FULL LENGTH ARTICLES

Boundaries of Autonomy: Exploring Parallels Between Mental Hospitals and Prisons in the United States

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Within the United States, a prevailing perception emerges that mental health facilities and prisons are unfavorably similar. This societal sentiment is quite concerning if true, as the prison system is known for its many societal failures within the U.S. Furthermore, mental hospitals aim to help individuals; thus, a comparison to a faulty system highlights a possible issue worthy of exploration. Unfortunately, little analysis exists, within academic research, comparing both institutions. The following comparative analysis looks at available research between mental hospitals and prisons to validate this issue and explore implications. Findings indicate a shared pattern between mental hospitals and prisons in the United States. This comparison can be used as a model to identify issues and solutions.

In the broader beliefs of mainstream American society, there's often a comparison drawn between the experience of mental hospital admission and criminal imprisonment. Informal online research reveals discourse on the resemblance between these institutions among unacademic sources such as online forums and traditional media. While the idea that "mental hospitals resemble prisons" might surface in unacademic mediums, current literature lacks a substantial exploration and validation of this concept.

Prison is seen by many Americans as a punishment-oriented institution, currently recognized as a flawed system which mentally damages individuals rather than rehabilitates them (Crutchfield, 2017; Kreager & Kruttschnitt, 2018; Parsons, 2018). The goal of modern mental healthcare is fundamentally different than correctional work, built on visions of improving human well-being alone (American Psychological Association, 2020).

While academic information elucidates the experience of prison and its often-detrimental effect on mental health, research on the standard mental hospital experience remains limited. Patient information is protected under various privacy laws, consequently, making it difficult to collect data in many contexts (Shields et al., 2018). This leaves a knowledge gap as to what specific practices may cause patient detriments within mental hospitals.

By synthesizing research exploring personal experiences and practices within mental hospitals and prisons in the U.S., notable similarities emerge between these institutions, indicating mental hospitals function like prisons. This comparative analysis sheds light on the consequential implications for mental hospitals to share these similarities, and the need for policy change/

other solutions. Four themes persist within both systems: custody, restraint/restriction, isolation, and surveillance. Ultimately, the goal of this analysis is to accentuate the need for further research on reformation/alternative solutions for existing mental health institutional design; utilizing the motif of a dysfunctional system (prison) to identify and summarize issues within the mental health hospital system in lieu of a limited amount of information.

U.S. Mental Hospitals and Adverse Mental Health Experiences

To get a substantial understanding of how U.S. mental hospitals function, it is important to establish a general idea of the procedures initiated within the average mental health facility. The practices of American mental facilities provide relevant context to the recorded experiences of patients who have encountered this institution.

Custody

The American Psychological Association (2020) recognizes two main forms of admission, involuntary and voluntary. Voluntary admission, or commitment, is the personal and lucid act of admitting oneself into a psychiatric hospital (American Psychological Association, 2020; Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, 2019). Involuntary admission is a process where an individual is forcibly held or immured within a psychiatric hospital on the basis of safety for the individual and/or others rooted in emergency mental health concerns (Fariba & Gupta, 2022; Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, 2019). The period of involuntary admission from initiation to release is called a 'psychiatric hold' or 'emergency psychiatric hold' (Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, 2019). A hold can permit legal third-party detainment of an individual before arrival at a psychiatric institution and continues after admission for a specific period based on law/policy (Fariba & Gupta, 2022; Hedman et al., 2016). Nearly always, a patient has no ability to leave a mental hospital, detailing the institutions right of full custody over an individual (Fariba & Gupta, 2022; Hedman et al., 2016).

Involuntary commitment is associated with patient feelings of violation, loss of control, loss of self-autonomy, and confinement, especially during initial admittance. For some, the experience of involuntary commitment was self-defined as 'traumatizing' (McGuinness et al., 2018). Common explanations for negative sentiments involve the loss of freedom and control individuals previously had. A sudden inability to control outside life, inability to leave the institution and make other choices, less privacy, and fear of stigma are cited as reasons for adverse encounters (McGuinness et al., 2018; Shields et al., 2018). One prevailing factor which seems to influence the nature of a patient's experience is perception of autonomy (McGuinness et al., 2018; Shields et al., 2018). Positive experiences during involuntary commitment typically manifest awhile after the initial shock of admission and drastic

changes of autonomy occur (McGuinness et al., 2018). Feelings of control were reported by patients who shifted their focus towards what choices they could make within the institution (choosing what to eat, where to walk, etc.). (Ezeobele et al., 2014; McGuinness et al., 2018; Shields et al., 2018).

Restraint/Restriction

Nationally, by law, the use of restraint during admittance: chemical, physical, or mechanical, is permitted to some extent within mental facilities (Brown, 2000). Restraint is ideally used in cases of aggression or physically explosive behavior that may harm others (Ye et al., 2019). The practice is also used in situations of personal danger, when one is exhibiting suicidal or other self-harm related behavior (O'Connor, 2020; Shields et al., 2018). Chemical restraint entails the use of sedative psychoactive drugs, physical restraint is the action of restricting a person using physical bodily force, and mechanical restraint involves devices such as straps or cuffs (Brown, 2000). On a secondary level, medication also serves to control the general mood and activity of patients, theoretically increasing safety. As a preventive effort, patients exhibiting manic and/or aggressive behaviors will often be medicated more heavily to prevent possible outbursts and any other disarray that may manifest (Lavelle & Tusaie, 2011). Policy makers and mental health professionals argue these practices are overused and initiated in inappropriate situations and for unnecessarily lengthy durations (Brown, 2000; Knox & Holloman, 2012; Shields et al., 2018; Ye et al., 2019). Data also reveals duration of restraint often goes beyond timing set or recommended by policy (Brown, 2000; Knox & Holloman, 2012).

The use of restraints can conjure trauma, decrease self-esteem, cause extreme distress, reduce a sense of hope, and in some cases reintroduce an episode(s) of sexual trauma. These effects also increase the chance an individual will be resistant to treatment (Ye et al., 2019). Although restraint methods have been associated with possibility of patient trauma, explanation of methods used before and explanation of reasoning after if restraint or seclusion is used likely reduces negative experiences (Brown, 2000; Georgieva et al., 2012). In cases of general medication administration, patients often lack a choice, or knowledge of what substance they are being administered. A right to refuse, or a minimal right to have an explanation provided greatly decreases possible patient distress (Bartholomew & Kensler, 2010).

Isolation

Seclusion is another method utilized with the goal of protecting facility and patient safety (Knox & Holloman, 2012). The measure involves placing a patient alone in a locked room utilizing sensory deprivation or sensory reduction (Georgieva et al., 2012). In cases of seclusion, the patient is prevented from leaving until deemed safe or it is necessary by law. This is typically used in cases of aggressive behavior (Ezeobele et al., 2014; Knox &

Holloman, 2012). Once more, policy makers and mental health professionals are concerned about the overuse of this practice (Ezeobele et al., 2014; Knox & Holloman, 2012).

During seclusion, patient experiences cite rude or judgmental attitudes towards staff, and the experience itself can feel isolating and neglecting (Ezeobele et al., 2014). A factor which decreases adverse experience is communication regarding why and how one is being secluded. Discussion beforehand specifically exists as an important measure with many individuals citing that they felt they did not properly understand rules and staff specifically targeted them (Ezeobele et al., 2014).

Surveillance

Surveillance and monitoring practices are another measure used to ensure a safe environment. These practices can be executed through staff interaction or the usage of surveillance technology (cameras, microphones, etc.). Typically, both measures are used within U.S. mental institutions (Abbe & O'Keeffe, 2021). Primarily, monitoring is ideally used to keep patients safe. In comparison to restraint and seclusion, which are often initiated by observable explosive or destructive behavior, monitoring generally helps in preventing harm to the self, which can go unnoticed (Abbe & O'Keeffe, 2021).

Video surveillance does have drawbacks, such as patient uncomfortableness and a false sense of security for staff (O'Connor, 2020). Unfortunately, video surveillance in more private areas invades patient privacy. In other situations, the mere presence of cameras may conjure feelings of paranoia (Abbe & O'Keeffe, 2021; O'Connor, 2020).

U.S. Prisons and Adverse Mental Health Experiences

There is significantly greater information regarding prisons as opposed to U.S. mental hospitals, as research is not limited to medical ethics of privacy as extensively (Shields et al., 2018; Swanson, 2016). This allows for a more straightforward connection between policy/practices and lived experience. Various practices indicate long-term and short-term consequences for incarcerated individuals.

Custody

The criminal justice system has been continually criticized in mainstream U.S. society based on injustices which occur within the institution (Crutchfield, 2017). Justifications for abuse of the rights of imprisoned people have often been met under the guise of ensuring public safety (Crutchfield, 2017). A main critique of policies within the prison system is that the philosophy behind various practices focuses on punishment and control while disregarding the importance of rehabilitation (Crutchfield, 2017). Overall, the rights of prison inmates are not always met adequately, sometimes even under the minimum legal level (Hill et al., 2016).

Unsurprisingly, most incarcerated individuals do not enjoy the experience of long-term confinement in the U.S. (Duwe, 2017; Shalev et al., 2013). Misconduct remains a focus of American prison policy, met with methods of control and authority. This desire to maintain order shapes the structural theme of how prison policies and practices manifest within the system (Shalev et al., 2013). This is not to mention the problematic cycle of how abuse of power increases perceptions of injustice (Shalev et al., 2013).

It is extremely important to note that People of Color (POC) and those of lower socio-economic status are disproportionately incarcerated. This social injustice does not stop at mere demographic imbalance. Intersectional criminology is commonly used as an approach to identify how the recorded injustices in prison manifest internally along the lines of race/ethnicity and gender (Bell, 2018). Based on race/ethnicity, POC face a harsher reality in prison compared to their white counterparts. This includes increased abuse, harsher punishments, and negative attention from prison personnel (Bell, 2018). Furthermore, women face additional challenges stemming from sexism and misogyny within the prison context. Overall, both racial and gender injustice, compound with the already dysfunctional and harmful state of incarceration (Bell, 2018)

Restraint/Restriction

A common control mechanism used within the prison setting is also restraint. The Bureau of Prisons outlines that correctional staff are authorized to use restraint as 'last option'/'last resort' efforts to maintain control of an incarcerated individual when all other options fail to ensure safety (U.S. Department of Justice & Federal Bureau of Prisons, 1994). This practice often involves the use of shackles, handcuffs, and sometimes chairs, although more controversially, high voltage devices are also used to 'stun' individuals (Champion, 2007). Use of restraint has been cited among professionals as improperly used and executed unnecessarily. Often, the measure is employed instead as a mechanism to enforce authority without any basic concerns of safety (Champion, 2007; Rock et al., 2018). Secondarily, the fear of restraint is used as a threat to maintain 'appropriate behavior' among inmates (Rock et al., 2018). Standards of how exactly restraint will be kept at minimal and valid usage is lacking (Champion, 2007). Another specific practice of restraint/restriction is medication coercion. Within a civil context, treatment against will involves extensive judicial action. However, multiple cases such as Harper v. State and Washington v. Harper, have set precedence asserting that prisons may authorize forced treatment through medical professionals employed by prisons, without judicial order, under the guise of protecting inmate wellbeing (Black, 2008). Today, law permits forced medication and policy remains lacking in detailed protocols which must be adhered to by prison medical staff (Black, 2008; Völlm & Nedopil, 2016). This practice is criticized by mental health and criminal justice professionals alike due to its potential for abuse outlined by lacking policy detail (Thomas et al.,

2020; Völlm & Nedopil, 2016). Forced medication is perceived favorably among prison staff as a form restraint/control mechanism; medication is quite valuable as a means of outburst prevention (Runte-Geidel et al., 2014).

The usage of restraints leads to multiple psychological consequences. Physically, use of restraint can inflict injury, including bruises, cuts, broken bones, and asphyxia (Rock et al., 2018). Victims of past trauma can re-experience difficult memories, especially for those who have experienced instances of sexual assault. Overall, restraint within prison often conjures up traumatic and hopeless feelings. This can result in depression, fear, and anxiety later and/or within the event of restraint (Champion, 2007; Rock et al., 2018). Unsurprisingly, forced medication is not viewed positively among inmates either (Runte-Geidel et al., 2014; Völlm & Nedopil, 2016). Other forms of mental health treatment, if needed, are commonly desired. Feelings of anger, forced submission, and hopelessness follow the experience. This is often exacerbated by other factors such as perceived disrespect and stigmatization (especially for those who are aware of their mental illness) (Runte-Geidel et al., 2014; Völlm & Nedopil, 2016).

Isolation

Solitary confinement is a notable topic of concern within the realm of prison policy. This practice is often regarded as inhumane due to its restriction of an essential human need, social connection (Siennick et al., 2022). Considering this criticism, the use of this practice is defended based on its use as a threat and theoretical ability to maintain order through punishment and the risk of punishment. Unfortunately, individuals suffering from mental illness are often placed within this context, regardless of safety concerns. (Hill et al., 2016). Solitary confinement typically entails separation from the general prison population far beyond what human rights organizations and psychological professionals would consider healthy (Hill et al., 2016; Siennick et al., 2022). Again, this issue persists likely due to a lack of national standards, similar to restraint (Champion, 2007). As an essential human need is social connection, solitary confinement implements the largest detriment towards mental health of most prison procedures/ punishments (Reiter et al., 2020; Siennick et al., 2022; Western et al., 2022).

Basic symptoms reported by individuals who experience solitary confinement are depression, anxiety, and hopelessness. More critical instances entail a loss of identity and sensory hypersensitivity, along with depression and anxiety. Adverse effects usually continue long after confinement has ended (Reiter et al., 2020). Of various methods used within prisons, solitary confinement has been critiqued particularly due to its potential for long-term psychological damage (Reiter et al., 2020; Siennick et al., 2022; Western et al., 2022). Loss of identity specifically is a contributor to the long-term mental effects of solitary confinement (Reiter et al., 2020). An extreme loss of personal autonomy within an already limited setting seems to take away what could be the last thing someone has control over, their perception of self (Erickson & Erickson, 2008; Hill et al., 2016).

Surveillance

Monitoring through digital cameras, guard use, and other methods encapsulates another integral practice commonly used within U.S. prisons: surveillance. Different from solitary confinement and restraint, monitoring is supposed to be a preventive effort, used to ensure safety in theory. In comparison to other countries, the United States lacks a clear illustration of privacy rights in its constitution. With consideration that inmate rights are already limited, within U.S. prisons the right to privacy remains almost non-existent. (Engstrom & van Ginneken, 2022; Ingel et al., 2021; Vanyur & Hussein, 2019). For instance, communication with family through various mediums is monitored, including cell phone calls, in person meetings, and mail letters. Prison cells are often searched, including the seizure of property, limiting autonomy of individuals even further (Vanyur & Hussein, 2019). Although surveillance is justified as a "safety measure", incarcerated people lack a right to privacy to a notable degree.

Imprisoned individuals cite a lack of privacy as a source of mental distress. While privacy must be violated within a certain degree of reason to ensure safety within certain situations, feelings of invasion among inmates have psychological consequences (Ingel et al., 2021). Camera monitoring and guard checks have less of an effect on individual wellbeing, likely as they remain less invasive compared to other methods. Reducing bodily autonomy through a strip search, on the other hand, can greatly increase negative psychological feelings (Ingel et al., 2021). Monitoring phone calls to family also violates the security and privacy of personal relationships (Ingel et al., 2021). Overall, a lack of privacy can result in feelings of hopelessness, fear, and shame (Ingel et al., 2021).

Discussion

The four sections outlined in the previous literature review show initial parallels between both institutions. Further analysis identifies core issues shared by both institutions, indicating mental hospitals share harmful attributes with prisons. These comparisons can be used to identify possible areas of further research on harmful mental health institution policies.

Thematic Similarity

Utilizing four themes to guide comparison, current literature reveals shared commonalities between mental hospitals and prisons. This similarity in research validates the social conviction outlined among informal sources.

Custody

Custody is inherent to the environments of mental hospitals (in the case of a hold) and prisons. Confinement is internally justified in mental hospitals by citing safety, while in prisons, also citing safety (to society), and justice/punishment. (Crutchfield, 2017; Fariba & Gupta, 2022; Office of the Chief Medical Officer, Substance Abuse and Mental Health Services

Administration, 2019). Involuntary commitment is associated with many adverse feelings (violation, loss of agency, fear) (McGuinness et al., 2018; Shields et al., 2018). Prison is more often associated with a personal sense of injustice (Shalev et al., 2013). Regardless, the inability to leave an institution inherently diminishes human well-being through the limitation of autonomy.

Restraint/Restriction

Restraint practices are one method supposed to be utilized in emergency situations with the goal of protecting others in both institutions. However, improper and overuse of this practice is criticized by professionals in both fields (Brown, 2000; Champion, 2007; Knox & Holloman, 2012; Rock et al., 2018; Shields et al., 2018; Ye et al., 2019). Restraint protocols are similar among mental hospitals and prisons, with both systems using staff and physical instruments to restrict the movement of an individual for safety reasons. In the prison and mental facility context, restraint causes physical injury, reiterates trauma (including sexual-assault trauma) and leads to feelings of violation and hopelessness. (Champion, 2007; Rock et al., 2018; Ye et al., 2019).

Forceful medicative methods are shared preventive measures. (Lavelle & Tusaie, 2011; Runte-Geidel et al., 2014). Again, in the two contexts this practice is associated with short-term distress and sometimes long-term trauma. (Bartholomew & Kensler, 2010; Runte-Geidel et al., 2014; Völlm & Nedopil, 2016).

Isolation

Isolation is used in both institutions to separate individuals after violent or explosive interactions with others or for other safety related reasons (Knox & Holloman, 2012; Reiter et al., 2020; Siennick et al., 2022; Western et al., 2022). Justification for this practice is once more cited under general safety (Knox & Holloman, 2012; Reiter et al., 2020; Siennick et al., 2022; Western et al., 2022). In the prison setting, this practice is well documented as extremely harmful to mental health (Reiter et al., 2020; Siennick et al., 2022; Western et al., 2022). In the mental hospital setting, the extent of harm seems less prevalent by comparison (Ezeobele et al., 2014; Knox & Holloman, 2012). This comparison questions whether this method of separation is truly necessary within the mental hospital context.

Surveillance

Surveillance is used within the two settings to protect safety, although in the mental health context this practice is focused more on self-harm (Abbe & O'Keeffe, 2021; Engstrom & van Ginneken, 2022; Ezeobele et al., 2014; Ingel et al., 2021; O'Connor, 2020). Regardless, the practice in both institutions leads to privacy violations and negative feelings associated with this measure (Abbe & O'Keeffe, 2021; Ingel et al., 2021; O'Connor, 2020).

By comparing research on practices and their effects on individuals in mental hospitals and prisons, the previous themes converge. "Safety measures" in mental hospitals conversely corelate with procedure justifications in the prison system, yielding similar results of mental health detriment. The shared existence of these four attributes supports the societal conviction that mental hospitals emulate the experience of imprisonment. While the fundamental goal of mental hospitals is not to cause harm, manifesting similar characteristics to a known problematic institution such as prisons indicates there is an ethical crisis which needs to be explored further.

Limitations

Utilizing a systematic analysis of existing literature, direct empirical relationships cannot be drawn between mental hospital practices and patient mental health. Regardless, identifying clear similarities between both these institutions reveals there are practices in mental health institutions which directly harm mental health.

Recommendations for Future Research

Currently literature only discusses detrimental practices and relationships to mental health outcomes on a surface level. Various areas are worthy of exploring based on the indication of problems in mental hospitals through a comparison to prisons.

Direct Experience

As previously stated, data on individuals who have gone through the mental health system is limited. Original research, done with methods such as surveys and interviews, regarding mental health experiences within hospitals, could identify further what specific issues in this system harm mental health and why.

Protective Factors

Research aimed at identifying policies which help patients, rather than harm them, can indicate what practices need to be encouraged to avoid harm. For instance, effective and clear two-way communication before and during methods utilized is cited within the practices discussed as a major protective factor against mental health detriment (Brown, 2000; Ezeobele et al., 2014; Georgieva et al., 2012). Researching helpful practices can also highlight what to avoid by contrast.

Mental Hospital Alternatives

One way to solve the conflict of safety vs. autonomy is to completely delineate the way mental hospitals currently utilize safety measures, through control; institutional authority itself might be a structural issue which guarantees human suffering. It is important to note that the two systems (prisons and mental hospitals) have been shaped by countless reformations, sought through societal pressure and criticism. Yet, as evident by previous

synthesis, mental health detriment still exists within both systems despite decades of policy changes (Parsons, 2018). Furthermore, closure of mental health facilities is directly linked to the incarceration of individuals suffering from mental illness (Gao, 2021). With that said, underexplored alternatives to mental hospitals, focusing on replacement rather than elimination alone, are worthy of exploring in their efficacy. These include community mental health centers, peer support programs etc. (Stupak & Dobroczyński, 2021). Research comparing the effectiveness of alternative mental health facilities to traditional mental hospitals can clarify if entirely dismantling this system is a viable solution.

Intersectionality

Bell (2018) describes how intersectionality interacts with imprisonment based on race/ethnicity, gender, and socioeconomic class. Unfortunately, current research lacks an adequate exploration of these topics within the realm of mental hospitals. Demographic data alone on mental hospital admission is difficult to synthesize based on medical privacy laws previously mentioned (Shields et al., 2018). In literature, on the topic of both prisons and mental hospitals, discussions on other intersectional factors such as queerness (transgender experiences, gay/lesbian experiences, etc.) are deficient as well. The observed social injustice seen in prisons points to an urgency to further investigate address systematic social issues which may exist within mental hospitals due to shared similarities. The themes presented likely involve intersectional issues not noted yet in research focusing on mental health treatment. Harmful attributes of mental hospitals would compound with already existing intersectional issues, highlighting the need for further research on this specific topic.

Conclusion

Prison can be utilized as a "model to avoid". Analyzing research through the topics of custody, restraint/restriction, isolation, and surveillance asserts a parallel between these institutions converges. Identifying issues in mental hospitals based on these areas clarifies the need for further research given the lack of vital information in literature currently. Looking at existing research alone on mental hospital practices, clearly, certain policies directly harm mental health. Further research can clarify a path forward to identify and solve these issues.

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