Carceral Politics, Inpatient Psychiatry, and the Pandemic
Risk, Madness, and Containment in COVID-19

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ABSTRACT
In this paper, we discuss how the COVID-19 pandemic offers a particularly salient moment in which to identify and reflect on shifts in psychiatric carcerality in highly concrete ways. Drawing from our own professional and practical experience as inpatient (acute-care) psychiatrists implementing changes in ward policies in light of infection control concerns and linking this experience with insights and tensions between Mad Studies, Critical Prison Studies, and the psychiatric writings of Franz Fanon, we focus on specific ways that therapeutic value is undermined within these complicated and complex settings. Using Repo’s metaphor of “carceral layers,” our analysis considers how particular infection control policies and practices, institutional approaches to pandemic management, and larger ideologies of risk have worked together to produce spatio-temporal aspects of carcerality in a psychiatric acute-care setting in Toronto, Canada.

KEYWORDS
COVID-19, acute psychiatric care, carcerality, madness, risk

It was in these spaces of confinement that Pinel and the psychiatry of the nineteenth century met the mad, and - lest we forget - it was there too that they allowed them to remain, while claiming to be their liberators. Since the mid-seventeenth century, madness had been linked to this place of confinement, and to the gesture that designated it as its natural place. (Foucault, 2006)

As institutional settings, inpatient psychiatric spaces are particularly susceptible to enacting complex carceral actions and practices. This is especially the case for members of Black, Indigenous, and Latinx communities, as well as members of other racialized and minoritized groups, who are more likely than members of dominant social groups to both face chemical and physical restraints and coercive measures in psychiatric settings (Gajwani et al., 2016), and have their actions interpreted through a lens of dangerousness (Vinkers et al., 2010). As a shift from notions of dangerousness to practices of risk assessment, prediction, and management has taken place across psychiatry broadly (Rose, 1998), it is increasingly apparent how institutional policies and practices relating to risk and risk management in psychiatric settings are sites where relations of power are rationalized.

The COVID-19 pandemic has collided with these very issues: it has brought about extensive and rapid changes in policies and practices within health-care institutions in an effort to limit the spread of infection. Newly adopted measures are ostensibly predicated on evolving scientific data about the SARS-CoV-2 virus and its behaviour in various populations and settings. COVID-19 has been found, for instance, to have asymptomatic carriers (Zhao et al., 2020); there are variations in the mechanism of spread based on physiologic events, i.e. generally behaving as a droplet, but sometimes airborne, as during intubation/extubation (Kohanski et al., 2020; Workman & Bleier, 2020); it also has a relatively long period of incubation (Lauer et al., 2020). These findings provide a rationale for the kinds of policies that have
become widespread in hospital wards since March 2020: visitors reduced or eliminated; cohorting of COVID-positive individuals; scaling up best practices around donning and doffing procedures while also directing what kind of personal protective equipment (PPE) is to be used for particular clinical situations versus what is to be used universally; and reducing the movement of hospital service users (and workers) throughout institutional sites, to name a few (see Chopra et al., 2020; Advani et al., 2020; Andrist et al., 2020).

As coercive powers have been extended to a larger range of health-care professionals and public servants – such as emergency measures that enable the compelling of isolation and quarantine – acute psychiatric settings where individuals are involuntarily treated and detained have been especially impacted (Thome et al., 2020). Within such settings, policy and procedure changes carry significant implications in light of connections between the organization and provision of mental-health services and carceral geographies (Schliehe, 2014; Repo, 2019). Such policy changes have taken place despite an explicit goal of many acute-care psychiatric settings, to develop a therapeutic and recovery-oriented milieu.1 And while care nonetheless tends to align with biopolitical mandates of evidence-based medicine and curative norms (Kafer, 2013), we also see that, on the ground, the relations between illness experience, care, and containment are always shifting. The COVID-19 pandemic offers a particularly salient moment in which to identify and reflect on such shifts in highly concrete ways.

In this paper, we examine how the COVID-19 pandemic has impacted spaces of acute psychiatric care, focusing on specific ways that therapeutic value is undermined within these complicated and complex settings. Using Virve Repo’s metaphor of “carceral layers” (Repo, 2019), we closely examine how particular infection control policies and practices, institutional approaches to pandemic management, and larger ideologies of risk have worked together to produce spatio-temporal aspects of carcerality in a psychiatric acute-care setting in Toronto, Canada. We come to this work from our positions of practising psychiatrists, all working for a substantial portion of our respective clinical time during the pandemic on an inpatient mental-health unit at a large, academic hospital in Toronto, Canada.2 We draw together an accounting of our combined experiences implementing a range of infection control policies within the unit, linking our account with intersecting literatures in Mad Studies as well as Critical Prison Studies. Here are two shifts, synced entirely with the pandemic, that we track and assess: (1) the ways in which renewed carceral mandates have been materialized through restraint policies, visitor policies, and off-unit policies and (2) how the use of universal PPE for physicians, staff, and now service users themselves – while necessary for managing infection control – nonetheless reinforces medicalization and diminishes therapeutic relationality within the acute-care space. Taking up the work of Franz Fanon and contemporary philosophical analyses linking Fanon with Foucauldian perspectives on psychiatric practices and relating these critical interventions to work in Mad Studies, we explore the ways in which institutional responses to the pandemic reinforce intersecting tropes of madness and risk, while situating how such tropes materialize particular forms of discipline and disability. Through this analysis, we aim to highlight tensions that exist with respect to relationships between care and containment in acute psychiatric settings – tensions that are exacerbated and shifted to new layers of carcerality within the pandemic context.
Carceral Layers of Resemblance in Pandemic Policies

Is it surprising that prisons resemble factories, schools, barracks, hospitals, which all resemble prisons? (Foucault, 1977)

Foucault’s concept of a “carceral continuum” is where we begin our discussion of policy changes within COVID-19. As Hamlin and Speer suggest, the prison remains the apotheosis of carceral power, but other institutions implement aspects of social control and spatial restriction in a spectrum of carcerality (Hamlin & Speer, 2018). The concept of a continuum emphasizes how spaces referenced as carceral are not all equally repressive, with variations in intensity across a range of sites (Hamlin & Speer, 2018). Institutions ranging from the medical to the penal are part of this continuum. Within literatures surrounding carceral geographies, it has been suggested (with some contention) that what constitutes a carceral space is relative, rather than absolute. Different qualities are thought to determine the conditions of carcerality, including (but not limited to) restriction, confinement, and control (Loughnan, 2018) with space as the key to its enactment (Moran et al., 2018). Debates within this literature aside, it is worth stating that how carceral spaces are conceptualized matters, if one is to be able to understand the role of space to the carceral state, as well as the role that carceral spaces themselves serve (Hamlin and Speer, 2018). To that end, we are drawing on the work of Virve Repo (2019) and the notion of carceral layers within psychiatric institutions, in order to articulate the imbrication of COVID-19 policies with the spectrum of carcerality in an acute-care psychiatric space.

As Repo describes, the concept of carceral layers helps us to understand the mechanisms and levels implicated in the construction of the psychiatric hospital/ward as a carceral space. By focusing on layers, we can understand how different aspects of carcerality are performed and built through the spaces and practices of psychiatric wards – from administrative levels to individual measures, including how laws, regulations, and policies are defined, enacted, misused, and possibly broken. Various layers also intersect and overlap with one another; for instance, legal frameworks are themselves one layer, but such frameworks also transfer power to staff, creating and defining roles of other layers. Within any given layer, there is a spectrum from restrictive/coercive measures to normative practices; these give further definition to the carcerality of a psychiatric ward (Repo, 2019).

As with many psychiatric settings, the carceral layers within our institutional context are both obvious and discrete. An easily identifiable layer is the use of physical restraints to contain an individual whose actions are believed likely to inflict (or have inflicted) bodily injury on themselves or someone else in the setting. Irrespective of whether restraint has been deemed necessary to prevent more serious injury, such a measure is coercive, restrictive, and serves a disciplinary function even when it is not carried out with the intent of “punishment.” More ubiquitous but less overt layers of carcerality include spatializing practices that control the movement of individuals within the ward, as well as on and off the ward itself. Practices such as the use of restraint are combined with other policies that shape movement on the basis of where an individual is located on the ward. For example, a service user is typically brought to our psychiatric intensive care unit (PICU) when they are assessed to be agitated or at risk of significant agitation; the PICU space is a much more highly
observed area than the general ward, with barriers and doors of plexiglass. In contrast, individuals are admitted to a general-ward room, which are more conducive to privacy, if they are felt to be “settled.” Service users in the PICU remain in hospital gowns/pyjamas, whereas service users admitted to the general ward are able to wear their own street clothes. There are layers of locked doors between the PICU and the general ward, restricting movement between these parts of the ward, while the inpatient unit as a whole uses a colour-coded system of “observational levels” to determine where/when a person can move between the PICU, the general ward, and the wider hospital. A pink wristband designates that someone can move about on the general ward (including individuals within the PICU, though they are only enabled to use the general ward at designated times). A yellow wristband indicates that an individual can leave the inpatient unit accompanied by another person (staff, friend, or family member). A green wristband demarcates that a person can go off the ward unaccompanied, at designated break times or when they have requested and been granted a “pass” from the staff. Movement off the unit outside of break times or requested passes is not permitted. Importantly, the wristband system is utilized because it is highly visible – it is quite straightforward to note a wristband colour from the nursing-station desk where the buzzer can unlock a door off the unit: a disciplinary gaze without words. With the onset of the COVID-19 pandemic, we saw, and were implicated in, dramatic changes to policies and practices that shifted these layers of carcerality further.

We watched the death toll climb in Italy. And then New York. And we waited. Echoes of SARS are loud in Toronto. I had a sense that now was our opportunity – potentially our only opportunity – to plan and implement risk-mitigating measures that might protect the service users on our unit and ourselves. How were we going to deal with individuals who needed to remain in isolation because of COVID infection, but who were too unwell or agitated to remain in a single room for fourteen days? The application of physical distancing policies in the setting of a psychiatric ICU, where disinhibited behaviours are common, seemed a futile endeavour. What if a service user refused to be tested? What if a service user with confirmed COVID refused to or was unable to self-isolate? What would justify further restrictions on people hospitalized? How do we maintain least restraint policies? The slow move to action from my less anxious colleagues felt infuriatingly passive. I felt unable to reconcile a “take it as it comes” approach when my mind was envisioning preventable calamities. (LM)

The hospital, as a whole, operates using a “least restraint” policy, which articulates justifications for physical and chemical restraint, while intending to prompt consideration of what would entail the least restrictive/coercive measure for a given situation. The rationale/policy exists whether the justification for use of restraints has been promulgated by the provincial Mental Health Act or the Patient Restraints Minimization Act. In a kind of double-speak, the very definition of chemical or physical “restraint” within the Patient Restraints Minimization Act uses the language, “to place the person under control by the minimal use of such force,” and outlines the context of the act as encouraging hospitals and facilities to use alternative methods to restraints wherever possible, despite the fact that the purpose of the Act is to legitimize that very same use of force (Patient Restraints
Minimization Act 2001, updated 2017). With the pandemic under way, we have become increasingly implicated in how the limits and boundaries of such policies are shifting and the acts that justify such shifts.

The sinking realization that physical restraint might be necessary to prevent transmission of COVID-19 was both disconcerting and damaging. We were conflicted about it, yet resolute that it was necessary to create some kind of policy, so that restraints weren’t being applied ad hoc for the purposes of infection control, without guidance or justification. As inpatient psychiatrists, we have been called on to order the physical restraint for hospitalized individuals in the past – this was always as a measure of last resort, and in response to a palpable and immediate threat of bodily harm. Restraint as a safeguard against an invisible, perhaps even theoretical threat was another matter entirely. (SB, LM, KS)

Self-doubt crept in – was this fear or sensible preparedness? Our COVID screening and isolation algorithm was developed in collaboration with bioethics and infection prevention and control (IPAC) colleagues. I reviewed and incorporated Ontario’s legal framework – the Patient Restraints Minimization Act, Common Law and the Mental Health Act all have provisions that allow for restraint when necessary to prevent serious bodily harm to another. The laws were helpful guideposts and yet these felt like tools selected to justify a gut-wrenching decision I had already made. I cried putting pen to paper. As I imagined this well-reasoned and legally permissible protocol being implemented across my institution, I watched my seemingly clean pedestal of advocacy crumble. This wasn’t supposed to be from my hand. (LM)

As much as health-policy decisions made within outbreaks and pandemics are linked to scientific information and evidence, they also simultaneously reflect deeply held normative beliefs relating to “risk” and danger. Risk is a concept that is itself a nebulous and ever-expecting category that is imbricated with practices of control, the management of uncertainty, and complex notions of safety (Beck, 1992; MacKenzie Bryers & van Teijlingen, 2010). Fears in relation to what constitutes a risk carry cultural weight and serve social functions, despite the seemingly neutral valence of the term. And of course, it is within the discourses surrounding dangerous individuals that the medical and judicial become increasingly intertwined (Foucault, 2003). The imbrication of medical and judicial discourse is particularly prominent at the intersections of disability and race, as those deemed to display unruly, irrational, unstable, or unpredictable behaviour are the same “Others” against whom notions of personhood are constructed (Aho et al., 2017; Erevelles, 2014).

We tried to see what other acute-care settings were doing. Many were working out the same issues, and a common refrain was “how else can we protect our most vulnerable inpatients?” As though risk and danger stemmed from one demarcated group on the unit, while another set of individuals required our protection and care. This kept intersecting with other sorts of logistics that were outside of our control: the acute area (the psychiatric “ICU”) only had two bathrooms, at either end of a fairly narrow space. Straightforward for being able to see into each room from the glassed-in nursing station,
but impossible to maintain physical distancing and the requirements of a private bathroom when someone was placed on contact and droplet precautions as they would be if COVID positive or pending a test. The general ward had single rooms with built-in bathrooms, but someone had to be well enough (i.e., “reliable”) to remain in their room if quarantined. Back to the dichotomization of service users as either dangerous or in need of protection. The question of whether locks could be installed on individual doors kept coming up. This wouldn’t be seclusion—it was an “environmental restraint.” (SB)

We struggled internally and professionally with the administrative aspects of the increased carceralty that we saw evolving on the unit: various presumptions about psychiatric service users and normative judgements regarding their actions justified a much more restrictive environment than we would typically be comfortable with, abetted by legal, bioethics, and infection-control frameworks. And while there was a certain kind of administrative banality to these frameworks, such frameworks ultimately contribute to the ways in which disciplinary practices materialize disability. At the same time, we felt trapped. Doing nothing in advance of having one of these scenarios unfold on our unit was also a recipe for a reactive kind of restriction and confinement, which was possibly more troubling for its tendencies to rely on, and reinforce, tropes of Otherness.

Beyond this, we were grappling with the tension between a clinical rationale that underpins each of these policy changes and the ways that the evolving policies would determine the parameters of the relationships between staff and service users. Chapman, Carey, and Ben-Moshe draw on Homi Bhabha’s “third space” or “the space between” (Bhabha, 2012) to argue that policies and procedures that delimit appropriate standardized responses to patient/inmate/consumer behaviour are a component of the space between staff and service user negotiations and relations, as is the rhetoric that service users benefit from or are transformed by their immersion in the physical space of an institutional site (Chapman et al., 2014). We saw this rhetoric emerge as the language of our policy shifted from using the term “seclusion” (containing a person within a single closed room rather than using physical restraint to prevent exposure on the unit) to the language of “environmental restraint,” to refer to precisely the same scenario. The euphemism didn’t absolve our struggle with the fact that confinement and restraint were conceptualized as useful for (to) the people restrained, as well as for staff and other service users on the unit. That either the Quarantine Act or the Patient Restraints Minimization Act backed up the policy likewise was no comfort.

The announcement went out with seven hours notice on March 20, stating that as of midnight we would join other hospitals in our province in moving to a no visitor policy. The reasoning was to protect the safety of service users and families, but also to conserve “precious” personal protective equipment (PPE). On the same day, our off-ward break periods and overnight passes were restricted for service users on our inpatient psychiatry unit. Our unit has always had a locked door, but that was frequently and easily unlocked to allow for service users, their families, friends, and other healthcare providers to come and go. What would it mean to have this door more closed? What impact would this have on service users’ mental state, already vulnerable as they were admitted for mental health concerns? (KS)
The restraint policy is, perhaps, the most obvious layer of carcerality, insofar as it explicitly engages with issues of confinement on the basis of one’s actions. But across the hospital, other policies have been implemented that also demand consideration, for these are less obvious carceral layers. Within days of the province of Ontario’s declaration of an emergency due to COVID-19, visitors to the hospital were restricted and passes off the unit were eliminated. Regardless of a person’s voluntary versus involuntary legal status, the wristbands were all switched to pink. No service users could leave the unit, even at designated break times. There were no in-person family meetings and no visitors to break up the tedium of the day. Service users indicated that they were increasingly “bored” as group activities were restricted (to maintain distancing between individuals in a given space) and off-unit or out-of-hospital passes were eliminated (due to concerns about exposure to COVID-19 in community settings, bringing this back to the unit). Activities were increasingly crossed out, that is, marked “cancelled” on the large, central, weekly calendar outside the nursing station. As Dominique Moran and Diana Medlicott identify, the temporal and spatial aspects of carceral institutions are experienced synthetically (Moran, 2012; Medlicott, 1999). The dwindling opportunities for programs, events, and group activities on the ward brought about shifts in temporality that stand out as another layer demarcating the increasing carcerality of the unit. The repetitiveness of each day increased and was accompanied by what Medlicott refers to as “dead time” – emptied of events and with decreased interpersonal interaction (Medlicott, 1999).

To understand the carceral implications for psychiatry settings especially, one needs to consider how acute-care psychiatry stands in contrast to the care of medical and surgical floors. Within the latter, confinement is often a temporary (if irritating) circumstance and not necessarily a function of disciplinary practices within the space. In contrast, the presence of magnetic locks that require someone to be permitted in or out of a psychiatric unit speaks to spatial restrictions that place acute psychiatric spaces on the carceral continuum. The restriction of movement of psychiatric service users, moreover, is often justified by virtue of their being, or potentially being, a “risk” to themselves or others: agitated, impulsive, and/or unpredictable due to mental distress. And yet among the aspects of acute-care units that tend to contribute to agitation are practices of confinement themselves, a self-justifying loop that reinforces the need for ongoing disciplinary practices. Boredom and “dead time” are of course issues in medical and surgical areas, though often less so (particularly in acute-care areas), as individuals are discharged much more quickly on the basis of evaluations about physical status than evaluations about psychological status. The focus on medical and surgical units is often rest and restoration of physical function, whereas psychiatric units focus more on active engagement in the activities of psychological recovery. In response to the pandemic, restrictions on the unit were becoming more frequent, stricter, and taking place without input or discussion from the clinical treating teams, enhancing these temporal and spatial aspects of carcerality for psychiatry in particular, given the already-present confinement and disciplinary practices.

The administrative aspects of the pandemic reinforce the carceral layers. Hospitals typically move to an incident management structure – e.g. an “incident command system” – in a time of crisis: decisions and communications are top-down (“command and control”) and...
enacted quickly (Glarum, 2017). When such changes are held within the larger history of the medical-judicial continuum, it becomes easier to recognize how an incident management structure is yet another layered aspect of carcerality. Since the mid-1800s, confinement has become conceptualized as a form of “care,” part of a political rationality that understands degenerate, disabled, or uncivilized peoples as brought “up” to normative standards vis-à-vis optimal conditions imposed from above (Chapman et al., 2014). The shift to an incident management structure is antithetical to shared decision-making with clinical staff, which is sometimes the primary means by which advocacy for psychiatric service users can at least be voiced within an acute-care setting. Just as significant, these administrative and policy changes undermine the sorts of practices that we (as inpatient psychiatrists) tend to think of as both therapeutic and important for assessment: interactions with support people from outside of the inpatient unit and opportunities to increasingly engage with one’s social world outside the observation or intervention of staff are part of a transition away from acute psychiatry care and are often relied upon in relation to determinations of voluntary status or discharge decision-making. Often prior to the pandemic, clinical interactions on Mondays, with service users who had enjoyed passes out of the unit, involved discussion of family dinners and haircuts. As these passes were no longer available, it was a kind of conservatism that took the place of the “dignity of risk” (Perske, 1972). Yet we could also appreciate how the limitations placed on these parts of our usual practice were conceptualized within the parameters of an infection-control rationale.

As a team, we had lengthy discussions about whether service users could make phone calls using the shared telephone on the unit. Did they need to wear masks while talking? Who was responsible for cleaning the phone with the anti-viral wipes afterwards? Similarly, how would people eat together? Shared meals on the unit was a time for people to socialize and to work on overcoming anxieties (they are of course also used by staff for observations relating to service users’ mental state). We had previously prided ourselves for the group therapy and activity programming offered on our inpatient ward, as it demarcated the space as one with therapeutic intent, not just containment. Now we were limiting the number of people in the shared dining and television room; group outings were stopped, and many other activities were put on hold. We were encouraging people to eat alone in their rooms. Nursing staff would deliver trays to doors. (SB, KS)

The intersections between the restriction of movement and the concept of risk were exacerbated by our feeling that, when we were discharging service users, it was to an entirely different landscape than when they had entered. A family member of a newly discharged individual had asked prior to their leaving hospital, “Do they know there’s a pandemic?” which highlighted just how radically different the world had become, how isolated service users were from this new world, and the intersections of time and space within the carceral geography of the inpatient unit.

On June 17, our hospital implemented an Essential Care Partner (ECP) policy which would enable people hospitalized to have someone visit. The policy differentiated between “priority categories” of service users across the hospital and intersected with
“hospital phases” depending on COVID status. It was a complex, yet somewhat algorithmic approach. Decisions of ECP visits needed to be approved by the nursing manager and the most responsible provider, which was usually the physician, in conjunction with the care team. Working on different units as part of my position took me off of the psychiatric ward and over to medical and surgical floors, I heard that the ECP policy was implemented in divergent ways. How strict the staff were in requiring that the “official paperwork” be submitted ahead of time before allowing someone to enter the hospital varied. How could staff members track each visitor who came to the unit to ensure that it was always the same person (the designated “ECP”) coming. Ultimately, this meant differential access to outside goods and relationships for different individuals who were hospitalized. Those who had loved ones who could get to the hospital could have food delivered, receive fresh clothing, toiletries; while those without family or friends (nearby or at all) had only what they had brought to hospital and were left to eat only the food provided by the hospital. As the case numbers decreased over the summer months, restrictions were lifted, but not for everyone – those on non-psychiatric units appeared to be able to move much more freely within the hospital and go outside. (KS)

That psychiatric service users on the inpatient unit seemed to be treated as more risky and more unreliable compared to other hospitalized individuals was not surprising to our nursing and physician staff and a frequent source of contention, with many staff advocating during morning rounds and safety huddles for greater balance and fairness in how policies were implemented. As much as normative judgements concerning risk and dangerousness may be enacted within the acute psychiatric setting, they may be even more pronounced in relation to psychiatry service users’ positionalities within the larger general hospital context.

The second wave of the pandemic is now upon us, in much of North America, and again we see policy and practice implications that intersect with the continuum of carcerality. In clinical areas outside of our psychiatry inpatient unit, for instance, the consultation of medical psychiatrists is often solicited to help with expression of distress or mental health symptoms amongst individuals admitted to medical or surgical units. At some points, we have been asked to designate issues with which they are challenged as a form of mental health “crisis,” in order to facilitate additional visitors (who continue to be termed, “essential care partners” within the new iteration of the visitor policy). This policy has again restricted who is able to enter the hospital, but with an attempt to address concerns from earlier in the pandemic, namely, that individuals who are very young, those who have critical illnesses, and those in “crisis” might need more support than what the blanket visitor policy allows. We appreciate that there has been thought put toward ways to build flexibility for circumstance, while balancing this with the risks of infection within the hospital given the rising community spread of COVID-19. That said, we cannot help but ask about the unintended consequences of labelling expected distress responses to difficult and challenging life situations as mental health crises.

As numerous scholars within the fields of Mad Studies and critical psychiatry have identified, this labelling can reflect a diagnostic or criterion “creep” that has significant implications for medicalization and a hegemonic wielding of the bifurcation between normal/abnormal (Kirschner, 2013). In particular, we struggle with the displacement of distress generated by
institutional policies designed to manage infection risk onto individuals and then framing this distress as a mental health crisis to work around it, for the very reason that it absolves institutions from the onus of responsibility in relation to the impacts and consequences of policy decisions. Visitor policies may indeed need to be restricted further but the weight and impact of these decisions cannot be obfuscated through individualizing of distress.

Medicalization and its Sociopolitical Consequences

As a psychiatrist, I don’t typically wear scrubs in the hospital. That changed when COVID started. First the scrubs, then masks, then masks and face shields. I was reticent about the scrubs, which were the first change to my work wear. I was mindful of protecting myself and my family, but this felt like a very outward sign that the situation with the pandemic was dangerous and reinforced the idea of contagion. With the psychiatrists now wearing scrubs, nursing staff who regularly wear these types of uniforms joked that we looked like “mini-surgeons.” Soon after, the hospital’s universal masking policy was put in place. In psychiatry, speaking is our main way of connecting and communicating – the masks limited this. Concerned that service users may be alarmed by these changes, staff members engaged people in regular unit meetings; however, service users on the unit seemed to take this in stride. When the announcement was made that staff members would now be wearing scrubs and masks because of the pandemic, one service user told me that this was “just fine” and “nothing to be concerned about.” In some ways, this uniform shifted the distinction of roles on the ward. The physicians, pharmacist, social worker, occupational and recreational therapist, administrative staff, and many nurses now wore identical hospital-issued uniforms and equipment. Our name tags were small, you couldn’t see someone’s smile or facial expression, and you couldn’t hear their voice clearly. Service users were not required to wear masks. Did this increase the differentiation of “us/Them” between service users and staff? Did it change the perception of the clinical staff as a singular unit? When we added clear plastic visors or goggles to this outfit in April, it felt like another barrier to communication, another barrier to separate and segregate. As the staff pulled down the face shields each time they left the nursing station, it reminded me a bit of riot gear. (KS)

As the pandemic has worn on, our gestures of care have been increasingly structured through layers of cloth and PPE that limit mutuality, shifting the relationality between staff and service users. To think through this aspect of carcerality, we turn to Franz Fanon’s psychiatric writings. Here we find an emphasis on the obligations of an institution to create an environment structured such that individuals might “finally feel understood” and the encounters disalienating (Fanon and Asselah, 1957, cited in Gibson and Beneduce, 2017). Focusing on the caregiver-patient relationship, Fanon articulates how staff (physicians, nurses, social workers, administrators) can step away from taking the form of repressive guards and instead reflect agentic encounters of freedoms for both care provider and care receiver (Fanon and Géronimi, 1959, trans. 2018). As a practice, gestures of care hold within them the possibility of reciprocity and mutuality (Mbembe, 2019) – they are not merely modes of disciplinary practice.
But reciprocity and recognition require the reforming of social relations within clinical settings – reforms that break down objectifying or “thingifying” practices (Gibson and Beneduce, 2017). The changes to PPE indexed more than infection control efforts to stop contaminating droplets from entering one’s mucosa, or the value of simple, inexpensive, easy to launder sanitary clothing such as scrubs. As much as these changes might have been necessary precautions in the midst of a viral pandemic, they index a kind of medicalization, separating staff from service users, solidifying roles and hierarchies within the institutional setting. Typically, pediatric, as well as psychiatric, clinical spaces avoid the standard physician’s white coat for exactly this reason – it symbolizes medical authority, even as much as it has been rebranded as a marker of cleanliness, beneficence, and compassion (see Hochberg, 2007). As a carceral layer, the shift toward these forms of PPE problematizes the claims to therapeutic environments, despite their being necessary to protect staff, service users, and others both in and outside of the hospital environment from infection. The sociopolitical consequences of this subtle erasure of reciprocity become magnified when we consider this layer in relation to the broader policy changes brought about by the pandemic.

Care, Containment, the Carceral Continuum in COVID-19

We have thus far relied a great deal on Foucauldian-informed discussions of carcerality in psychiatric spaces. There is a tension, of course, between our doing so and our assertion that the pandemic has shifted the inpatient unit further from a therapeutic or recovery-oriented milieu, toward an increasingly carceral space. Foucault’s insights would suggest that “care” has always been intertwined with discipline and that therapeutic notions merely attempt to disguise the moral and political functions of psychiatry as medical ones (Foucault, 2006). One might respond to the concerns about carcerality that we have flagged by asserting that such concerns ought to prompt the eradication of acute psychiatric spaces. Likewise, an anti-carceral analysis also considers critically the issue that some service users chose to remain in hospital voluntarily during the early days of the pandemic, despite the fact that their freedoms were limited by numerous policies and the therapeutic aspects of the unit were undermined both by pandemic-related restrictions and our changing PPE. An anti-carceral stance leads us to acknowledge that the usefulness of hospitalization, for some, is structured by the precarity that they face in the wider community. As prison abolition scholars have identified, crises of housing and carceral systems are intertwined (Hamlin, 2020). That the inpatient unit might actually be a “safe haven” for some individuals still speaks to the larger community continuum of carcerality within which we are situated.

We also acknowledge the importance of service-user perspectives and that we have not formally explored these perspectives within this paper, except with respect to our own reflections on our interactions with service users. That said, a range of literature has demonstrated that health-care providers, service users, and their next of kin differ in their attitudes toward the use of containment and coercive measures (Reisch et al., 2018) and that service user perceptions of coercion are not solely congruent with legal status, but reflect intersections of the voluntary versus involuntary nature of a psychiatric admission as well as the service user’s rating of therapeutic relationship and their sense of the usefulness of hospitalization (Sheehan & Burns, 2011; Golay et al., 2019).
Our experiences as inpatient psychiatrists open us to the possibility that psychiatric services might at times be needed and welcomed by service users themselves, and that the spaces of acute-care psychiatry are not only valued for a role that they might play in regulating social or moral norms, or the troubled way in which hospitalization can be an answer to precarity. As much as the Mad Studies literature has been crucial for identifying how experiences of psychiatrization vary materially, based on shifting positionalities and placements along multiple axes of social power, it is more firmly rooted in projects of abolition (Menzies et al., 2013) than our own stances. Nonetheless, we take seriously the idea that, from a service user’s perspective, psychiatric care can be simultaneously reflective of both care and carcerality. We turn briefly now to Margaret Price’s work on disability, desire, and the complexities of pain to articulate this further.

Price, in “The bodymind problem and the possibilities of pain” (2015), discusses how forms of mental disability (like physical disability) are contingent on the organization of the world; at the same time, as phenomena, mental disabilities are also contingent on the affective response of those who observe and interpret them. Price’s solution is to consider pain (and severe forms of mental distress, including mental distress that might be labelled psychosis) through a feminist disability studies (DS) ethics of care. Writes Price:

> care must emerge between subjects considered to be equality valuable . . . To be “considered equally valuable” when I am in the midst of a violent break means to be treated as someone who is having a meaningful experience, even if my actions are not always safe (and thus sometimes need to be curtailed). (Price, 2015)

Curtailing harmful actions, on Price’s account, cannot be done in a way that fails to see what is communicated within the act. Words and gestures, to hold the balance of containment and care, need to be directed toward a witnessing and alleviation of pain, rather than the denial of its reality, as often happens in psychiatric settings (Price, 2015).

To think through the tensions between care and containment further within our own positionalities as psychiatrists, we return to the writings of Franz Fanon. Contra Foucault, Fanon does not argue that the function of psychiatry relates entirely to maintaining social order, though it is often mobilized in such a direction. For as much as Fanon criticizes the practices of psychologists and psychiatrists in relation to their political motivations and use by colonial powers, he makes explicit his own use of psychiatric practice as a positive political force (Taylor, 2010). He also emphasizes the importance of understanding relationships between madness, politics, and psychiatry (Eromosele, 2020). As Femi Eromosele explains, the conscription of Fanon to deeply constructivist views of madness is not entirely aligned with the larger body of his work. “While Fanon emphasizes the impact of political, economic, and social factors in the development and understanding of madness, he is never in doubt that what he is dealing with are mental disorders, palpable aberrations in human functioning” (Eromosele, 2020). Fanon also stops short of rejecting biological explanations relating to mental disorders. Writes Alice Cherki, “Fanon did not deny the existence of madness. He was no anti-psychiatrist . . . However, he always advocated for the relational, personal, and institutional context that favored the emergence of speech and the retrieval of fragments of histories suffered, silenced, forgotten, and especially censored” (Cherki, 2017).
There is an alignment between Fanon’s view of what a positive psychiatric practice could entail, and the witnessing within a feminist DS ethics of care that Price articulates.

Fanon’s critical ethnopsychiatry was oriented toward exposing and undermining the kind of psychiatry that reifies individuals within narrow diagnostic categories even as it attempts to approach cultural forms and processes, calling out the ways in which racism was deeply embedded within the psychiatric practices of his time (Gibson and Beneduce, 2017). Similarly, Price raises two challenging questions at the end of the piece that speak to the issues that we struggle with as psychiatrists and with which the psychiatrist Fanon struggled. What if the pain or harm at hand is directed toward another rather than to oneself? What if the individual inflicting harm and the one attempting to curtail this harm inhabit very different positions of power, especially those that end in being enacted through transnational violence (such as war)? (Price, 2015). These questions highlight a tension between Fanon, critical Disability Studies, and the aspects of Mad Studies that would move quickly past the issue of pain to that desiring madness and mad identity.4

In reflecting on the ways in which policies and practices enacted within our institution have generated further shifts in psychiatric carcerality within the COVID-19 pandemic, it strikes us that thinking through these measures with Fanon and Price leads us to our own set of challenging questions. First, is it possible that containment can be a part of care within the context of the inpatient setting? Our analysis thus far wavers on the issue on whether containment is too close to confinement, whether containment is too carceral to lessen the grip of discipline and reflect the kind of care that Fanon emphasizes as geared toward returning freedom to those who are struggling with mental distress. The carcerality of containment is particularly challenging when care/containment takes place within a sociopolitical context of differential powers and authority, as well as in light of the particulars of the intersectional identities of service users/service providers.

More pressing at this juncture is the extent to which having a dynamic balance between containment and care is even possible within the COVID-19 pandemic. We have a less optimistic response here, in light of the intensified and shifted carceral layers. If care and containment are to not be entirely at odds with one another, a broader context of mutuality is required than the supervision and control that the pandemic reinforces.

ENDNOTES
1. In contrast to the overlap between carceral spaces and involuntary admission to closed inpatient wards, inpatient psychiatry units are also considered “new” spaces of care, with greater aspects of permeability and transition between hospital and community life (see Curtis et al., 2009).
2. To further position ourselves within this analysis: as authors, each of us identifies as white settlers and as cis women who generally live without significant ongoing disability. We each spend some of our clinical work in acute psychiatric settings (e.g. the inpatient unit, the emergency department), but also have additional areas of focus – for instance, LM and KS also work in the area of medical psychiatry. We are also researchers with a diverse set of interests, from quality and safety (KS), to functional movement disorders (LM), to feminist philosophy of science/science and technology studies (SB). One important positionality that we do not hold or endeavour to represent is the position of psychiatry service users themselves. This is clearly a perspective that would add important complexity to the issues we raise in this paper.
3. Appendix 1 describes the restraint algorithm created at our institution for contending with COVID-19 related infection risks within acute-care psychiatric spaces. The algorithm is a two-page document
beginning with a red diamond labelled “COVID SCREEN” and negative versus positive as options from this point. Negative screen leads to treatment as usual. Positive screen leads to a decision box titled “NP Swab” (nasopharyngeal swab). Choices are then detailed from the NP Swab decision box, including determining whether an individual can self-isolate or not. Assessments are required for need for detention in hospital, and the next decision point identified as to how they are being detained (i.e. under the Mental Health Act or not). The decision tree continues to ask whether the individual is capable with respect to refusing a swab, and which additional legislative Acts would justify the use of restraints for the purposes of isolation if a capable individual with symptoms continues to refuse an NP swab. Isolation via environmental restraints would be potentially applied for up to 14 days in the absence of an NP swab. Text boxes also outline additional steps that should be taken, including education regarding the importance of swabs, language-specific signage for the individual’s room, offering activities and as-needed medication to manage boredom or agitation, and steps for managing exit-seeking from one’s room if the individual is isolated. The second page of the algorithm outlines the algorithm rationale as well as legal information and considerations from hospital bioethics. See https://www.clpsychiatry.org/wp-content/uploads/University-Health-Network-Covid-Screening-and-Isolation-Algorithm-041620.pdf

4. Femi Eromosele offers a thorough discussion of the tensions between Fanon and Mad Studies, additionally identifying that Fanon’s observations on psychiatry and the formation of subjectivity signal a contradiction or ambiguity surrounding the relationships between madness, subjectivity, and freedom that leads his work to diverge from the arguments that subtend Mad activism. (See Eromosele, 2020.)

REFERENCES


Appendix 1

**UHN Centre for Mental Health Protocol for Patients Unable to Self-Isolate**

1. Patient education
2. Language-specific signage placed in patient’s room:
   *To prevent spread of the virus, you MUST stay in your room. If unable to check required*
3. Proactively offer activities and PRN medication to help manage boredom and agitation
4. Use verbal redirection if patient attempts to exit their room
5. If patient continues to exit-seek from their room, use chemical and/or mechanical restraint. This is for the safety of co-patients and staff.

**COVID SCREEN**

- Positive
  - NP Swab
    - Can the patient self-isolate?
      - Yes
        - Is pt detained under MHA on basis of COVID-related risk?
          - Yes
            - Apply environmental restraint or other forms of restraint as needed**
          - No
            - Is pt capable of consenting to COVID-related tx?
              - Yes
                - Is there a SDM immediately available?
                  - Yes
                    - Obtain SDM consent for restraint under healthcare consent act (HCCA)
                  - No
                    - If urgent, restrain under Patient Restraint Minimization Act (PRMA)
              - No
                - Use clinical judgment. If necessary, restrain under PRMA. Otherwise, consult IPAC for potential AMA discharge
            - No
              - Is pt detained under MHA?
                - Yes
                  - Assess need for detention in hospital and COVID-related treatment capacity
                - No
                  - Conclude to isolate patient as per IPAC recommendations & clinically monitor
          - No
            - Conclude to isolate patient as per IPAC recommendations & clinically monitor
        - Negative
          - Isolate and Await Test Results (In the absence of NP swab, isolate for 14 days)
    - Ongoing education
  - No
    - Treatment as usual
- Negative
  - Contact IPAC for guidance on discontinuation of isolation, treatment as usual