

**Involuntary Psychiatric Commitment in the Era of COVID-19:
Systemic Social Oppression and Discourses of Risk in Public Health and Bioethics**

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**This is an author copy of an article scheduled to be published in:
International Journal of CRITICAL DIVERSITY STUDIES
Volume 4, Issue 1, June 2021
Special Issue
Philosophies of Disability and the Global Pandemic**

Abstract

This paper considers the continuation of involuntary psychiatric hospitalization during the COVID-19 pandemic, with a focus on the United States of America. Situating psychiatric diagnosis and hospitalization within the broader context of decades of social and historical research, as well as emergent fields such as feminist philosophy of disability, critical diversity studies (CDS), and mad studies, I argue that a socially mediated process which is legitimated with appeals to “health” and “safety” should not be maintained during a pandemic of a readily communicable virus that is especially dangerous for individuals clustered in inpatient settings. A CDS approach allows the clear identification of “severe mental illness” as a marked category of social difference which leads to multiple forms of social oppression. In this paper, I show how involuntary psychiatric hospitalization is a social process through which marked individuals are dehumanized and confined. Furthermore, I consider why the maintenance of the status quo, even under pandemic conditions, demonstrates that involuntary treatment is primarily a political, rather than a medical, process. Finally, I outline why the politics of involuntary treatment should concern longstanding disciplines such as public health and bioethics, as well as emergent disciplines like CDS.

Introduction

COVID-19 is itself a new phenomenon, but its emergence as a global pandemic has starkly revealed many structures and processes of inequality and social oppression that are not at all new. Some of these underlying disparities have received ample attention, others much less so. Regardless, the energy that government entities, social advocates and political pundits, medical establishments, and even academic disciplines put into sustaining expected divisions and procedures in these inappropriate circumstances can reveal clear information about the systems, structures, and assumptions that shape and maintain the status quo in society. This paper considers the continuation of involuntary psychiatric hospitalization

during the COVID-19 pandemic, with a focus on the United States. I argue that a socially mediated process legitimated with appeals to notions of “health” and “safety” should not continue during a pandemic of a readily communicable that is especially dangerous for individuals who are clustered in congregate inpatient settings. I point out, furthermore, that the continuation of this process reveals the workings of power and oppression that underlie the use of “mental health” as a marker of social difference.

Situating psychiatric diagnosis and hospitalization within the broader context of decades of social and historical research, as well as emergent fields such as feminist philosophy of disability, critical diversity studies (CDS), and mad studies, I examine the ways in which medicalized concepts of danger and risk are deployed or ignored in ways that perpetuate processes through which individuals in psychiatric settings continue to be silenced and restricted, both physically and socially. Arguments that systematically prioritize hypothetical psychiatric risk over the proven risks of viral transmission permeate public health, policy, and bioethics, as well as medicine. The maintenance of the status quo, even under pandemic conditions, demonstrates that involuntary treatment is primarily a political, rather than a medical, process. I discuss how involuntary psychiatric hospitalization is a social process through which marked individuals are dehumanized and confined and how the shape of this process mirrors other systems of marginalization and oppression. Finally, I outline why this particular process of dehumanization and confinement should be a pressing concern for longstanding disciplines such as public health and bioethics, in addition to the interest that this process garners in emergent disciplines like CDS.

Madness as Otherness, Still and Again

Many social theorists have used madness and psychiatry as paradigmatic case studies of social regulation of difference and thus the emerging tools of inquiry have become common in studies of power, disadvantage, and threats to diversity. Many of Michel Foucault’s formative concepts were developed around an examination of madness, psychiatric power, and abnormality as social constructs (e.g., Foucault, 1961/1988, 2003). This thread of inquiry, as described by historian Roy Porter (2002), suggests new directions for understanding madness and its implications: “The history of madness properly written would thus be an account not of disease and its treatment but of questions of freedom and control, knowledge and power” (p. 3). The insights gained in part from this history have been applied widely to other world structures and processes by social scientists, philosophers, and humanities scholars, with a focus on understanding the common mechanisms by which phenomena and people are marked and become objects of excess social and governmental

intervention, surveillance, and control. As Shelley Tremain puts it, “Foucault’s studies of abnormality, madness, and deviance ... were designed to show how these phenomena became thinkable, that is, emerged as problems to which solutions came to be sought” (Tremain, 2017, p. 5).

International social movements in the mid-twentieth century focused on the practical dimensions of the daily lives of psychiatric inmates, showing that these dimensions of their lives were suffused with violence, oppression, and dehumanization. The insights of these movements were a foundational part of trends towards psychiatric deinstitutionalization and movements of anti-psychiatry. For example, Franco Basaglia, who was instrumental in the “democratic psychiatry” movement in Italy, defined the concept of mental illness as a “socio-political problem” rather than as an example of individualized disease, identifying parallels between psychiatric institutionalization and the overarching tendency towards institutionalized violence and exclusion in society:

The main characteristic of these institutions is the clear division between those with power and those without it. The division of roles involves a relationship of abuse and violence between the powerful and powerless, which turns into the exclusion of the powerless from power. Violence and exclusion underlie social relations in our society ...

This is the recent history of a society organized on the clear division between the haves and the have nots, which leads to deceptive dichotomies between the good and the bad, the healthy and the sick, and the respectable and the disreputable. The situation is quite transparent – paternal authority is oppressive and arbitrary; schools are based on threats and blackmail; the employer exploits the worker; asylums destroy mental patients. (Basaglia et al., 1968/1987, pp. 60–61)

To take another example, Thomas Szasz (1973), a leader within the anti-psychiatry movement of that period, similarly described psychiatric power as one of social control:

According to the view I have endeavoured to develop and clarify, however, there is, and can be, no such thing as mental illness or psychiatric treatment; the interventions now designated as "psychiatric treatment" must be clearly identified as voluntary or involuntary: voluntary interventions are things a person does for himself in an effort to change, whereas involuntary interventions are things done to him in an effort to change him against his will; and psychiatry is not a medical but a moral and political enterprise. (p. 306)

It is notable that even though the words of so many prominent social theorists, over so many years, have been dedicated to the entanglement of madness and otherness, medicalization of psychiatric difference and marginalization on its basis are still widely accepted and broadly ignored across the globe, including in the United States.

Numerous academic disciplines and subdisciplines, which themselves tend to merge at margins and intersections of traditional and recent academic categories, could productively take on questions of madness as difference in parallel to other systems of differentiation and marginalization. Feminist disability studies, which defines disability and femaleness in social terms, rather than as natural forms of deficiency, flaw, lack, or excess (Garland-Thomson, 2005), is one promising arena for such critical theoretical interventions. Both mad studies (and the “mad pride” movement from which it derives) and critical disability studies, which are concerned with resisting individualizing and medicalizing approaches by focusing on social restriction and oppression, are other promising arenas of critical intervention (Lewis, 2006). Furthermore, feminist bioethics, which could call for the adoption of a social justice approach to the restoration of rights and dignity that have been denied through psychiatric disablement, is another potential theoretical ally (Thachuk, 2011). Finally, feminist philosophy of disability, a new subfield of philosophy that Tremain introduced, which remains in critical dialogue with these fields, sharing some of their theoretical and political assumptions while retaining a distinct identity from them, is yet another promising line of inquiry for the expansion of critical analyses about madness as difference. Tremain’s work in feminist philosophy of disability is especially distinct insofar as she defines disability as an “apparatus,” that is, as a “far-reaching and systemic matrix of power that contributes to, is inseparable from, and reinforces other apparatuses of historical force relations” (Tremain, 2017, p. 22). At the intersections of Tremain’s work, in particular, and feminist philosophy of disability, more generally, as well as these other related strands of inquiry, emerge productive conversations about how psychiatric categories can be analyzed through the lenses of feminist philosophy and disability studies (e.g. Bergstresser, 2011; Wolframe, 2012; Mollow, 2014).

Initially drawn from Foucault, the concept of biopolitics now refers to multiple strands of interrelated inquiry within the social sciences and humanities, which identify the centrality of the normal and normalization to general principles of exclusion. Within this frame of analysis, disability can be recognized as central to the operation of biopower (Tremain, 2017; Mills, 2018). Intersections of social science, ethics, and public health approaches have contributed empirical works that interweave the study of disability,

marginalization, psychiatry, and stigma in everyday life (e.g. Wiener, 2014; Kleinman, 1999; Bergstresser et al., 2013; Brodwin, 2013; Sabatello et al., 2020). In addition, emergent fields that specifically address psychiatric categories and the concept of developmental disability include mad studies and neurodiversity studies, and both fields of inquiry focus on societal marginalization, emphasizing the inclusion of lived experience and community self-advocacy in academic and policy processes (Price, 2011; Jones & Brown, 2012; McWade et al., 2015).

A CDS approach allows the clear identification of “severe mental illness” as a marked category of social difference which leads to multiple forms of social oppression (Thomas, 2014) and can support the analysis of disability as an apparatus of power relations (Tremain, 2018). While there is a great deal of overlap between CDS and the other academic disciplines discussed above, there nevertheless remains substantial fragmentation and division in academia that impedes both fully multidisciplinary work and social and academic solidarity. “Colonialised, gendered, raced, classed, abled, heterosexed and other such unequal relations need to be deconstructed and built upon new foundations” (Steyn, 2018, p. 8). This rebuilding should include an examination of the enduring parallels between othering and dehumanization of the “mad” and dehumanization of other groups of people who have been systemically stigmatized, marginalized, and subjected to eugenic policies. Historically, groups of people identified as “problems” have often been painted with the same brush. Distinct forms of marginalization and stigmatization too can be identified, such as rhetorics of “primitivism” and inadequate moral, intellectual, and rational development, which have been a major source of imagery to describe mental illness, informing both popular and professional discourse (Lucas & Barrett, 1995). Furthermore, psychiatric marginalization and disadvantage accrue with other categories of difference, creating intersectional situations of repression (Bergstresser, 2011; Friehe, 2020). For example, in the United States, African American men are disproportionately subject to involuntary psychiatric hospitalization (Merritt-Davis and Keshavan, 2006; Davis et al., 2010), shuffled between psychiatric hospitals, homeless shelters, and prisons in the “institutional circuit” (Hopper et al., 1997). The COVID-19 pandemic has disproportionately sickened and killed many of these men, as well as members of other marginalized groups in the United States who at present are confined and institutionalized in prisons and psychiatric hospitals.

COVID-19 in Psychiatric Hospitals and Other Forgotten Institutions in the USA

The arrival of COVID-19 has had a catastrophic impact in the United States, with over 9 million cases and over 230,000 deaths as of November 1, 2020 (*New York Times*, 2020).¹ As in other social and political domains, more moral weight has been placed on the illness and

experiences of some people than on the experiences of other people whose situations continue to be ignored. Over the spring and summer months of 2020, as it became apparent that congregate residential institutions were particularly risky settings for the spread of the virus, special tracking categories were designated by the *New York Times* to track cases in institutions, including jails and prisons, nursing homes, and colleges. An additional category, labeled “Other significant clusters,” also exists among the *New York Times*’s classifications to identify “some of the country’s less-noticed coronavirus clusters.” This category includes a wide range of facilities, including military installations, industrial manufacturing plants, religious institutions, psychiatric hospitals, residential institutions for individuals with developmental disabilities (generally called “developmental centers” and “intermediate care facilities”), homeless shelters, institutions for “troubled” adolescents (“adolescent treatment centers” and “alternative schools”), and treatment centers for substance abuse; most of these facilities include areas with locked residential components, and many of them treat individuals committed involuntarily (either “forensic” or “civil” commitments), individuals under other types of court order, or individuals under conditions of severe scarcity and duress. In short, there is clear evidence that people who reside in congregate settings of this sort are at greater risk from COVID-19 (Landes et al., 2020). Of the top 131 centers listed as “Other significant clusters,” 44 of them are designed to contain individuals deemed developmentally disabled, psychiatrically ill, troubled adolescents, abusers of substances, and the unhoused, and 13 locations are specifically psychiatric hospitals or residential centers, with case numbers ranging from 279 at Trenton Psychiatric Hospital in New Jersey to 55 at Middle Tennessee Mental Health Institute (*New York Times*, 2020).

As COVID-19 began to spread within the United States in spring of 2020, some Northeastern states were the hardest hit initially. New York and New Jersey, in particular, had very high case counts in April and May. By April, substantial frustration was expressed by psychiatric hospital staff in these states, with one New York hospital worker saying: “they treat us the same way they treat the mentally ill. They want to forget us” (Hakim, 2020). New Jersey, in addition, also had notably high counts in particular types of institutional settings, with the country’s highest case count at any psychiatric hospital (279 cases) and nursing home (375 cases), as well as the second highest national count at a developmental center (324 cases) (*New York Times*, 2020).² Around 2,500 prisoners were released from Rikers Island, New York by mid-June (Rodriguez, 2020) and New Jersey released 1,200 prisoners by October through a state executive order, with plans to release 3,000 more by the end of the year (Vogt, 2020). So, it would be reasonable to have expected that a similar public and

public-health system outcry would be mobilized to encourage decarceration and limits on new involuntary treatment orders in psychiatric hospital settings, settings that are also high-risk locations where residents often cannot leave by choice. However, no such outcry occurred. To the contrary, though the situation in these institutions was severe, individuals were not released from hospitals nor were the criteria for involuntary commitment made more stringent; rather, protections and procedures were cut back, and some of the traditional checks on the system were removed, making involuntary commitment easier to implement and relaxing or eliminating the typical requirement for timely discharge planning.

On March 25, 2020, New York State issued a statement that documentation regulations would be relaxed in psychiatric hospitals, that the procedure for initiating involuntary treatments could newly be initiated and virtually signed by an off-site psychiatrist: “For [civil commitment] involuntary paperwork, an off-site psychiatrist can print and complete paperwork and then send electronically to an on-site clinician to be placed in the patient's record” (Smith, 2020a). Possible treatment options were limited: “Programs should cancel all therapeutic, rehabilitative, and recreational groups that do not align with physical distancing and other mitigation recommendations.” In addition, the statement decreed that discharge planning could be delayed as long as “attempts” at timeliness were made, that discharge plans “for identified high-risk patients” could be delayed indefinitely.³

Multiple regulations ensuring patient rights and safety have also been waived or relaxed in psychiatric hospitals, including in New York which waived the typical requirement that a physician must examine a patient before ordering “seclusion and restraint,” allowing a licensed nurse practitioner or physician assistant to do so instead. As infections decreased in New York State in June, the emergency declarations were not reversed; rather, they were put into effect “indefinitely” (Smith, 2020b). The US Centers for Disease Control also waived national requirements under the rubric of patient rights for hospitals in states impacted by a widespread COVID-19 outbreak, including the requirement to provide medical records in a timely manner and requirements outlining visitation rights and limiting seclusion.

The rationale for involuntary admission to, or retention in, an inpatient psychiatric unit in the US varies by state and involuntary commitment can be either forensic or civil; in either case, however, a person must be declared mentally ill. Forensic commitments are directly connected to the criminal-justice system. Civil commitments go through civil courts and typically require a professional determination that, without immediate treatment, the person is at risk of significant self-harm, or is a danger to others, or is “gravely disabled” (Dailey et al., 2020). In some states, including New Jersey, a risk of danger to property is also

included as a possible criterion. Though the exact term is not always used, the concept of “gravely disabled” requires a determination that, due to mental illness, an individual is unable to provide for their own basic needs, with risk of psychiatric deterioration sometimes included as part of this definition. For example, in Connecticut:

“Gravely disabled” refers to a person who, due to mental or emotional impairment, is in danger of serious harm because he has failed or is unable to provide for his basic needs such as essential food, clothing, shelter, or safety. The person needs hospital treatment, which is available, but his psychiatric disabilities make him incapable of determining whether to accept it. (Conn. Gen. Stat. Ann., 2006, § 17a-495(a))

New York State does not use the “grave disablement” category, but instead defines a similar category of “in need of involuntary care and treatment” to mean that “a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment” (NY Ment Hygiene L, 2015, § 9.03).

Ethical practice should include that the risks described above be balanced against the risk of contracting COVID-19 in a facility. Consideration should also be given to the ways in which viral infection introduces substantial excess risk in psychiatric populations, who are often taking psychotropic medications that may have dangerous adverse reactions with medications used to treat the virus (Luykx et al., 2020). Antipsychotic medications are also linked to the development of obesity and diabetes (American Diabetes Association, 2004), and psychiatric populations are disproportionately affected by relevant comorbidities such as diabetes, which likely augment the risk of severe forms of infection and death from COVID-19 (Mantovani et al., 2020).

Pandemic-related seclusion and isolation from personal contact also disproportionately impact individuals who are institutionalized and thus likely to be marginalized. New Jersey, by November 2020, reported that statewide 223 of 1,157 state hospital patients and 545 staff tested positive, with 13 patient deaths and 8 staff deaths (New Jersey, 2020). Nevertheless, the state focused its regulation changes primarily on the introduction of telehealth and reduction of virus transmission through sanitary measures. A number of these measures serve to put individuals who are already heavily surveilled and marginalized into an even more isolated situation. For example, in May 2020, Trenton State Hospital stopped visits, dining in the cafeteria, and group programming (Wramage-Caporoso,

2020). It is therefore questionable to what degree in-person social contact has been available to inpatients of New York and New Jersey psychiatric institutions during the pandemic.

Danger to Whom? Risk to What?

In the case of involuntary psychiatric hospitalization during the COVID-19 pandemic in the United States, the concepts of health and risk have been used to maintain the status quo rather than to protect psychiatrically disabled individuals from viral illness. Furthermore, this maintenance process has relied on strategic use of the concepts of health, illness, public safety, and health care to justify keeping individuals in congregate situations where risk of contagion is demonstrably high. Nevertheless, the hypocrisy inherent in this formulation is ignored, or perhaps never perceived at all. Examples can be found both in medical literature and in government public health regulations.

Multiple letters have been written to medical journals by ethics-conscious psychiatrists debating the conditions that necessitate involuntary psychiatric hospitalization of individuals who test positive for COVID-19 and are deemed unable to follow sanitary regulations, either because of their mental illness or for unrelated reasons (Gold et al., 2020; Parker et al., 2020; Sorrentino et al., 2020; Ghossoub & Newman, 2020). This situation is considered to be a potential “danger” to others, where these others include health-facility staff and individuals in the general community. While it is heartening that these psychiatrists wrote the letters to implore other psychiatrists not to abuse commitment laws by hospitalizing potential patients deemed mentally ill due to viral infection and regardless of current severity of their psychiatric symptoms, it is less heartening that psychiatrists felt compelled to write the letters because they had already witnessed this type of inappropriate use of commitment law during the pandemic.

A notable exception is a column written by psychiatrist Brian Barnett (2020), who admits explicit concern for inpatients in a pandemic. He states: “I am concerned for my inpatients. There is no guarantee we can keep them safe from this insidious threat, and many of them are at high risk for serious COVID-19 complications” (p. 979). It is also notable that this letter appears in the “Personal Accounts” section of *Psychiatric Service*, a trade journal that is co-edited by Pat Deegan, Ph.D., a prominent researcher who works on advocacy for recovery empowerment for mental health services users and was herself diagnosed with schizophrenia as a teenager (Deegan, 2020). The contributions of individuals with lived experience of the mental-health system process allows a wider range of viewpoints to be heard in general.

Bioethics commentaries have been written that express concern for the serious risk of infection within psychiatric hospitals, but they do not typically go on to argue for decarceration of uninfected residents, not even of residents who are still present in the system merely because their discharge process has been delayed. Instead, these commentaries, after mentioning the preferability of voluntary hospitalization because of its higher effectiveness, eventually draw conclusions according to which most involuntary hospitalization should proceed as normal. For example: “However, should shared decision-making fail, more assertive interventions may be needed. These include judicial review and action, where a judge is petitioned to order the treatment of a patient over their objection” (Russ et al., 2020, p. 579). Alongside discussions of risks to inpatients due to COVID-19, there are descriptions of risks to the perpetuation of the system that might occur if patients catch the virus: “Contracting Covid-19 during an involuntary psychiatric hospitalization could reinforce patients’ paranoia and distrust of the health care system, creating yet another future barrier to adequate medical and psychiatric treatment” (Conrad et al., 2020). It is notable that patient mistrust here is cataloged with “paranoia,” even though the psychiatric health care system clearly continues to mismanage the COVID-19 outbreak. Some bioethicists have in addition pushed for a return to the “asylum” model of psychiatric care (Sisti et al., 2015), essentially supporting medicalization processes.⁴

It is instructive to compare discussions of decarceration from jails and prisons due to COVID-19 with discussions around involuntary psychiatric confinement and COVID-19. For example, arguments for the former include that “Properly managed, correctional depopulation will prevent considerable COVID-19 morbidity and mortality and reduce prevailing socioeconomic and health inequities” (Franco-Paredes et al., 2020, p. 1) and, in addition, that the unjust and dire situation in US correctional facilities “necessitates rapid decarceration measures that effectively balance public safety and public health” (Abraham et al., 2020, p. 780). The potential dangers of releasing prisoners are described, in general, as outweighed by the injustice of mass incarceration in the United States, which disproportionately impacts already marginalized groups.

In April 2020, Public Defender Service filed an emergency motion in the District of Columbia Superior Court to release prisoners and “some mentally ill people from District facilities and detainees at the city’s only halfway house for men because of the coronavirus” (Moyer, 2020). This motion applied only to individuals charged with misdemeanors who were undergoing competency proceedings, with no mention of civilly committed individuals who had not been charged with any crime. A Federal judge later intervened, but only to force

city officials to change procedures at St Elizabeth’s psychiatric hospital to “individually quarantine patients exposed to the coronavirus, to limit employees from moving between units each workday, and to conduct regular system-wide testing even for those without symptoms” (Peak, 2020).

In their argument that health care professionals should “lead the charge” for prison-system decarceration, Sivashanker and colleagues (2020) mention that people with mental illness are disproportionately imprisoned, but rather than draw parallel calls for decarceration from psychiatric hospitals, they blame “psychiatric deinstitutionalisation” for this situation. For the United States, this charge amounts to a well-worn trope that serves to absolve the government from responsibility for closing hospitals without providing any sort of compensatory medical, financial, housing, educational, or financial support. A relevant comparison can be made to Italy, which did create a national system of post-deinstitutionalization community mental health care and general health care, as well as offering many other general forms of social support that the United States lacks (Amaddeo et al., 2012). With neither large long-term psychiatric hospitals nor involuntary commitment for reasons of hypothetical danger to self or others, Italy’s violent crime rates are comparatively low. For example, the 2018 intentional homicide rate (per 100,000) in the United States is 5.0, while in Italy it is 0.6 (UNODC, 2020). The prison population rate per 100,000 for 2018 in the United States was 647.5, while in Italy it was 100.8 (UNODC, 2020). Italy’s suicide rate is less than half that of the United States (OECD, 2019).

The concepts of danger, risk, and public safety are inextricably intertwined with the status quo of psychiatric systems. In many cases, these concepts are so embedded in these systems as to be taken for granted as necessary components of health and personal safety. As a result, the underlying patterns of systemic marginalization and exclusion to which they contribute can become invisible. Robert Castel (1991) explains that systems have shifted towards a calculation of risk at population levels, with a new focus on “the probabilistic and abstract existence of risks. One does not *start from* a conflictual situation observable in experience, rather one *deduces* it from a general definition of the dangers one wishes to prevent” (Castel, 1991, pp. 287–288). Nevertheless, while the word “danger” has sometimes been recast as “risk” in lists of criteria for involuntary civil commitment, dangerousness is still a prominent feature of the broad conception of the dangers that one wishes to prevent, leaving the psychiatric system suffused with both risk prediction and the underlying fear of danger from madness.

Many psychiatrists supported the advent of the “grave disablement” criterion and similar criteria for involuntary treatment as a means with which to combat the stigma that “dangerousness” labels impart to the process; however, the concept of “dangerous” is also quite problematic. Determinations of risk in these cases are not only based on a need for support in daily life, but rather on the assumption that, due to a person’s diagnosis of psychiatric disability, they are unable to “rationally” determine their own needs. Often this assumption is expressed as “lack of insight” into one’s own illness. As Margaret Price (2011) notes, however, along with the ideas of “objectivity” and “scientific,” the rhetoric of rationality itself has been and can be an oppressive construct meant to designate groups of individuals who should be excluded from decision-making of all sorts. This rhetorical gesture reinforces the notion that mental disability, and by extension disability in general, is inherently connected to a lack of autonomous capacity. In the United States and elsewhere, the notion of autonomy rests at the center of academic bioethics (Tremain, 2017), with the discipline at large tending to discard any curiosity about the lives of certain people once a determination of “limited capacity” or lack of “rationality” is proclaimed. Once a person’s autonomy can be discounted, all that remains, according to the bioethicist, is beneficence, which in the case of involuntary psychiatric confinement tends towards the default of paternal decision-making for another’s own good. Moving beyond the disciplinary focus on individual autonomy and away from the dichotomization of autonomy and beneficence could allow bioethics scholars to rediscover hidden yet systematic processes of dehumanization that underlie psychiatric disablement.

Conclusion: Remembering and Refusing to Forget

As academic disciplines continue to struggle with systemic inequalities and the meanings of difference, it is important to acknowledge that populations which are isolated, marginalized, and silenced can be easily forgotten and ignored. Remembering is worth the effort. One might think, after all of the academic and social revelations that have occurred in the United States since the mid-twentieth century, that Americans would reflexively consider the socially oppressive aspect of involuntary hospitalization in psychiatry. In the United States, however, involuntary commitment continues to be classified as a medical problem, a legal problem, and a problem of danger and risk, rather than a question of human rights. Careful observation of the narratives that surround institutionalization show that it remains a biopolitical process focused on rhetoric of rationality and the management of risk.

Human beings in the United States continue to be institutionalized in psychiatric hospitals and denied control over their own lives, including denial of their right to avoid

congregate situations where the transmission of COVID-19 is common. These people have been forgotten. Although concern for people involuntarily institutionalized and other invisible populations should be of interest to emergent disciplines like CDS and disability studies, the circumstances of these populations should also be a pressing concern for longstanding disciplines such as public health and bioethics; at present, they are not.

Although there is a promising trend in academic bioethics to attend to questions of social justice, such as the issues that the Black Lives Matter movement has made evident and the inhumane detention of immigrants in the United States (e.g., Mithani et al., 2020; Pilkington, 2020), a disciplinary core remains resistant to engaging deeply with questions of social oppression or with the narratives of lived experience that members of marginalized groups and people deemed abnormal tell (Asch, 2001; Ouellette, 2011; Tremain, 2017; Hall, 2017). Hope for the future can be glimpsed, nevertheless, in the prospect of shared insight between disciplines, including between a disability-conscious bioethics, feminist philosophies of disability, and human rights approaches to health and disability (United Nations, 2006; Farmer, 2005). Medical education curricula can begin to teach future doctors how to envision and carry out structural interventions (Metzl & Hansen, 2014). Inclusion can be an ethical project (Allan, 2005) and, likewise, ethics can be inclusive. What remains to be seen is whether the tenacious strength of academic, social, and institutional boundaries can be overcome and reconfigured enough to include the concerns and voices of the people who have been forgotten.

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¹ All current data are taken from *The New York Times* online feature “Covid in the U.S.: Latest Map and Case Count,” which is updated continuously. All numbers cited correspond to the data presented on November 1, 2020, with page marked as “Updated November 1, 2020, 9:22 A.M. E.T.”

² Trenton Psychiatric Hospital, Trenton NJ; Bergen New Bridge Medical Center nursing home, Paramus NJ; New Lisbon Developmental Center, New Lisbon NJ.

³ Under the 1999 Olmstead United States Supreme Court decision, it was that the unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act, and that failure to enact timely discharge plans in psychiatric hospitals was an example of this type of discrimination.

⁴ I wrote a letter to *JAMA* in response to this article in February of 2015 outlining the history of abuse and neglect in asylums, and arguing that there is no reason to believe that a new asylum, regardless of how similarly benevolent the current intentions, would evolve differently. The letter was not accepted for publication. There was, on the other hand, a letter published expressing concerns that: “the reintroduction of the asylum system would worsen the plight of persons from ethnic minority backgrounds, based on the discriminatory practices of the health care system in the Western world” (Mfoafo-M’Carthy, 2016, p. 68).