulative processes embedded within educational systems. From initial behavioral documentation to special education placement and medication initiation, institutional structures influence how behaviors are

understood and managed. When trauma exposure, cultural expression, and environmental stressors are insufficiently considered, diagnostic precision is compromised. Ensuring accurate differentiation between hyperactivity, hypervigilance, and oppositional behavior is essential to preventing inequitable labeling and inappropriate intervention.

Addressing inequities in ADHD diagnosis and overmedication does not require rejecting clinical categories or pharmacological treatment. Rather, it requires strengthening contextual assessment, enforcing bias-aware referral safeguards, and expanding access to comprehensive mental health services within schools. By centering developmental science, cultural responsiveness, and structural accountability, educational systems can move toward diagnostic practices that prioritize clinical accuracy and equitable care. For Black boys navigating elementary and middle school, such reforms would lead to not only improved mental health evaluation but expanded opportunity for academic and psychological development. Without these reforms, disparities in diagnosis and treatment will continue to shape not only educational outcomes but also long-term trajectories of mental health, opportunity, and systemic inequity.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.).

Annamma, S. A., Morrison, D., & Jackson, D. D. (2019). Disproportionality fills in the gaps: Connections between achievement, discipline, and special education in the school-to-prison pipeline. *Berkeley Review of Education*, *9*(1), 33–58.

Bradshaw, C. P., Mitchell, M. M., & Leaf, P. J. (2010). Examining the effects of schoolwide positive behavioral interventions and supports on student outcomes: Results from a randomized controlled effectiveness trial in elementary schools. *Journal of Positive Behavior Interventions*, *12*(3), 133–148. https://doi.org/10.1177/1098300709334798

Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist*, *35*(1), 13–105. https://doi.org/10.1177/0011000006292033

Danielson, M. L., Bitsko, R. H., Ghandour, R. M., Holbrook, J. R., Kogan, M. D., & Blumberg, S. J. (2018). Prevalence of parent-reported ADHD diagnosis and associated treatment among U.S. children and adolescents. *Journal of Clinical Child & Adolescent Psychology*, *47*(2), 199–212. https://doi.org/10.1080/15374416.2017.1417860

Emdin, C. (2016). *For White folks who teach in the hood . . . and the rest of y'all too: Reality pedagogy and urban education*. Beacon Press.

Fairchild, G., Hawes, D. J., Frick, P. J., Copeland, W. E., Odgers, C. L., Franke, B., Freitag, C. M., & De Brito, S. A. (2019). Conduct disorder. *Nature Reviews Disease Primers*, *5*(1), 43. https://doi.org/10.1038/s41572-019-0095-y

Fergus, E. (2016). *Solving disproportionality and achieving equity: A leader's guide to using data to change hearts and minds*. Corwin Press.

Gershenson, S., Hart, C. M. D., Lindsay, C. A., & Papageorge, N. W. (2016). The long-run impacts of same-race teachers (IZA Discussion Paper No. 10630). IZA–Institute of Labor Economics.

Goff, P. A., Jackson, M. C., Di Leone, B. A. L., Culotta, C. M., & DiTomasso, N. A. (2014). The essence of innocence: Consequences of dehumanizing Black children. *Journal of Personality and Social Psychology, 106*(4), 526–545. https://doi.org/10.1037/a0035663

Huguley, J. P., Wang, M.-T., Neal, R., & Jackson, S. (2019). Racial/ethnic disparities in school belonging: The role of relationships and school climate. *Educational Psychologist*, *54*(2), 93–113. https://doi.org/10.1080/00461520.2019.1633928

Milner, H. R. (2012). But what is urban education? *Urban Education*, *47*(3). https://doi.org/10.1177/0042085912447516

Morgan, P. L., Staff, J., Hillemeier, M. M., Farkas, G., & Maczuga, S. (2013). Racial and ethnic disparities in ADHD diagnosis from kindergarten to eighth grade. *Pediatrics*, *132*(1), 85–93. https://doi.org/10.1542/peds.2012-2390

Moynihan, R., Doust, J., & Henry, D. (2012). Preventing overdiagnosis: How to stop harming the healthy. *BMJ*, *344*, e3502. https://doi.org/10.1136/bmj.e3502

MTA Cooperative Group. (1999). A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Archives of General Psychiatry*, *56*(12), 1073–1086.

National Association of School Psychologists. (2020). *The professional standards of the National Association of School Psychologists.*

National Association of Social Workers. (2021). *NASW code of ethics*.

National Center for Education Statistics. (2022a). Digest of education statistics, 2022 (Table 209.10: Public school teachers, by race/ethnicity). https://nces.ed.gov/programs/digest/d22/tables/dt22_209.10.asp

National Center for Education Statistics. (2022b). Digest of education statistics, 2022 (Table 203.50: Enrollment in public elementary and secondary schools, by race/ethnicity). https://nces.ed.gov/programs/digest/d22/tables/dt22_203.50.asp

Office for Civil Rights. (2014). Civil rights data collection: Data snapshot (school discipline). U.S. Department of Education. https://ocrdata.ed.gov/assets/downloads/CRDC-School-Discipline-Snapshot.pdf

Okonofua, J. A., & Eberhardt, J. L. (2015). Two strikes: Race and the disciplining of young students. *Psychological Science*, *26*(5), 617–624. https://doi.org/10.1177/0956797615570365

Overstreet, S., & Chafouleas, S. M. (2016). Trauma-informed schools: Introduction to the special issue. *School Mental Health*, *8*(1), 1–6. https://doi.org/10.1007/s12310-016-9184-1

Skiba, R. J., Horner, R. H., Chung, C.-G., Rausch, M. K., May, S. L., & Tobin, T. (2011). Race is not neutral: A national investigation of African American and Latino disproportionality in school discipline. *School Psychology Review*, *40*(1), 85–107. https://doi.org/10.1080/02796015.2011.12087730

Skiba, R. J., Michael, R. S., Nardo, A. C., & Peterson, R. L. (2014). The color of discipline: Sources of racial and gender disproportionality in school punishment. *Urban Review, 46*(3), 317–342.

Stevens, J., Harman, J. S., & Kelleher, K. J. (2005). Race/ethnicity and insurance status as factors associated with ADHD treatment patterns. *Journal of Child and Adolescent Psychopharmacology*, *15*(1), 88–96.

Sugai, G., & Horner, R. (2002). The evolution of discipline practices: School-wide positive behavior supports. *Child & Family Behavior Therapy*, *24*(1–2), 23–50. https://doi.org/10.1300/J019v24n01_03

Sullivan, A. L., & Bal, A. (2013). Disproportionality in special education: Effects of individual and school variables on disability risk. *Exceptional Children*, *79*(4), 475–494.

Thomas, C. R., & Holzer, C. E. (2006). The continuing shortage of child and adolescent psychiatrists. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(9), 1023–1031.

Trauma and Justice Strategic Initiative. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* Substance Abuse and Mental Health Services Administration.

U.S. Department of Education. (2020). Individuals with Disabilities Education Act (IDEA) data. https://sites.ed.gov/idea/idea-data/

Welch, H. G., Schwartz, L. M., & Woloshin, S. (2011). *Overdiagnosed: Making people sick in the pursuit of health*. Beacon Press.

THE SHACKLING OF INCARCERATED PREGNANT WOMEN: ANALYSIS OF ALTERNATIVE POLICY

GEORGIA BERRY, ANGELA HARRISON,
FLYNN HOLMAN & SOFIA ZOGRAFOS

GEORGIA BERRY

BIO

Georgia is a 2026 graduate of Columbia School of Social Work, specializing in Advanced Clinical Practice. She is a member of the second cohort of Columbia's Psychedelic Therapy Training Program. Her MSW training includes a practicum with Futures Ignite as a high school counselor, and a current placement with NYU Langone's Center for Psychedelic Medicine, where she continues to bridge her backgrounds in neuroscience and social work at the forefront of emerging mental health treatment. Georgia received her undergraduate degree in neuroscience with a minor in art history from Skidmore College, where her research thesis focused on neurodegenerative diseases. Prior to pursuing her MSW, Georgia worked in developmental neuroscience, studying early life adversity and stress-associated pathology. Georgia is a member of both the Sleep Mind Health Lab and the Action Lab for Social Justice at CSSW. Her current research centers communities of color and women's health, with a particular focus on the impacts of systemic inequity.

ANGELA HARRISON

BIO

Angela is a graduating MSW student at Columbia School of Social Work on the Advanced Clinical Practice track. She is a former professional dancer and dance educator and is passionate about the mind-body connection and the role movement plays in supporting mental health. Currently, Angela works as a Research Assistant with the Action Lab for Social Justice and an Orientation Leader with Student Life. She looks forward to serving Black and Brown children, youth, and communities in NYC and beyond.

FLYNN HOLMAN

BIO

Flynn Holman is a Master of Social Work Student at Columbia University on the Advanced Clinical Practice track. Her professional experience includes providing compassionate and comprehensive trauma-focused care to survivors of violence, leading family workshops, and establishing trauma-informed programming. She is passionate about working with diverse populations facing systemic inequality and continuing to connect one-on-one client care with systemic change.

SOFIA ZOGRAFOS

BIO

Sofia is a graduating MSW student at Columbia School of Social Work in the Policy Practice track. Throughout her academic and professional experience, she has specialized in international social welfare, immigration, and refugee resettlement. She currently works on the research team at Columbia's Social Intervention Group, contributing to projects focused on strengthening social welfare infrastructure in Uzbekistan. Sofia is passionate about strategic, human-centered humanitarian work, particularly through research, policy development, and program reform. She looks forward to continuing her advocacy in the field following graduation.

INSPIRATION

This paper originated as a broad inquiry into policy reform within carceral systems. When we dug deeper, the overlooked and unethical practice of shackling pregnant incarcerated women emerged as a critical concern. Our policy analysis transitioned from a general examination of systemic inequities in the criminal legal system, to a focused investigation of a practice shaped by racism, misogyny, and reproductive injustice. The evidence underscores the urgency of this issue, given the significant vulnerability and trauma experienced by this population. Employing a policy analysis approach, this paper calls for immediate action to dismantle the practice of shackling pregnant women behind bars.

ABSTRACT

The shackling of pregnant incarcerated individuals, through restraints such as handcuffs, waist chains, and leg irons, is a dehumanizing practice that poses serious physical and mental health risks to both parent and child. This practice is disproportionately imposed on women of color, who are vastly overrepresented in the incarcerated population. Black women are three times more likely than white women to be incarcerated, and women overall represent the fastest-growing segment of the detained population, with an 800% increase over the last 30 years (American Civil Liberties Union [ACLU], 2007; Keyes, 2014). As the number of incarcerated women has grown, so too has the number of pregnancies and births occurring within carceral systems, making the absence of strong anti-shackling protections an urgent public health and civil rights concern. Despite well-documented health risks and widespread recognition of the practice's discriminatory nature, many states maintain weak laws, and some have no laws, prohibiting the shackling of pregnant women (Bandele, 2017). This policy analysis paper exposes the discriminatory practice of shackling, specifically of marginalized pregnant populations in prison, and proposes steps toward ethical policy alternatives. Using the IRAC framework for legal policy analysis (Issue, Rule, Analysis, Conclusion), this paper examines shackling policies from U.S. regulations to global policies, and from the most humane laws to the most restrictive. From this, we developed concrete policy solutions. The proposed *Resilient Mothers Act* addresses the needs of the most marginalized—pregnant Black women experiencing incarceration—as a pathway toward broader equity and justice within prison reform efforts.

Keywords: shackling, mass incarceration, women, pregnancy, discrimination, marginalization, dehumanization, racism

THE SHACKLING OF INCARCERATED PREGNANT WOMEN: ANALYSIS OF ALTERNATIVE POLICY

Pregnancy is a moment of profound vulnerability, requiring care and support. Yet inside carceral systems, pregnant individuals are stripped of both. Women are the fastest-growing population in the prison system; pregnant women are an even more marginalized subgroup (ACLU, 2007). Shackling is a dehumanizing practice designed to impede the movement of incarcerated individuals in prison through the use of physical restraints. For many, especially the most marginalized groups of incarcerated people, shackling can have devastatingly harmful outcomes.

The physical devices used in shackling often consist of handcuffs, waist chains, and leg irons. Various types of steel and metal are forged together to create these devices. Leg irons, similar to handcuffs, can be around nine inches long. They consist of two circular openings for the wrists or ankles connected by either a bar or a chain. The inner workings of the cuffs are such that the "teeth" on the mouth of the cuffs, or "ratchet," interact and can lock with an inside mechanism called a "pawl," which allows the cuff to constrict around the wrist or ankle, preventing full rotation (National Institute of Justice, 1982). Waist chains are used in situations where elevated security is deemed necessary. This involves a chain that can cover up to a 54-inch waist that is placed above the hip bone (ICS Jail Supplies, n.d.). The chain has a special link that loosens once the handcuffs are added, so the chain must be tightened onto the belt to prevent additional movement. Handcuffs are attached to the chain through a piece called a "connector chain" and, in more severe instances, connected to leg irons as well. In some cases, to connect the leg irons, an incarcerated person would have to position themselves on their knees facing away from the corrections officer. The

officer would then tighten the leg irons around the individual's ankles and secure the waist chain with a padlock, which prevents the individual from removing the chain.

Shackling in healthcare environments refers to restraining a patient's body through physical, medical, or mechanical means when there is no medical necessity. While often defended as a safety measure, shackling is a harmful and violent act that negatively impacts both patients and healthcare workers' ability to assess and treat. Shackling is widely considered a violation of human rights, particularly for incarcerated pregnant or perinatal individuals, yet it persists because of ongoing systemic inequities within the criminal legal system. Policy reforms are essential to prevent continued discrimination related to this practice (American Public Health Association [APHA], 2023).

Using the Issue, Rule, Analysis, and Conclusion (IRAC) method for legal policy analysis, we aim to expose the discriminatory practice of shackling pregnant women in prison. We close by proposing the *Resilient Mothers Act*, which would take the necessary first steps toward ethical policy reform.

ISSUE

Mass incarceration serves as the bedrock of modern-day racism in the United States. One of this system's most vulnerable and at-risk populations is pregnant women. Although people of color represent roughly 30% of the population in the U.S., they represent about 60% of the population of incarcerated individuals (Keyes, 2014). Women are the fastest-growing segment within these systems, as the number of women in detention has increased by 800% in the last 30 years and has increased twice as fast as the number of men in detention since 1985 (ACLU, 2007). Women of color are significantly overrepresented in this population,

with Black women being three times more likely than white women to be incarcerated (Keyes, 2014). It is estimated that roughly 55,000 pregnant individuals are admitted to jails each year, many of whom are shackled throughout all stages of pregnancy and postpartum (Dufresne, 2023). Pregnant women are often continuously shackled during labor and delivery, one of the most vulnerable and usually traumatic stages of pregnancy (Bandele, 2017). While it is difficult to gather representative information due to limited transparency, bias, and underreporting, Goshin and colleagues (2019) found that around 83% of perinatal nurses who worked with incarcerated women during pregnancy and postpartum stated that their patients were shackled part of the time to all of the time. Additionally, only 7.4% of nurses correctly identified whether their state had shackling laws.

The U.S. criminal legal system is framed as an effort to maintain public safety and deter crime. But it functions alongside policies and practices that perpetuate racial segregation, disenfranchisement, and systemic inequity to create a modern Jim Crow order. In the U.S., incarceration has become the nation's default response to crime, with 70% of convictions leading to confinement, which is far more than in other countries. Furthermore, carceral systems are driven by racist policies like the "War on Drugs," politically motivated public fear, and capitalism, not actual crime rates (Widra, 2024). Due to intentional discrepancies in how laws are written and upheld, mass incarceration maintains the racial hierarchy established by white supremacy, where whiteness is held as the ideal standard and other races and ethnicities are ordered in subordinate positions based on their proximity to whiteness. This hierarchy aims to enshrine the disempowerment of Black individuals, with other intersecting identities such as gender, sexuality, ability, and class contributing to even further marginalization within

society. This marginalization can be observed in part through limited economic opportunities, decreased social capital, discriminatory policies, adverse health outcomes, and disproportionate representation in systems of incarceration. These unjust outcomes are impacting people of color on a massive scale.

In 2024, nearly 2 million people were detained in this nation's expansive criminal legal system, including state, federal, local, and tribal detention facilities (Sawyer & Wagner, 2024). In early 2025, we observed a notable increase in federal and immigration detention, with an overall systemwide cost of at least $182 billion per year to maintain existing carceral systems (Ghandnoosh & Pearce, 2025; Sawyer & Wagner, 2025). Furthermore, the Justice Policy Institute found that during the 1990s, the New York state prison budget grew by $761 million. In contrast, New York's budget for higher education dropped by $615 million during this decade. Statistics like this show the financial impact of mass incarceration, as the federal government increasingly fails to allocate funding toward social services and education, which would reduce the need for jails (Irwin et al, 1999).

With the population of incarcerated women increasing drastically, the number of pregnancies and births within the criminal justice system has increased as well. According to a 2024 report from the ACLU, about 60% of women in prison were the primary caregivers to a child under 18 years old before their sentencing. Additionally, every year, 80% of women in jail are mothers of children under the age of 18 years old (Kendrick, 2024).

A common justification that state judicial systems use to defend shackling is that it prevents escapes. When incarcerated individuals are taken out of the correctional

facility and transported to nearby hospitals or clinics to give birth, they are often deemed a flight risk. However, according to the American Medical Association (AMA), the overwhelming majority of incarcerated pregnant individuals are unlikely to try to escape, harm others, or harm themselves. Women have been the fastest-growing and least violent population in the prison system since the 1990s (Advocacy Resource Center, 2015; Budd et al., 2025; Kajstura & Sawyer, 2024).

Unequal pain treatment in the U.S. medical system is directly tied to white supremacy culture and racism. Research shows that medical trainees in the U.S. often demonstrate bias against Black patients' pain—for instance, as seen in the false belief that Black people have thicker skin and fewer nerve endings. These biases are directly related to historical narratives used to justify the abuse of enslaved Black Americans (Morais et al., 2022). Additionally, patients with sickle cell disease, which disproportionately affects Black populations, experience 50% longer physician wait times than patients with long bone fractures (Haywood et al., 2013). A 2024 systematic review and meta-analysis found that Black patients were less likely to receive opioid prescriptions than non-Hispanic white patients presenting with the same type of pain (OR = 0.83, 95% CI [0.73–0.94]). These results have stayed consistent for over a decade from the original study (Hirani et al., 2024; Meghani et al., 2012). Racism in the medical system is particularly pronounced for Black women, who face the intersectional effects of both racial and gender bias on how their pain is perceived, reported, and treated.

The practice of shackling incarcerated women during labor not only undermines principles of justice by dehumanizing them and violating their dignity, but also poses serious physical and mental health risks to both the parent and the

baby. Physical risks of shackling include severe bruising, fractures, abrasions, lacerations, infections, scarring, and nerve damage. Pregnant women are especially susceptible to the harms of shackling, as it increases their risk of abdominal trauma, hemorrhage, and preterm birth, as well as risks to the fetus (APHA, 2023). Shackling is also directly linked to limited mobility and forced limb movements that increase the extreme risk of falls, which can lead to heart attacks, strokes, and fetal death (Robinson et al., 2021). Moreover, shackling can hinder the processes of labor and delivery, limit emergency obstetric care, and impede postpartum recovery, including the mother's ability to safely hold and breastfeed her infant (APHA, 2023).

Through qualitative studies that included provider interviews and patient experiences, the American Public Health Association (APHA) found a plethora of emotional harms. They found that witnessing a patient in shackles can exacerbate the existing negative bias toward incarcerated patients. This bias increases inappropriate use of force among healthcare providers and security guards. Incarcerated patients may view their provider as complicit with shackling, which further breaks down trust between patients and providers (APHA, 2023). The presence of shackles heightens feelings of extreme disrespect and a violation of human dignity. According to Goshin et al. (2019), incarcerated women already have disproportionately high rates of depression and posttraumatic stress disorder, which is further intensified by shackling. The inability to adjust their bodies while in pain is degrading and cruel. Immediate separation of infants from parents can lead to extreme behavioral and emotional dysregulation for both the child and the mother. Without maternal–newborn bonding, incarcerated mothers can experience low self-esteem, depression, anxiety, anger, and psychiatric disorders (Ferszt et al., 2018; Franco et al., 2020). Shackling prevents pain-management practices, impedes

time-sensitive lifesaving medical interventions, and can lead to post-birth psychological conditions.

Hessami and colleagues (2022) conducted a systematic review and meta-analysis looking at the inadequate prenatal care and birth outcomes of incarcerated individuals compared to non-incarcerated individuals. They found preliminary results that incarcerated individuals have a higher risk for inadequate prenatal care compared to non-incarcerated individuals. Although their sample comprised 11,534 pregnant women, they suggest that further research is needed. The minimal research in the past decade on pregnant incarcerated demographics does not represent reality, as many reports are unfinished or births are not documented (Bronson & Sufrin, 2019; Sufrin et al., 2019). It is important to note that limited research has been conducted on the full impact of shackling and the quality of healthcare for incarcerated pregnant women, further marginalizing this population through under-documentation.

On a societal level, shackling is inextricably linked to anti-Black racism, as it was used to facilitate the subordination, dehumanization, and control of enslaved individuals. Given the disproportionate incarceration of Black and Brown women, shackling exacerbates the white supremacist racial order (Dufresne, 2023). From forced reproduction during slavery to coercive sterilization practices, Black women's bodies have been objectified, dehumanized, and controlled. Shackling during pregnancy perpetuates this legacy and disproportionately targets Black women, who are overrepresented in prisons due to systemic racism (Weber et al., 2018). Black women are often seen as dangerous or unworthy of compassion, thus making them more likely to experience the degrading practice of shackling (Marsh, 2009). These damaging perspectives lead to harmful

expressions, like the "strong Black woman" trope, which denies Black women the care and attention they need.

From a social work perspective, adopting a liberatory framework in the policy design process would center the voices of Black women, which is vital to this policy (Hacker, 2013). Policymakers would work with currently and formerly incarcerated women and advocacy organizations led by women of color to ensure adequate prenatal care. Social workers and learning coaches would develop provisions for culturally competent, trauma-informed care and staff education on implicit bias, which would affect maternal outcomes and help ensure equitable implementation (Crenshaw, 2014).

RULE

After identifying the issue, we outline the rules and laws governing shackling policies across the U.S. Although many states have individual laws prohibiting restraints, "extraordinary circumstances" loopholes in these laws allow correctional officers' biases to influence the use of shackles. State bans on shackling have been ineffective, as cases have come forward where women were shackled unlawfully despite supposed state protection (Dufresne, 2023). A federal law would better protect the rights, dignity, and health of pregnant women who are incarcerated by creating a widespread shift in attitudes, treatment, and outcomes for people who are incarcerated.

The Eighth Amendment to the U.S. Constitution states that cruel and unusual punishment is prohibited, which most states interpret as a prohibition on shackling pregnant individuals, particularly during childbirth. However, there are many loopholes that correctional facilities use that we believe are human rights violations and violate the Eighth Amendment.

Additionally, the Fourteenth Amendment's Due Process and Equal Protection clauses assert the dignity and worth of every person as a fundamental human right—a principle that shackling infringes on, particularly for vulnerable populations who require additional protection. Take the state of Louisiana as an example, in which Black incarceration rates are one of the highest in the nation, with Black individuals being incarcerated at a rate nearly five times higher than whites. There is a widening public health concern that mass incarceration may be a contributing factor in reproductive health disparities, with a notable 3% risk of preterm births among Black women in Louisiana (Dyer et al., 2019).

In the last 10 years, Louisiana has enacted three state laws to provide better health support for incarcerated women. Act No. 761 (2012) requires staff training and prohibits the shackling of pregnant individuals. Along with this, the Safe Pregnancy for Incarcerated Women Act was established to require all local and state correctional facilities to provide records on the use of restraints, allow incarcerated individuals to request medical staff during body searches after returning from the hospital, and provide written information to pregnant women on their restraint policies. Act No. 392 (2018) requires correctional facilities to provide healthcare products for women. Lastly, Act No. 140 (2020) prohibits the use of solitary confinement for pregnant women.

Despite these laws, the use of restraints, denial of medical professionals' advice, and unclear documentation on incarcerated pregnant women still exist to this day. Only a few facilities complied with providing incarcerated individuals with a written restraint policy. If documentation of shackling is provided under Act 761, it is often left blank or incomplete, leaving out the reason for shackling or the duration of restraint. As for Act 392, many facilities still charge women

for feminine hygiene products unless they have less than $2 in their bank account, and even then, they add this cost as a debt that the incarcerated individuals must pay back (Louisiana Public Health Institute, 2023). This is an inequitable practice, further marginalizing women in prisons.

In 2015, the Rebecca Project for Human Rights and the National Women's Law Center published *Mothers Behind Bars*, a state-by-state report card on shackling policies for pregnant women. They found that 31 states do not require medical staff input when determining whether a pregnant woman should be restrained. 36 states received a failing grade because they do not limit the use of restraints, including the harmful leg irons and waist chains that could injure the mother and the fetus during transportation, labor and delivery, and the postpartum period (Advocacy Resource Center, 2015).

ANALYSIS

For over a decade, the practice of shackling pregnant women in prison in the U.S. has been widely criticized. National correctional and medical associations like the American Congress of Obstetricians and Gynecologists (ACOG), AMA, APHA, and the Federal Bureau of Prisons have all vocally opposed the shackling of pregnant women due to its inhumane, hazardous, and avoidable nature (Advocacy Resource Center, 2015). ACOG released an updated committee opinion concluding that physical restraints impede physicians' ability to effectively care for pregnant people and fetuses, causing serious risk. This includes added bruising and pain, risk of falls, and inability to effectively treat preeclampsia, vaginal bleeding, nausea, and many other medical emergencies during labor, delivery, and postpartum (ACOG, 2021).

Despite these open criticisms citing the understood health risks and the blatant racism and misogyny embedded in this discriminatory practice, most states maintain laws that leave significant room for harm, and some states have no laws prohibiting the shackling of pregnant women. As of August 2024, approximately 40 states had legislation prohibiting the shackling of pregnant women, but reports of prison and hospital staff ignoring these policies are rampant (Rayasam, 2024). Even when the laws are in place, there is limited oversight, confusion about their meaning, and wide loopholes for staff to exploit. These loopholes lead to unsafe childbirth experiences and deliberate discrimination against women of color (Rayasam, 2024).

We began our policy solution search by identifying model policies in states with the most progressive and humane laws. These states include California, New York, Illinois, Vermont, Washington, Connecticut, Colorado, and Minnesota. These states have progressive and protective legislation that emphasizes humane treatment. Some important features of more progressive policies include the prohibition of shackling during labor, delivery, or the postpartum period, except when a clear, documented security risk is present in the most exceptional circumstances. They also make it clear that if restraints must be applied in extraordinary circumstances, they must be removed immediately if they interfere with medical care. There are clear and extensive guidelines for the removal of restraints, and the policies specify that healthcare professionals, not prison staff, make decisions about shackling. These policies also all, in some form, ensure mental health support and trauma-informed prenatal and postpartum care (Kramer et al., 2022). In the U.S., the First Step Act of 2018 could be a beginning step toward a nationwide policy against shackling pregnant women (Federal Bureau of Prisons, n.d.). It prohibits the use of restraints on

pregnant women during all stages of pregnancy, and ensures that medical staff, not corrections officers, are involved in making decisions about the use of restraints. Unfortunately it applies only to federal facilities, and even then is enforced inconsistently (Samant, 2018).

We then looked at other countries for the most humane and restrictive shackling laws in the world. We did this because, despite the progressive policies the aforementioned states enacted, the U.S. continually disregards legal restrictions that promote human rights, medical standards, racial equality, and gender equality. Some of the most humane shackling laws for pregnant women exist in the U.K., Canada, Australia, Norway, Sweden, and New Zealand. These countries have similar laws as the progressive states listed previously, but their restrictions put an extra emphasis on human rights and gender equality. These laws also apply nationwide, rather than leaving jurisdiction to states or territories. Most notably, Norway and Sweden have a more human-rights-based model, prioritizing medical care, dignity, alternatives to incarceration, and gender-sensitive approaches. Within this model, efforts are made to amend legislation to ensure humane practices (United Nations Office on Drugs and Crime, 2014).

Based on this review, we developed a list of proposed policy solutions that constitute our *Resilient Mothers Act*. The *Resilient Mothers Act* will protect women who are pregnant and facing incarceration through all stages of pregnancy, including transportation, labor, delivery, and postpartum recovery. Our justification for this policy draws on research demonstrating that banning the practice is essential to addressing systemic inequities, protecting human rights, closing gaps in state law, countering security myths, and improving health outcomes (Project Nia & Barnard Center for Research on Women, 2020).

First and foremost, we call for a complete prohibition of shackling, including all use of physical restraints. The sole exception would be in cases where the individual poses an immediate threat to themselves or others. This exception, however, would have to be properly documented and justified by medical staff. We would mandate detailed reporting and justification and propose regular audits and reviews by independent bodies. This would ensure that accountability is at the forefront of every decision. If the justification is not sufficient, we propose legal repercussions. Shackling pregnant women in prisons would be a violation of federal law, and therefore, there would be penalties for those who do not comply and legal pathways for individuals to seek civil damages. We hope the detailed paperwork, consistent accountability, and federal repercussions would help mitigate the loopholes that currently lead to rampant racial biases and misogyny.

The Resilient Mothers Act would also require medical oversight and ensure that medical staff, not prison staff, are responsible for any final decisions regarding shackling. Currently, most legislation does not consider medical implications and silences physicians' voices (Dufresne, 2023). A physician's job is to prevent the health complications and harm that shackles cause during birth, but as of now, their requests to remove shackles are often ignored.

In addition to these measures, the law will require staff training, focusing on trauma-informed, antiracist, and gender-sensitive education for all prison staff who oversee pregnant women. This education would include the physical and psychological risks and harms of shackling during pregnancy, such as increased risk of fall, inability to quickly perform medical care (which can lead to complications as drastic as death), increased pain during delivery, fetal distress,

breastfeeding complications, humiliation, triggered PTSD from past trauma, and the inability for parent and child to bond (Hall et al., 2015). Additionally, this training must include diversity training, as the majority of these pregnant individuals are non-white. As the U.S. incarcerates more and more people for nonviolent offenses, minority populations, specifically African Americans and Latinos, unjustly comprise over 70% of new admissions (Irwin et al, 1999).

To ensure the successful implementation of the *Resilient Mothers Act*, we offer a sustainable funding strategy that lays the groundwork for advancing reproductive justice for all incarcerated women. This includes reallocating funds from the prison budget: We propose introducing a dedicated pre-allocation (similar to the pretax system) for the budgets of prison facilities housing women. This funding would be reserved for costs directly associated with compliance, training, implementation, ongoing education for medical and prison staff, feminine care provisions, and enhanced maternal healthcare services. This pre-allocation recognizes facilities' responsibility to address gender-specific needs and ensures that funds are directed toward the initiatives. By reallocating existing resources within the carceral system, we uphold justice and human rights without imposing additional financial burdens on taxpayers.

Approximately two-thirds of incarcerated individuals are employed while in prison. Many earn pennies on the dollar, while states such as Arkansas and Texas do not pay wages at all (Eisen, 2023). We propose that corporations benefiting from incarcerated labor pay a surcharge or fee. This fee would function similarly to employer-paid health benefits (like Uber's driver benefits fee, which customers pay in service charges). It would contribute to the *Resilient Mothers Act* account, which will be dedicated to funding research and

key initiatives to ensure compliance. This fee would serve as a commitment by corporations that profit from the labor of incarcerated individuals, aligning with the growing societal demands for accountability and equitable practices.

This law supports the immediate implementation of bans on shackling and lays the foundation for systemic reforms. By meeting the needs of the most marginalized populations experiencing incarceration, we can create a pathway for more expansive justice within prison reform efforts.

CONCLUSION

We firmly believe a solution that acknowledges the intersectional and systemic oppressions and racism embedded in shackling practices must include a comprehensive federal ban on this cruel and dehumanizing practice. This includes fully dismantling its harmful effects and restoring the dignity and humanity of all pregnant women who are incarcerated. By addressing injustice at its core, we move toward protecting the human rights and health of incarcerated women nationwide.

We envision challenging societal views of incarcerated women by emphasizing their dignity as human beings deserving of equitable treatment and systemic support. *The Resilient Mothers Act* would address the historical and systemic injustices faced by Black and Brown women while creating a foundation for future maternal care reform in carceral systems. This act affirms their humanity, ensures uniform national protection, and eliminates the bias of correctional staff when making decisions about shackling. This approach is not only a matter of justice but also a reaffirmation of the human rights to which all individuals are entitled.

REFERENCES

Advocacy Resource Center. (2015). *An "act to prohibit the shackling of pregnant prisoners" model state legislation.* American Medical Association. https://www.ama-assn.org/media/9791/download

American Civil Liberties Union. (2007). *Facts about the over-incarceration of women in the United States.* https://www.aclu.org/documents/facts-about-over-incarceration-women-united-states

American College of Obstetricians and Gynecologists. (2021). Reproductive health care for incarcerated pregnant, postpartum, and nonpregnant individuals: ACOG committee opinion summary, number 830. *Obstetrics & Gynecology*, *138*(1), 164–165. https://doi.org/10.1097/AOG.0000000000004430

American Public Health Association. (2023). *A call to stop shackling incarcerated patients seeking health care.* https://www.apha.org/policy-and-advocacy/public-health-policy-briefs/policy-database/2024/01/16/shackling-incarcerated-patients

Bandele, M. (2017). *Here's how prison and jail systems brutalize women, especially mothers.* American Civil Liberties Union. https://www.aclu.org/news/womens-rights/heres-how-prison-and-jail-systems-brutalize-women

Bronson, J. & Sufrin, C. (2019). Pregnant women in prison and jail don't count: Data gaps on maternal health and incarceration. *Public Health Reports, 134*(1): 57–62. https://doi.org/10.1177/0033354918812088

Budd, K. M., Napal, D., & Rovner, J. (2025). *Incarcerated women and girls* [Fact sheet]. The Sentencing Project. https://www.sentencingproject.org/fact-sheet/incarcerated-women-and-girls/

Crenshaw, K. (2014). *On intersectionality: Essential writings*. New Press.

Dufresne, L. (2023). Pregnant prisoners in shackles. *Voices in Bioethics*, *9*. https://doi.org/10.52214/vib.v9i.11638

Dyer, L., Hardeman, R., Vilda, D., Theall, K., & Wallace, M. (2019). Mass incarceration and public health: The association between Black jail incarceration and adverse birth outcomes among Black women in Louisiana. *BMC Pregnancy Childbirth*, *19*(525). https://doi.org/10.1186/s12884-019-2690-z

Eisen, L. (2023). *America's dystopian incarceration system: Pay to stay behind bars.* Brennan Center for Justice. https://www.brennancenter.org/our-work/analysis-opinion/americas-dystopian-incarceration-system-pay-stay-behind-bars

Federal Bureau of Prisons. (n.d.). *An overview of the First Step Act.* U.S. Department of Justice. Retrieved April 13, 2026, from https://www.bop.gov/inmates/fsa/overview.jsp

Ferszt, G. G., Palmer, M., & McGrane, C. (2018). Where does your state stand on shackling of pregnant incarcerated women? *Nursing for Women's Health, 22*(1), 17–23. https://doi.org/10.1016/j.nwh.2017.12.005

Franco, C., Mowers, E., & Lewis, D. L. (2020). Equitable care for pregnant incarcerated women: Infant contact after birth—a human right. *Perspectives on Sexual and Reproductive Health, 52*(4), 211–215. https://deepblue.lib.umich.edu/bitstream/handle/2027.42/166238/psrh12166.pdf

Ghandnoosh, N., & Pearce, S. (2025). *America's incarceration crossroads: Reversing progress amid record-low crime rates.* The Sentencing Project. https://www.sentencingproject.org/policy-brief/americas-incarceration-crossroads-reversing-progress-amid-record-low-crime-rates/

Goshin, L. S., Sissoko, D. R., Neumann, G., Sufrin, C., & Byrnes, L. (2019). Perinatal nurses' experiences with and knowledge of the care of incarcerated women during pregnancy and the postpartum period. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 48*(1), 27–36. https://doi.org/10.1016/j.jogn.2018.11.002

Hacker, K. (2013). *Community-based participatory research.* SAGE Publications.

Hall, R. C. H., Friedman, S. H., & Jain, A. (2015). Pregnant women and the use of corrections, restraints, and substance use commitment. *Journal of the American Academy of Psychiatry and the Law, 43*(3), 359–368. https://jaapl.org/content/43/3/359

Haywood Jr., C., Tanabe, P., Naik, R., Beach, M. C., & Lanzkron, S. (2013). The impact of race and disease on sickle cell patient wait times in the emergency department. *The American Journal of Emergency Medicine, 31*(4), 651–656. https://doi.org/10.1016/j.ajem.2012.11.005

Hessami, K., Hutchinson-Colas, J., Chervenak, F., Shamshirsaz, A., Zargarzadeh, N., Norooznezhad, A., Grünebaum, A., & Bachmann, G. (2022). Prenatal care and pregnancy outcome among incarcerated pregnant individuals in the U.S.: A systematic review and meta-analysis. *Journal of Perinatal Medicine, 51*(5), 600–606. https://doi.org/10.1515/jpm-2022-0412

Hirani, S., Benkli, B., Odonkor, C. A., Hirani, Z. A., Oso, T., Bohacek, S., Wiedrick, J., Hildebrand, A., Osuagwu, U., Orhurhu, V., Hooten, W. M., Abdi, S., & Meghani, S. (2024). Racial disparities in opioid prescribing in the United States from 2011 to 2021: A systematic review and meta-analysis. *Journal of Pain Research, 17*, 3639–3649. https://doi.org/10.2147/JPR.S4771

ICS Jail Supplies. (n.d.). *Peerless waist chain* [Product page]. Retrieved April 13, 2026, from https://www.icswaco.com/PEERLESS-WAIST-CHAIN

Irwin, J., Schiraldi, V., & Ziedenberg, J. (1999). *One million nonviolent prisoners.* Justice Policy Institute. http://www.justicepolicy.org/images/upload/99-03_REP_OneMillionNonviolentPrisoners_AC.pdf

Kajstura, A., & Sawyer, W. (2024). *Women's mass incarceration: The whole pie 2024*. Prison Policy Initiative. https://www.prisonpolicy.org/reports/pie2024women.html

Kendrick, C. (2024). *The painful reality of being an incarcerated mother.* American Civil Liberties Union. https://www.aclu.org/news/prisoners-rights/the-painful-reality-of-being-an-incarcerated- mother

Keyes, O. (2014). *Mass incarceration and people of color.* Southern Coalition for Social Justice. https://southerncoalition.org/mass-incarceration-people-color

Kramer, C., Thomas, K., Patil, A., Hayes, C. M., & Sufrin, C. B. (2022). Shackling and pregnancy care policies in US prisons and jails. *Maternal and Child Health Journal, 27*(1), 186–196. https://doi.org/10.1007/s10995-022-03526-y

Louisiana Public Health Institute. (2023). *Pregnancy and maternal health for incarcerated women in Louisiana*. https://www.incarcerationtransparency.org/wp-content/uploads/2024/02/HCR-85-Report-Final-Corrected.pdf

Marsh, S. (2009). The lens of implicit bias. *Juvenile and Family Justice Today.* https://www.ncjfcj.org/wp-content/uploads/2025/12/The-Lens-of-Implicit-Bias_0.pdf

Meghani, S. H., Byun, E., & Gallagher, R. M. (2012). Time to take stock: A meta-analysis and systematic review of analgesic treatment disparities for pain in the United States. *Pain Medicine, 13*(2), 150–174. https://doi.org/10.1111/j.1526-4637.2011.01310.x

Morais, C. A., Aroke, E. N., Letzen, J. E., Campbell, C. M., Hood, A. M., Janevic, M. R., Mathur, V. A., Merriwether, E. N., Goodin, B. R., Booker, S. Q., & Campbell, L. C. (2022). Confronting racism in pain research: A call to action. *The Journal of Pain, 23*(6), 878–892. https://doi.org/10.1016/j.jpain.2022.01.009

National Institute of Justice. (1982). *Technology assessment program: NIJ standard for metallic handcuffs* (NIJ Standard 0307.01). U.S. Department of Justice. https://www.ojp.gov/pdffiles1/nij/082981.pdf

Project Nia & Barnard Center for Research on Women (2020, October 13). *What is accountability?* [Video]. YouTube. https://www.youtube.com/watch?v=QZuJ55iGI14

Rayasam, R. (2024). *Most states ban shackling pregnant women in custody, yet many report being restrained.* KFF Health News. https://kffhealthnews.org/news/article/pregnant-women-prison-handcuffs-restraints-laws/

Robinson, M., Lavere, K., & Porsa, E. (2021). End the routine shackling of incarcerated inpatients. *Journal of Hospital Medicine*, *16*(19), 376–377. https://doi.org/10.12788/jhm.3581

Samant, A. (2018). *The First Step Act is a small step for incarcerated women.* Human Rights Documents Online. https://doi.org/10.1163/2210-7975_hrd-9970-20180275

Sawyer, W., & Wagner, P. (2024). *Mass incarceration: The whole PIE 2024*. Prison Policy Initiative. https://www.prisonpolicy.org/reports/pie2024.html

Sawyer, W., & Wagner, P. (2025). *Mass incarceration: The whole PIE 2025.* Prison Policy Initiative. https://www.prisonpolicy.org/reports/pie2025.html

Sufrin, C., Beal, L., Clarke, J., Jones, R., & Mosher, W. D. (2019). Pregnancy outcomes in US prisons, 2016–2017. *American Journal of Public Health, 109*(5), 799–805. https://doi.org/10.2105/AJPH.2019.305006

United Nations Office on Drugs and Crime (2014). *Handbook on women and imprisonment: 2nd edition, with reference to the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (The Bangkok Rules)*. https://www.unodc.org/documents/justice-and-prison-reform/women_and_imprisonment_-_2nd_edition.pdf

Weber, A., Collins, S.-A., Robinson-Wood, T., Zeko-Underwood, E., & Poindexter, B. (2018). Subtle and severe: Microaggressions among racially diverse sexual minorities. *Journal of Homosexuality, 65*(4), 540–559. https://doi.org/10.1080/00918369.2017.1324679

Widra, E. (2024). *States of incarceration: The global context 2024. Prison Policy Initiative.* https://www.prisonpolicy.org/global/2024.html

COLUMBIA

SOCIAL WORK REVIEW