DREAMING OF WORLDS WITHOUT PSYCHIATRIC INCARCERATION

"PSYCH WARDS KEEP US ~~SAFE~~"

and 7 other myths about psychiatric incarceration

written and illustrated by @embracing.ambiguity

grounding in survivorship

I write this zine as a 23 year old proudly Mad psychiatric survivor.

I also write this zine as a 15 year old experiencing psychiatric incarceration for the first time. I write this zine as a 12 year old watching my loved one get stuffed in the back of a cruiser en route to the ward. I write this zine as a 19 year old voluntarily driving to the ER hoping that "this time it'll be different". I write this zine as a 21 year old trying to claw my way out of the back of the cop car. I write this zine having been liberated from the system for 2 years now, fighting to never, ever be forced back.

This experience and identity of survivorship is what guides everything I chose to include in this zine. Even so, the zine is written from a largely academic point of view. I intentionally chose to pack the text full of references. I view this choice as a compromise. More than anything, I wish that the screaming voices of psychiatric survivors alone would be enough to drive a bountiful movement of abolition. And yet, it's not. People want facts, figures, and "logical" arguments. I write this zine partly out of frustration: "why is my story (and the stories of so many others) not enough?". And it is this frustration that has driven me to compile everything included in here, even if it meant reading books and articles that told me nothing that my lived experience hadn't already given me... just so I could provide a "valid enough" citation.

*So, an ask for you, reader: if you are using this text to engage with the concepts of psychiatric incarceration for the first time, don't let this text be your last engagement. Take time to appreciate the facts and figures, sure, but take **more time** to seek out the testimony of survivors. We need to be heard.*

In solidarity,
S

Lineage Statement

a lineage statement is a recognition that all ideas are inspired, influenced, and co-created in community, no matter how unique or novel they may seem. often, those with privilege take and commodify ideas from marginalized populations. in recognition of this, i choose to include some wise figures, ancestors, organizations, and pieces of literature and teachings that have shaped the way I think about this topic.

Ysabel Garcia, Estoy Aqui

Project LETS + Stefanie Lyn Kaufman-Mthimkhulu

My forever friend and wise teacher, Duly

Thabiso Mthimkhulu

Liat Ben-Moshe, Decarcerating Disability

Mia (Queen Bulimia) @the_deathsongdoula

Dr. Samah Jabr

Kiera Lyons, @neuroabolition

Leah Lakshmi Piepzna-Samarasinha

My grandmother, Helen, who I've never met but am often guided by

Ndeye Oumou Sylla, @connectwithoumou

Myth #8

We just need to improve the quality of our psych wards.

Reality:

Psychiatric hospitalization is inherently carceral. It does not matter if we add windows, get folks out of paper gowns, and stop the strip searches. We could turn the wards into five-star resorts for all that matters... if there is a lock on the door, an inability to leave, or coercion to stay, it has no place in a truly liberated future.

Your ideas of fancy food or comfy clothes cannot remove the harms of incarceration. Changing the name and diguising the bars of the cages that surround us doesn't mean that you've created something new.

We must continue to push for absolute and total abolition. We cannot settle for reform. Burn it down.

Table of Contents

Myth #1

Psychiatric hospitals are places to "get better"

Reality:

People discharged after inpatient psychiatry experience a suicide rate estimated to be 200-300 times the general suicide rate [1].

Psychiatric hospitals are often viewed as places to "get better". We romaticize the concept of the ward, assuming they offer therapy, access to doctors, someone to talk to at all hours, a place to rest your head, and a reprieve from outside stressors. Unfortunately, this pretty picture of relief that we paint in our heads is just that: a pretty picture with little relationship to the reality of psychiatric wards.

The truth of psychiatric wards, acknowledged not just by patients but also by staff and doctors, is that they function more-or-less as sterile locked boxes. More often than not, there is no individual therapy. A brief 15 minute intake questionnaire with an overworked and underpaid social worker is the closest you might get to "therapy". Instead of "someone to talk to at all hours", you might encounter an understaffed "team" of behavioral health technicians focused more on making it to the end of their 12 hour shift than holding space for you to chat. In some wards, you may not have a bed to rest your head, but instead spend your 72 hour hold in a plastic chair due to overcrowding.

Step up, step back

So much of care work is not just stepping up, but also stepping back. Care work can look like saying "you deserve autonomy, and I'm going to respect your wishes even if I want something different for you". When we stop clinging on to guilt and liability, we can move from a place of love. And sometimes that looks like desperately wanting one form of safety (such as the safety we imagine to exist in a psych ward), but trusting that our comrade may be searching for a different type of safety - a type of safety our own mind cannot comprehend... a type of safety that might not be found in the world we currently occupy.

Seeking safety outside the ward...

If you're seeking safety (for yourself or a comrade) → here are some places, spaces, items, and activities that might invite safety!

- food that brings back an embodied sense of safety
- scents or aromas
- temperature shifts - hot bath, cold shower, ice
- closed space (closet)
- open space (top of a mountain!)
- pressure: blanket burrito! a tight hug!
- substances (edibles, plants + much, much more)
- co-regulation (sometimes even just a voice on the phone!)
- silence
- music (listening or creating)
- rest
- movement
- routine, planning, brainstorming
- repetition (repetitive movements like rocking, or sounds!)
- time with animals, plants, non-human spirits!
- touch OR intentional lack of touch
- white noise
- connection to earth

Myth #7

Sometimes there is no choice but to send someone to a psych ward.

Reality:

Many of us have been there: we have a friend who reaches out. They say "help, I'm suicidal, I don't know what to do". And our first reaction, as their friend, is one of fear. We can't bear to lose them, we say, and we think that there's no other option but to take them to the local ward, or even call 911.

But the reality is, there's often so much more that we can do instead of resorting to confining our friend to the ward out of our own fear. In fact, there's so many options out there that it would be impossible to put them all in this one zine. A few examples are listed below:

Peer-run respites

Respites are often home-like environments that are staffed 24/7 by a team of peer support specialists. They are typically small, might offer light programming, and someone to talk to at all hours. Stays are often limited to a few days, and are completely voluntary at all times.

Check out this directory: https://power2u.org/directory-of-peer-respites/

Make your own respite

If there isn't an existing respite in your area, or it is inaccessible to your comrade for any reason, you can try to organize your own. Start by asking the friend you are supporting where they would feel most safe. Do they need to stay in their own space? Or would a change of environment feel helpful? Next, show up! Make space for your friend to stay on your couch. Gather a team of comrades that can work together to provide peer support when needed. Wrap your friend in a tight blanket, run the bath water, prepare nourishing food, hold space when needed. Throughout this process, tend to yourself as well! Call in your own care team to lighten the load.

Proponents of psychiatric wards do not argue against this reality: they willingly acknoweldge that wards don't offer therapy or therapeutic resources. They emphasize that the purpose of the psychiatric ward is largely NOT therapeutic. Instead the purpose of the psychiatric ward is often cited as two-fold: 1) to provide a short-term "safe" environment for containment (the concept of a "safe" environment will be further explored in Myth #3) and 2) serve as a short-term bridge to community-based support [2]. Note that neither of these stated goals include a patient "getting better". Patients are expected to "get better" upon receiving continued services in the community after discharge.

The idea that psychiatric hospitals are not meant for long-term containment and "treatment" comes in part as a success from the 1960s and 1970s movement for deinstitutionalization of the "mentally ill" in the US. This movement, pioneered by psychiatric survivor advocates resulted in massive reform of institutional settings and the elimination of asylums as they existed. [3]

As goals of inpatient psychiatric settings were reformed, they shifted from holding people "until they get better" (or die) to more short-term containment and resource bridging (which we see in today's models of psychiatric hospitals). The myth that people "get better" in psychiatric hospitals can therefore be viewed as not only untrue by experiences of those incarcerated within them, but also by the explicit intentions of the psychiatrists who staff them.

References:

1. Chung D, Hadzi-Pavlovic D, Wang M, Swaraj S, Olfson M, Large M. Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalisation. BMJ Open. 2019;9(3):e023883.
2. Clarke, A., & Glick, I. D. (2020). The Crisis in Psychiatric Hospital Care: Changing the Model to Continuous, Integrative Behavioral Health Care. Psychiatric Services, 71(2), 165–169. https://doi.org/10.1176/appi.ps.201900259
3. Ben-Moshe, L. (2020). Decarcerating Disability: Deinstitutionalization and Prison Abolition. University of Minnesota Press. https://doi.org/10.5749/j.ctv10vm2vw

Myth #2

Forced treatment is effective.

Reality:

A large analysis of Community Treatment Orders (CTOs) which require compliance with forced outpatient treatment programs finds that CTOs do not prevent (higher-level) admissions or confer patient benefits. [1]

A study on involuntary mental health treatment found no benefit to patient well-being and no lower risk of death. [2]

Patients who perceive coercion during an inpatient psychiatric hospital admission are more likely to attempt suicide after release as compared to those who do not. [3]

In Massachusetts, data from the public health department found that the risk of fatal overdose was twice as high after involuntary treatment (Section 35) as opposed to voluntary treatment. [4]

[1] Barnett P, Matthews H, Lloyd-Evans B, Mackay E, Pilling S, Johnson S. Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: a systematic review and meta-analysis. The Lancet Psychiatry. 2018;5(12):1013–22.

[2] Nyttingnes, O., Benth, J.Š., Hofstad, T. et al. The relationship between area levels of involuntary psychiatric care and patient outcomes: a longitudinal national register study from Norway. BMC Psychiatry 23, 112 (2023). https://doi.org/10.1186/s12888-023-04584-4

[3] Jordan JT, McNiel DE. Perceived Coercion During Admission Into Psychiatric Hospitalization Increases Risk of Suicide Attempts After Discharge. Suicide Life Threat Behav. 2020 Feb;50(1):180-188. doi: 10.1111/sltb.12560. Epub 2019 Jun 4. PMID: 31162700.

[4] Massachusetts Department of Public Health, "An Assessment of Opioid-Related Deaths in Massachusetts (2013-2014)". 2016 Sept

Under the current sanist models of mental health "treatment", virtually anything can be readily pathologized. "Well-meaning" psychiatrists and social workers often want to "play it safe" and "just" keep you a few days for "observation". Might as well make sure you're okay, right? More like: might as well make sure they protect their license at all costs, even if it means causing trauma in the process.

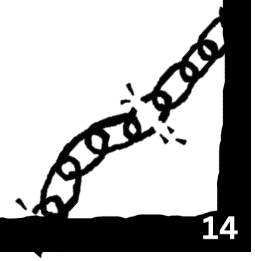
But what happens when "well-meaning" psychiatrists and social workers start working in for-profit corporations? In a 2024 New York Times investigation, journalists found that patients were held against their will in Acadia-run psychiatric facilities with the clear intention to maximize insurance payout and therefore increase profit margins. [3]

By relying on Florida involuntary commitment laws, one facility, "North Tampa Behavioral Health Hospital", exhibited a clear pattern of intentionally lengthening patients' stays, with questionable evidence as to whether these patients still qualified for commitment. From 2019 to 2023, North Tampa filed more than 4,500 petitions to extend involuntary stays. Filing such a petition allows the facility to continue to confine the patient until their hearing. During this time, the hospital can continue to bill insurance. Reporters found that at North Tampa, only 54 of the 4,500 petitions were actually granted by judges - a mere 1% of the total. This investigative reporting exposed and emphasized something that survivors of psychiatric incarceration have long been saying: psychiatric hospitals do not have patients' best interest in mind.

Whether you find yourself in a money-hungry corporation-run hospital, or even at the hands of a "well-meaning" psychiatrist, one this is certain: you are unlikely to be able to leave when you please. Even if you're not a danger to yourself or others.

References:

1. MHL §§9.37, 9.41 & 9.45
2. § 122C-261.
3. Silver-Greenberg, Jessica., Thomas, Katie. "How a Leading Chain of Psychiatric Hospitals Traps Patients". The New York Times. Sept 1 2024



Myth #6

If you don't "belong" in a psych ward, you'll be released.

Reality:

Under law, specific conditions must be met in order to involuntarily commit someone to a psychiatric hospital. Although the specifics of these conditions vary between states, they often center around whether a patient is evaluated to be a risk to themselves or others. These conditions are intentionally ambiguous and are up to the interpretation of figures granted the power to involuntarily commit someone. In some states, this power is given to not just mental health professionals such as psychiatrists and social workers. In New York City, law enforcement are granted the power of involuntary committment [1]. In North Carolina, the power to petition for involuntary committment is extended to anyone who has first-hand knowledge of the person in question [2]. Yes, you read that right: anyone. People with absolutely no training or knowledge in evaluation, assessment, or mental health treatment are awarded the right to involuntarily confine someone else.

Once you've been locked behind the heavy ward doors, you might also assume that perhaps this is a mistake that can be easily rectified. Once you talk to the psychiatrist on staff, this will all be sorted out, right? Of course, the psychiatrist will immediately realize that you don't need to be there - it'll all be cleared up soon! (... right??)

Unfortunately, once you've been committed to the locked ward, it is an uphill battle to get out. The label of "insane" that gets assigned once you walk through the doors is not one that is easy to get rid of. This label means that your words are no longer automatically trusted. For example, your attempts to connect with staff for support are subject to pathologization as attempts to manipulate, in line with a diagnosis of "BPD". Alternatively, your repeated requests to leave, saying "nothing is wrong with me", might be pathologized as "this patient is non-compliant and refuses to accept help".

Myth #3

"Voluntary" psychiatric incarceration is voluntary.

Reality:

In (partial) acknowledgement that involuntary hospitalization is indeed not effective and imposes inherent harm, there is signficant motivation to encourage patients to admit themselves "voluntarily". This preference for "voluntary" incarceration is codified in the legislature of several states. For example, New York legislature prompts state and local mental health professionals to encourage "mentally ill" individuals to voluntarily apply for treatment at a psychiatric hospital under mental hygiene law § 9.21. In Florida, statute § 394.4625 prompts all staff members at treatment facilities to encourage involuntary patients to transfer to voluntary status.

These arguments unfortunately remain ignorant of the realities of "voluntary" treatment that cause some to question whether any form of psychiatric incarceration is "voluntary" at all.

<u>In the case of so-called "voluntary" treatment:</u>

- the patient is not free to leave
- the patient is subject to coercion
- the patient has fewer opportunities for discharge
- the patient is admitted under the threat of involuntary committment
- there is no maximum length of stay

[1]

Most notably, voluntary patients in most states cannot decide to leave on their own accord. After agreeing to voluntary admission, it is the treating psychiatrist that determines the length of their stay and ability to discharge. Patients may make a request to leave, at which point the hospital is typically given 72 hours to either approve their request or convert their status to “involuntary”. This system results in the reality that many so-called “voluntary” patients are being detained in wards anything but voluntarily.

An analysis of rights guaranteed to involuntary versus voluntary patients further obviates the backwards nature of these legalistic terms. Whereas involuntary patients enjoy the right to judicial review and legal representation, a voluntary admission is often signed without representation. In this respect, by consenting to “voluntary” admission, patients have relatively less access to outside judicial review and representation and instead a totality of power is awarded to the treating psychiatrist.

The opportunities for coercion by staff members add an additional level of complexity that obscures the true carceral nature of a “voluntary” stay. Patients are often subject to manipulation on several levels. Patients on involuntary status may be told by staff that if they convert their stay to “voluntary”, they will increase their chances of a faster release (and avoid a supposedly lengthy judicial process). In reality, the conversation from involuntary to voluntary of course does not always guarantee faster release, but it does guarantee a loss of their right to judicial review. In other situations, patients are coerced to consent to unwanted “treatments”. Patients are “promised” release upon complete “cooperation”, underlining the totality of power that the psychiatrist possesses.

For these reasons, “voluntary” psychiatric incarceration is not only incredibly misleading, but can be considered a pervasive myth that only serves to fuel carceral, oppressive systems.

References:

1. The Benefits of Voluntary Inpatient Psychiatric Hospitalization: Myth or Reality?, 9 B.U. Pub. Int. L.J. 25 (1999)

Similar to incarceration within the criminal legal system, patients are isolated from community, family members, and supportive individuals. Through the process of psychiatric incarceration, lives are interrupted and destabilized. Jobs, student status, and financial security can all be lost. With repeated incarceration, relationships and lives continue to destabilize and fray. Is this how we are supposed to prevent violence and harm in community?

Research into the impacts of the criminal legal system has shown that incarceration is associated with an increase in recidivism, or committing a new crime, especially when compared to non-prison consequences, such as probation [3]. Given the commonalities between criminal legal and psychiatric incarceration, it would be a relatively small jump to hypothesize that similar results could be observed in both contexts.

References:

1. Law, V. (2021). "Prisons make us safer": and 20 other myths about mass incarceration. Boston, Massachusetts, Beacon Press.
2. Metzl, J. M. (2009). The protest psychosis: How schizophrenia became a black disease. Beacon Press.
3. SPOHN, C. and HOLLERAN, D. (2002), THE EFFECT OF IMPRISONMENT ON RECIDIVISM RATES OF FELONY OFFENDERS: A FOCUS ON DRUG OFFENDERS*. Criminology, 40: 329-358. https://doi.org/10.1111/j.1745-9125.2002.tb00959.x

Myth #5

Psych wards are needed protect society from dangerous mentally "ill" folks.

Reality:

"Americans have been sold the story - lock 'em up and you're safe. But you create a more damaged person." [1]

- KAMADIA, imprisoned in Texas since 2007

"But what about the violent mentally ill?" is one of the most popularized critiques of psychiatric abolition movements. It's first important to note that our understanding of so-called violence is shaped by racial, socioeconomic, and xenophobic bias. For example, anger or political resistance to oppression has a long historical lineage of pathologization and conflation with violence - particularly when witnessed in Black men. [2] When we examine this myth, it is important to consider: who is more likely to be labeled as violent? how does this intersect with our concepts of sanity and insanity? are we using psychiatric incarceration as a convenient (*but similarly carceral and ineffective*) alternative to the increasingly frowned-upon incarceration within the criminal legal system?

Putting aside these questions of unequal application of labels of "violence", we can move to exploring the supposed efficacy of psychiatric incarceration of violent individuals. Often, those who engage with this myth argue that wards are places for rehabilitation: that the root of the violence can actually be addressed through treatment and care. But what are the roots of violence? Are they truly being addressed inside the ward?

Myth #4

Psych wards keep mentally "ill" folks safe.

Reality:

Up to half the suicides among patients with schizophrenia occur during inpatient treatment. [1]

When confronted with the reality that psychiatric wards are not places to "get better", advocates of hospitalization typically pivot their claims towards ones of safety. They often argue that hospitalization provides necessary containment in cases of suicidality, and that the sterile, locked box of the ward is necessary and helpful in keeping patients "safe".

These claims of "safety" can be considered vast oversimplifications in three separate realms: (1) are wards "safe" for everyone? (2) "safe" from what? (3) "safe", but for how long?

Are wards "safe" for everyone?

Psychiatric hospitals impose carceral violence and trauma on almost everyone who enters. But for some, this carceral violence and trauma is much more extensive.

Let's first consider the process that many go through to reach the ward: police are called in for a "wellness check" and the next thing you know, you've got your arms cuffed behind your back in you're sitting in a cruiser on the way to the local ER. For everyone, this process is terrifying. For Black and Indigenous folks especially, this process can be not just terrifying, but deadly. Black Americans are 3.23 times more likely to be killed by police than white Americans [2]. The risk of being killed while being approached by law enforcement is 16 times higher for individuals with "serious mental illness" than other civilians [3]. One can easily assume that a combination of being perceived as both Black and "mentally ill" puts you at serious risk of deadly force. Is this what they mean when they say they are trying to keep us "safe"?

Of course, even if you do make it "safely" from police custody and into the ward, Black and Indigenous patients remain at higher risk of harm than their white counterparts. In an analysis of retraint and seclusion usage in hospitals across the United States, wards varied greatly according to the demographics of the county in which they were located. For example, hospitals located in predominantly Black neighborhoods logged 3 times more time spent using physical restraints (compared to hospitals in predominantly white neighborhoods) [4]. Use of seclusion follows a similar trend, with time spent in seclusion rising to 2.5 times longer in predominantly Black neighborhoods [4]. Another analysis found that biased use of restrictive force extended to chemical restraints (PRN medications) as well. Black patients received more PRN medications overall compared to White patients. This effect is heightened for patients labeled with some form of psychosis: 17.7% of Black patients were administered PRN antipsychotics compared to 8.2% of white patients. [5]

Who exactly are psychiatric wards keeping "safe"? Are they truly "safe" for all of us?

"Safe" from what?

Even if you were to assume that psychiatric wards were 100% successful in removing the means to harm oneself or others, does this mean that you've kept patients "safe"? How are we defining safety?

In medicine, a "risk vs. benefit" analysis is often performed when prescribing new medications or therapies. This holistic analysis includes the potential for side-effects and overall quality of life. In the realm of psychiatric hospitalization, we often throw away this analysis. We define "safety" solely on the basis of whether a person remains alive. Often not considered are the risks of inpatient treatment: coercion, abuse, trauma, isolation from community, stigmatization, and worsening of distress.

By committing someone to a ward, what are we keeping them "safe" from?

"Safe" but for how long?

Let's say that psychiatric wards do promote safety of patients (which again, is questionable). Let's say that the ward successfully saved (or more accurately, prolonged) someone's life by removing means of ending it. What happens when they are released from the ward? Have any problems been solved? Have their needs been addressed? As mentioned in Myth #1, psychiatric wards are not intended as places to "get better", only as temporary holding cells. So again, what happens when it's time for release?

People discharged after inpatient psychiatry experience a suicide rate estimated to be 200-300 times the general suicide rate [6].

After discharge, not only has little to no treatment been received, the patient has now experienced a significant trauma.. The impacts of carceral treatment remain:

One study found that the mere perception of coercion during hospitalization is associated with an increased risk for suicide attempts upon discharge [7].

References:

1. Pompili M, Girardi P, Ruberto A, Tatarelli R. Toward a new prevention of suicide in schizophrenia. World J Biol Psychiatry. 2004 Oct;5(4):201-10. doi: 10.1080/15622970410029934. PMID: 15543514.
2. Schwartz GL, Jahn JL (2020) Mapping fatal police violence across U.S. metropolitan areas: Overall rates and racial/ethnic inequities, 2013-2017. PLOS ONE 15(6): e0229686. https://doi.org/10.1371/journal.pone.0229686
3. Treatment Advocacy Center, "Overlooks in the Undercounted: The role of mental illness in fatal law enforcement encounters". Dec 2015
4. Self-conducted informal analysis of data from Centers for Medicare and Medicaid Services (CMS)
5. Kassam AS, Karalis P, Aydinian T, Panjwani A, Martinez G, Whiteman A, Daas M, Cunningham EA. Racial disparities with PRN medication usage in inpatient psychiatric treatment. Schizophrenia (Heidelb). 2024 Apr 13;10(1):46. doi: 10.1038/s41537-024-00461-5. PMID: 38615056; PMCID: PMC11016118.
6. Chung D, Hadzi-Pavlovic D, Wang M, Swaraj S, Olfson M, Large M. Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalisation. BMJ Open. 2019;9(3):e023883.
7. Jordan JT, McNiel DE. Perceived Coercion During Admission Into Psychiatric Hospitalization Increases Risk of Suicide Attempts After Discharge. Suicide Life Threat Behav. 2020 Feb;50(1):180-188. doi: 10.1111/sltb.12560. Epub 2019 Jun 4. PMID: 31162700.